Alliance Care (Dales Homes) Limited

Hungerford Care Home

Inspection report

Wantage Road
Newtown
Hungerford
Berkshire
RG17 0PN

Tel: 01488682002
Website: www.brighterkind.com/hungerford

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Hungerford Care Home is a nursing home providing personal and nursing care to up to 59 people in one adapted building. The service provides support to older people and people with physical disabilities. At the time of our inspection there were 42 people using the service.

People's experience of using this service and what we found
People and staff told us they felt there had been a lack of leadership at the service which had led to concerns not being addressed and people and staff not feeling listened to. Quality assurance systems had not been effective in ensuring people's opinions were heard and improvements in the quality of the service made. Where feedback had been sought, this had not been acted upon.

Risks to people's safety and well-being were not consistently monitored and there was a lack of guidance for staff in supporting people's emotional needs. Some people told us they had to wait for their care due to staff always being busy. Staff told us they did not always have time to fully support people with their care or spend time with them socially. The home was not always cleaned to a good standard and there was a strong odour in some areas.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The principles of the Mental Capacity Act 2005 were not always followed to ensure people's legal rights were protected.

At the time of our inspection a new management team had been in post for 3 weeks. During this time, they had made progress in reviewing the current concerns and implementing actions to monitor and address these areas. People and staff felt the new management team were listening to concerns and trust was being built. The provider ensured CQC were notified of concerns in line with their statutory responsibilities.

People had access to healthcare professionals when required and received their medicines in line with their prescriptions. People provided mixed responses regarding the quality of the food provided but confirmed they were always offered a choice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection – The date of the last inspection at which we awarded a rating was 3 November 2017 and the service was rated good.

Why we inspected
We undertook this inspection as part of a random selection of services rated good and outstanding.

This was a focused inspection which looked at the key questions of Safe, Effective and Well-led. For those

key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hungerford Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to people's safe care and treatment, consent to care and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Hungerford Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 3 inspectors.

Service and service type
Hungerford Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hungerford Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was no registered manager in post. A manager had begun their employment at Hungerford Care Home 3 weeks prior to our inspection and had started the process of registering with the CQC.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since their registration. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 8 people who lived at Hungerford Care Home and 3 relatives about their experience of the care provided. We spoke with 12 members of staff including the manager, regional support manager, regional manager, nurses, and care staff. We reviewed a range of records including 9 people's care plans and medicines records. We looked at recruitment checks for 3 staff members. A variety of records relating to the management of the service, including policies and audits was also reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's safety and wellbeing were not always robustly managed. Hungerford Care Home supported a number of people living with dementia, some of whom experienced distress and anxiety at times. Systems for monitoring this were not consistently completed or reviewed to identify possible triggers and any action required. Staff told us they were fearful for their safety when supporting one person as the person would regularly become highly distressed and confused. There was no guidance for staff to follow regarding how to support the person. One staff member responsible for implementing care records told us, "I know what I do (to support the person) but it's hard to know how to write it down for staff."
- Staff did not always respond to people's anxiety to ensure others felt safe. We observed one person shouting and appearing agitated. Staff did not respond to the person's agitation for over 30 minutes and did not recognise the impact this was having on others. There was limited guidance for staff on how to minimise the risk of this happening or how to respond to the person despite staff and records confirming this was a regular occurrence.
- Accidents and incidents were not always reviewed in detail to ensure risks were minimised and lessons learnt. Although records of incidents were maintained, details of how these had been investigated and the action taken was not always recorded in detail. Records showed that some incidents recorded had taken several months to be reviewed and concluded. This meant there was a risk of incidents such as falls and medicines errors happening again.
- People's fluid intake levels were not always monitored to ensure good hydration was maintained. The recording of people's fluid intake varied, and systems were not followed to record the total amount people drank each day. We observed some people were left with drinks beside them for long periods without support from staff to drink. This presented additional risks to people whose drinks were made using prescribed fluid thickeners as the consistency may change if not consumed in a timely way.
- Risks within the environment were not always identified and addressed. At the top of one staircase a door/gate had been fitted. The lock could easily be reached from both sides. No risk assessment of people's safety had been completed prior to our inspection.

The failure to ensure risks to people consistently received safe care and treatment was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the manager and regional support team provided assurances they were aware of concerns regarding risk management. They shared information regarding how they intended to approach these issues including a full review of care records, skills mentoring with staff and greater attention to detail when addressing accidents and incidents. We received evidence these systems were in the process of being

implemented.
● We found other risks were managed well. This included monitoring risks such as nutrition, specific health conditions and skin integrity. Staff were aware of the support people required in these areas and records showed this was being provided.

Staffing and recruitment
● Staff were not effectively deployed in all areas of the home to ensure people's care could be delivered in a timely way. Once person told us, "I have to wait for the toilet. I can be in agony but there's no staff." One relative told us, "You go looking for a carer and it can take a long time to find anyone."
● Staff told us that due to staffing levels and the routines of the home they did not always have time to fully support people with their care. One staff member said, "If we give personal care to everyone, then we can't do the tea trolley in the morning, because there is just not time. People have to wait for care. People complain. Most people are in bed and need 2 staff. We end up giving people a freshen up, rather than a full wash."
● We observed staff were constantly busy supporting people with care, food and completing functional tasks around the home. This meant on occasions people were left in communal areas without being able to access support. Staff did not have the opportunity to spend time with people who were cared for in bed which placed people at risk of social isolation. One staff member told us, "They (people) have so many stories to tell but I have to say I don't have time and leave them. I would like to sit and hear their stories."
● No system was in place to review how long it took staff to respond to call bells. This meant the provider was unable to assure themselves people were being supported promptly with their needs.

The failure to ensure sufficient staff were effectively deployed to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and regional team were in the process of reviewing people's dependency and engaging with staff to review staffing levels. They had identified changes were required in the day-to-day routines of the home which would ensure staff time was used more effectively and people's care was more personalised.
● In one area of the home people told us staff were on hand when they needed them. One person told us, "I just press the bell and they (staff) come. I'm very happy."
● Staff were recruited safely. Relevant checks were made to ensure staff were suitable for their roles including Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. There was a strong odour in the home. The manager told us this had improved following the purchase of 20 new mattresses. We found prior to this mattress audits had not been completed to identify the concern. The lack of thorough cleaning and failure to identify the cause of malodours put people at increased risk of infection.
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. Some areas of the home were not cleaned to a good standard. The manager and regional team acknowledged areas needed a deep clean, new carpets and furnishings. They had begun to implement plans to address these concerns and orders for additional cleaning and furniture had been placed.
● We were not assured that the provider was preventing visitors from catching and spreading infections due to the need for additional cleaning and monitoring as stated above.

The failure to implement robust infection prevention and control systems was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was admitting people safely to the service. We found areas
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at Hungerford Care Home. One person told us, "I feel safe here. Especially when I'm in bed." A relative told us, "They really look after her. It gives us peace of mind to know she is safe. Especially after she was so ill."
● Staff had received training in safeguarding from abuse. However, not all staff were aware of the different types of potential abuse or reporting procedures outside of the service. This meant there was a risk staff may not identify and correctly report concerns. The management team provided assurances that staff would receive additional training and mentoring in relation to safeguarding.
● Appropriate action had been taken where reportable concerns had occurred. Records showed the relevant safeguarding authorities had been informed and where additional information was requested, this had been provided.

Using medicines safely
● Medicines were securely and safely stored. Each person had a medicines administration record (MAR). This included an up-to-date photo along with information regarding any allergies. MAR charts had no gaps in administration and stock balances were correct.
● People received their medicines from staff who were competent to support them. Staff completed medicines administration training and their competency was assessed. We observed staff followed safe procedures when administering medicines.
● There were processes for the administration of as and when required medicines (PRN) and homely remedies. PRN protocols were used to inform staff how and when PRN medicines should be administered.

Visiting in care homes
The manager supported visits for people in accordance with government guidance. This meant people could have relatives and friends visit at any time.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The principles of the MCA were not being followed to ensure people's rights were protected. Capacity assessments in relation to restrictions had not been consistently completed. Where capacity assessments were in place, best interest decisions were not always recorded to demonstrate the least restrictive options had been considered.
- DoLS applications and authorisations were not routinely monitored. The manager and regional team informed us no DoLS monitoring had been completed. This meant they were not fully aware of who had authorisations in place, expiry dates, conditions relating to the authorisations or who had applications pending. We asked for information regarding a condition regarding one person's community access. Staff supporting the person had no knowledge of this or how it should be reviewed.
- Staff were not fully aware of the MCA or how it impacted on their role. They were not able to describe the processes to follow, the type of restrictions which should be considered or who should be involved when decisions about people's care were being considered. This meant there was a risk restrictions would be implemented without the correct legal authorisations being in place.

The failure to ensure the principles of the Mental Capacity Act 2005 were followed was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager and regional team had identified the need to review how the MCA was being implemented

across the service. This was evidenced within their service improvement plan.

Adapting service, design, decoration to meet people's needs

● The needs of people living with dementia had not been fully considered in the decoration of the service. There was very little signage to guide people around the home and few areas of interest to engage people. The manager and regional team had identified the need to enhance the dementia environment and had plans in place to address this.

● On the day of our inspection people and staff told us care was being delayed due to a hoist having been broken for over a month, prior to the manager coming into post. The manager had not been made aware of this and took immediate action to have 2 additional hoists delivered to the service the following day. With this exception, people had access to the equipment they required and were able to access all areas of their home should they wish.

● People's rooms were personalised with items such as pictures, ornaments, and cushions. One person told us, "My room is how I like it; I have everything I need."

Staff support: induction, training, skills, and experience

● Staff received training in areas including moving and handling, safeguarding, health and safety and supporting people at the end of their life. Despite the completion of training, we found staff continued to lack understanding in some areas such as the Mental Capacity Act 2005, safeguarding and infection prevention and control. The management team assured us they were reviewing how training was provided and taking a mentoring role with staff to aid their understanding.

● Staff supervision had not always been provided consistently. Staff said this had been difficult at times although they felt more confident now the new manager was in post. One staff member said, "Without supervisions it has been hard to understand what is expected of us. This feels better now with (manager's name), and we are all having meetings." Records demonstrated that supervisions had recently taken place with staff and follow-up meetings were planned.

● Nurses told us they felt supported in their roles. One nurse told us, "Things are going well now, and we are prompted to update our training." Clinical training for nurses had been updated to support them in areas such as taking blood and supporting people at the end of their life.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed prior to them moving into the service to ensure they could be met. One family member told us they were reassured by how staff continually assessed and adapted to their loved one's needs as they had changed. They told us, "She has been through a lot with her health. They are on top of everything and change things when she changes."

● Health support provided was in line with best practice guidance. The use of recognised tools to monitor risks to people's health demonstrated an awareness of best practice. This included the monitoring of risks for skin breakdown and malnutrition.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us meals were sufficient although not always to their personal taste. One person told us, "It's not been too bad this week, but they don't always cater for what I like." A second person told us, "The food is alright, although we miss fresh vegetables and home cooking. We can choose what we want, though."

● People were offered a choice at mealtimes. Staff asked each person what their preference was and explained the options to them. The regional support manager told us they were discussing offering people a visual choice where people may find making a decision from the menu difficult. Alternatives were offered where people did not like the options available. For example, one person indicated they would prefer a sandwich, and this was provided.

● People were supported with their meals in a safe and respectful way. Staff sat alongside people who required support and went at their pace. Staff ensured people were sitting in a safe position prior to supporting them.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People had access to healthcare professionals when required. One visiting healthcare professional said, "This is one of the nicer care homes in the area." They told us they felt confident when visiting the home as staff were proactive and followed advice.

● Records showed referrals and support was sought from a wide range of professionals including the GP, district nurses, speech and language therapy, occupational therapy, and chiropody. During our inspection we observed staff working closely with a healthcare professional to organise the care one person needed.

● Clinical staff monitored people's individual health conditions closely. This included where people required catheter care, diabetes support and wound management. The monitoring completed meant any concerns could be raised with external healthcare professionals promptly when required.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- A number of management changes had negatively impacted on the culture of the service. Some people and relatives told us they did not feel listened to and thought standards within the home had dropped. People spoke positively of the new manager but felt time to build trust was needed.
- There had been a lack of consistent leadership at the home. Staff told us this had led to them feeling unsupported and not protected in their roles. They felt the new management team were beginning to address these concerns. One staff member told us, "Staff have been holding up the care home. The new management are for the better." A second staff member told us, "We have felt frightened to do our jobs as the different managers have had different ways (of working). It feels better now and (manager) tells us to go and speak to them with problems. They are getting things done."
- Quality assurance systems had not been effective in ensuring standards were maintained and improved. Audits demonstrated low levels of compliance in areas including infection prevention and control, care records, oversight of accidents and incidents and internal meetings to aid oversight. We found the provider had failed to act in a timely manner to rectify these concerns and ensure effective management oversight.
- Action plans had not been effective in making improvements. Prior to the new management team coming into post the action plan for the service was difficult to navigate and repetitive. The plan contained almost 500 actions, some of which had been duplicated which meant it was not clear where the progress had been made.
- There was a lack of provider oversight to ensure the service received the support they required. Senior managers had been aware of known risks such as the service having low audit scores and no manager or deputy being in post. Despite this knowledge they had not acted to ensure additional resources were deployed to support staff and people.
- People's care records lacked detail and were not routinely read by staff. Staff told us they found information within care records difficult to find and instead learnt from each other. Although care plans were reviewed monthly, original plans were not always updated when people's needs changed. This meant care plans did not contain the most up to date information. Daily care records were task-focussed and did not routinely contain personalised information about people's care and well-being.

The failure to embed a positive culture and to ensure robust management oversight was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new manager and regional support team had been in post for 3 weeks at the time of our inspection. During this time, they had completed reviews and audits of areas of immediate concern, devised a more robust action plan, completed supervisions with staff and implemented the provider's policies in relation to internal meetings. Care plan training had also been delivered and staff time allocated to revise plans.
● The manager had a clear vision of how they intended to support the service to improve through building trust, creating a shared vision, and implementing effective systems. The new regional manager provided assurance regarding action being taken by the senior leadership team to implement additional monitoring tools to ensure action would be taken promptly should concerns be identified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives had not been routinely involved in the running of the service. One person told us, "We are rarely kept informed of what is happening here." Resident and relatives' meetings were not held on a regular basis and were not always well attended. Other forms of communication to share important information had not been considered.
● Feedback was not always acted upon. An annual survey of people and relatives had been completed in October 2022 and comments reviewed. This highlighted lower than average scores for the provider in areas including the care and support provided, cleanliness, food, and communication. Despite these concerns, there was no evidence of an action plan being implemented. During our inspection in October 2023, we found these areas had not been addressed a year later.
● Monthly audits did not consider the experience of people living at Hungerford Care Home or for the staff working there. This meant the provider did not have regular feedback available regarding people's quality of life or how supported staff felt.

The failure to ensure people, relatives and staff were fully involved in the running of the service was a further breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and regional support team had held or scheduled several meetings for people, relatives, and staff. They gave assurances these would be held regularly going forward. People and staff told us they felt the new management team had been responsive to their feedback.

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The service had developed positive working relationships with health and social care professionals. The manager told us that going forward they wanted to begin working with the local community to regain links which had been lost due to restrictions in place during the COVID-19 pandemic.
● The provider had a duty of candour policy in place. They told us there had been no incidents which had reached this threshold. Relatives told us they were informed of accidents and incidents involving their loved ones.
● The manager was aware of their responsibilities in ensuring CQC were notified of significant events which had occurred within the service. Notifications had been forwarded to CQC as required to ensure risks within the service could be monitored.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the principles of the Mental Capacity Act 2005 were followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people consistently received safe care and treatment The provider had failed to implement robust infection prevention and control systems

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to embed a positive culture and to ensure robust management oversight The provider had failed to ensure people, relatives and staff were fully involved in the running of the service

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure sufficient staff were effectively deployed to meet people's needs