S5 Care Ltd

George Hythe House

Inspection report

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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
George Hythe House is a residential care home that can accommodate up to 43 people across four separate wings, each of which has separate adapted facilities. They are registered to provide personal care to people aged 55 years or over with a range of physical and/or mental health needs including dementia. On the day of our inspection there were 23 people who were living at the service.

People's experience of using this service and what we found
Care plans provided enough guidance to staff to keep people safe. People received enough food and drink, however we saw one person did not always receive the correct consistency diet.

Staff were not always safely recruited to ensure they were of good character. They had received recent training and had the skills to provide safe care. Lessons had been learnt when things went wrong.
Staff did not always wear personal protective face masks to keep people safe from COVID-19 transmission. However, other infection control procedures were followed. External health and social care professionals had been contacted as needed to help guide effective care.

There were enough staff to support people at the service. We observed some mixed quality of staff interactions. There were some caring staff interactions, other interactions were less caring.

The service had undergone refurbishment since the last inspection. The provider had plans to further improve the physical state of the service. People received activities at the service and the refurbishment allowed people to use more areas of the home than the last inspection.

People were provided with end of life care, and staff were trained to do this. Care plans for end of life care were holistic.

People's ability to make decisions were not always clearly recorded in required mental capacity assessments. People were suitably referred for deprivation of liberty safeguard referrals when needed

Staff, people and relatives spoke about the improved quality of service. There was no registered manager, but the acting manager was in the process of registering as the manager. We received positive feedback about the quality of their work.

The last inspection report was rated inadequate. The provider had created an action plan and many areas of the service has improved, however governance had not improved: recruitment safety, choking risks and mental capacity assessments. The provider has advised that further changes will be made to make improvements in these areas.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 12 January 2022). At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
At the last inspection, we rated the service inadequate. We received positive feedback from the Local Authority that the service had improved. We also received regular action plans from the provider, suggesting that changes had been made. We decided to inspect the service to see what changes had been made.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for George Hythe House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safe recruitment, consent, and good governance.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The last inspection resulted in the service being in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

At this inspection, the overall rating for this service is now 'Requires improvement'. We found significant improvements have been made since the last inspection. However, we have identified some ongoing breaches of regulation, which the provider has told us they will take action to resolve.

Due to the improvements made, the service is therefore no longer in 'special measures'. 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 caring?

Requires Improvement

The service was not always caring
Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive
Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led
Details are in our well led findings below.

George Hythe House

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 Care Act 2014.

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
The inspection was completed by two inspectors.

Service and service type
George Hythe House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the provide alone is legally responsible for how the service is run and for the quality and safety of the care provided. There was an acting manager in place, who was in the process of completing their registration.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before our inspection, we spoke with the local authority about their experiences of the service. We also reviewed the action plan that the provider sent us on a monthly basis.

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 of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and thee relatives about their experience of the care provided. We spoke with eight members of staff including care staff, chefs and domestic cleaners. We also spoke with the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included the relevant parts of nine people's care records and multiple medication records. We looked at two staff files in relation to the safety of recruitment. A variety of records relating to the management of the service, including policies, training records and procedures were reviewed.

After the inspection we continued to seek clarification from the provider to validate evidence found.

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 inadequate. 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; preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Staff had received moving and handling training. However, we saw two unsafe moving and handling practices at the service. One, where a staff member supported someone to stand by pulling their trousers. Another, where a person had slid down their wheelchair and the staff did not support the person to reposition into a safe position before pushing their wheelchair.
● At the last inspection, we observed concerns with people being given the incorrect texture diet. This put them at risk of choking. At this inspection, the manager had improved the care plan guidance. However, we saw staff did not give one person the correct texture diet. This incorrect diet increased the risk of the person choking.
● We observed some staff did not always wear their face masks correctly as required by government guidance. This poor use of face masks put people at risk of COVID-19 transmission.

The provider responded immediately during and after the inspection. They gave assurances that moving and handling practices, choking risks and face mask wearing would be improved at the service.

● Care plans and risk assessments at the service had been improved, to provide clearer guidance to staff on how to support people effectively.
● At the last inspection, fire evacuation procedures were not always safe. At this inspection, people had good quality personal evacuation plans to help guide staff.
● Excluding the poor use of face masks, the service otherwise had good processes in place to manage the risk of COVID-19 transmission. New people were admitted safely to the service, visitors had appropriate safety checks and government guidance was followed, appropriate polices were in place and the service was clean.
● Improvements had been made to supporting people's mental health needs. Staff were seen to be more pro-active at responding to behaviour that may challenge them. This resulted in improved safety for people at the service.

Staffing and recruitment
At our last inspection the provider had failed to follow safe recruitment checks to ensure that newly recruited staff were of good character. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19 for recruitment safety.

● We reviewed recruitment files of staff employed since the last inspection. Safe recruitment processes had not been followed again, as suitable references were not gathered and gaps in employment history had not been explored.

At our last inspection the provider had failed to deploy enough staff around the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18

● We observed there were enough staff during our inspection visit.
● Our previous two inspections, highlighted concerns with the deployment of staff across the service, this left areas unsafely unattended as staff needed to leave areas to support other staff. At this inspection, similar numbers of staff were deployed across the service which left areas of the home unattended for short periods. However, as people using the service had lower care needs than before, we saw no impact on safety of this ongoing deployment decision.

Using medicines safely
● Some further improvements were needed to the use of 'as needed' medicines. This is because staff did not always have clear written guidance on when to give these medicines. The provider had already identified this in their own audit and were working to improve this guidance for staff.
● Medicines were stored safely and appropriately.
● People were given routine medicines as prescribed.

Systems and processes to safeguard people from the risk of abuse
● Staff had received training in how to recognise signs of abuse, and how to report their concerns. Staff had good knowledge about this when asked and felt confident reporting concerns.
● Records showed us that the manager promptly contacted the local safeguarding team if they had any concerns.

Learning lessons when things go wrong
● Where incidents occurred (for example, a person falling), then quick action was taken to review the circumstances and prevent re-occurrence.
● The home layout had been refurbished to ensure that there were multiple areas for people to access. This helped people access quieter areas which supported their mental health. A staff member said, "People are calmer now, we don't use as many calming medicines because people are better occupied."

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 inadequate. 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.

At our last inspection, people were not effectively supported in line with the mental capacity act and deprivation of liberty safeguards. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11

- Since the last inspection, more mental capacity assessments had been completed. However, these were not always of sufficient quality. For example, one person was assessed as being unable to manage their own finances as they could not recognise what a £5 note was. The principles of the capacity act, would require further assessment detail before deciding that the person could not make any financial decisions.
- Staff had identified nine people who would not call for support if needed, so they had motion sensors in place to automatically alert staff if they moved. There had been no mental capacity assessments into the use of these motion sensors. The manager had already recognised this and intended to complete these capacity assessments, however these assessments should have been completed prior to putting in place the motion sensors.
- One person's mental ill health assessment required their medicine to be given covertly (hidden in their food). This is because they did not have the mental capacity to understand their need to take medicine. The person's doctor had specified the person should still be offered this medicine overtly once a week and this was recorded in a best interest decision document. However, this had not been happening, which meant the

prescriber's instructions were not being followed. This risked the person continuing to be given hidden medicine's, when their acceptance of this medicine may have changed. This is an ongoing concern from the previous inspection.
● Where people required a deprivation of liberty safeguard referral to the local authority. This had been completed in a timely way.

Staff support: induction, training, skills and experience
● Staff had received training since the last inspection, to ensure they were skilled to support the needs of the people using the service.
● Staff spoke highly of the quality of training that had been provided. One staff member said "I love the training we've had. It is more face to face now - which helps me learn better"
● When we spoke to staff, they had good knowledge of how to support people effectively.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Care plans provided clear advice to staff on how to support people's holistic care needs. Including, religious, social, sexual, mental and physical health needs.
● National tools had been used effectively to guide safe care. For example, the Waterlow Scale helps identify the risk of a person developing pressure related skin damage. This tool had been used to assess people's risk of developing skin damage and helped guide preventative strategies.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat enough. People at risk of weight loss, were regularly weighed to ensure changes in weight were recognised and acted on. People were given high calorie diets if needed.
● People were supported to drink enough. Staff recorded how much people drank during the day. If they did not drink enough, this was recognised by staff and responded to.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Where people required referral's to other professional's this was done in a timely way. For example, one person was struggling to chew their food. A referral had been made to a health professional to assess their ability to swallow and make recommendations or a suitable diet.
● Where professional advice was sought, this was recorded in people's care plans to ensure staff knew how to support people effectively. For example, some people required regular repositioning to prevent pressure related skin damage. Specialist nurses had been contacted to get advice on how often these people needed to reposition. This nurse advice was recorded for staff to follow.

Adapting service, design, decoration to meet people's needs
● Staff spoke positively about refurbishments that had happened since our last inspection. More communal areas had been created, which allowed people to move into separate areas throughout the day. Staff felt this allowed them to support people's mental health more effectively as quieter areas were available.
● We observed a notice board was now displayed. A staff member said, "It helps visitors keep up to date. You can see what's happening in the home now".

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- We observed mixed interactions between staff and people. For example, one staff member was seen to push a person's hand away from them and harshly say, "Stop it". This was an overly harsh response to a person with mental health difficulties.
- Where we saw less positive interactions with people and staff, we reported these to the management team. They told us they would take action to address these specific concerns.
- Other staff were seen to have positive interactions with people at the service. For example, saying good morning, asking about their day or saying jokes. People appeared to positively engage with staff and enjoy their company.

Supporting people to express their views and be involved in making decisions about their care

- People were not always offered choices about their care. For example, staff did not always offer people a choice of where they would like to sit at meal-times.
- However, we observed that staff did offer some positive choices. For example, some people required support to reposition to reduce the risk of pressure related skin damage. These people had been engaged in discussions to decide how often they would like support to be repositioned, so they still got a restful night sleep.

Respecting and promoting people's privacy, dignity and independence

- At the last inspection, low staffing levels resulted in rushed care. This impacted people's dignity. At this inspection, there were enough staff. People's care needs were therefore met in a more timely way – resulting in more dignified care.
- People were encouraged to be as independent as possible. For example, the use of brightly coloured plates had encouraged people with mental health needs to be more focused on eating their food independently.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At the last inspection, people did not receive person centred care. This was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had been made and there was no longer a breach of regulation 9.

● At the last inspection, we found routines were focused around completing daily tasks rather than providing person centred care. While this had improved at the service, we observed some task-focused routines still in place. For example, staff moving a person's wheelchair without communicating with them.
● Records had improved to provide a more holistic understanding of people's care needs. For example, a person's religious needs were clearly recorded. Including their attendance to a place of worship, and engagement with religious holidays. This allowed staff to understand the person's religious needs and provide more responsive care.

Improving care quality in response to complaints or concerns
At the last inspection complaints were not appropriately responded to. This was a breach of regulation 16 (receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, improvements had been made and there was no longer a breach of regulation 16.

● There were less complaints received since the last inspection. Where complaints had been received, these were now responded to appropriately and promptly.
● Relatives were communicated with weekly about their family member's care. This was usually by email, but where the relatives preferred communication was by phone then phone calls were also made. Relatives told us that this communication allowed them to feedback any comments, which were quickly acted on.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's sensory needs were recorded in their care plans, so staff could understand how to support people's communication needs.

● Staff communicated with people in a way they understood, and by using clear language
● The manager explained that they had access to different formats (For example, larger font writing) if needed to aid communication. We saw that food menus were available in picture format.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● People took part in activities inside the service that interested them. For example, one person was observed to enjoy gardening.
● Where people were interested in leaving the care home, support was given to do this.

End of life care and support
● People at the service received good end of life care. Care plans described how their religious and social needs would be effectively met when they reached the end of their life
● During the inspection, one person's health had deteriorated. Staff had promptly contacted health professionals for medicine changes and were pro-active in providing good quality end of life support.
● Staffing levels at the previous inspection impacted the quality of care. However, staffing levels had improved at the service. So, end of life care was no longer impacted by staff numbers.

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 inadequate. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection, the provider failed to ensure robust systems were in place, and that required improvements were made to the service. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had made enough improvements to meet the warning notice that we sent. However, there are some ongoing governance concerns meaning the service is still in breach of regulation 17.

● We have some ongoing concerns from the previous inspection. These include: unsafe recruitment practices, mental capacity assessments and choking risks. These are reported in the 'safe' section of the report.
● These risks resulted in three ongoing breaches of regulation that had not been resolved as expected. Due to ongoing breaches of regulation, we have some ongoing concerns about governance.
● These areas had been covered in the provider's action plan, however insufficient action had been taken to improve the safety of these areas.
●The manager has given us assurances that further action will be taken to improve these areas. However, we remain concerned that the current action plan for the service was not effective at creating improvement in these areas.

● Excluding recruitment, mental capacity and choking risks; the management team completed some good quality audits and spot checks. These were clearly organised and routinely completed. These audits highlighted where improvements were needed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● All staff spoken to, spoke positively about the new manager and the positive impact they had on the home. One staff member said "This manager you can go to about any resident and they are on the ball. Sorts it out straight away." We found the manager had good knowledge about the people that used the service and how to support their diverse needs.
● There was improved ethos of high-quality care at the service, and staff morale had improved. One staff member said "I was embarrassed to work there before. But staff are happier, wanting to work and wanting to make a change. I would happily have a relative live their now"

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

● Where incidents occurred, these were now thoroughly recorded and action taken to ensure the information was shared with external stakeholders as needed.

● During the inspection, we highlighted some concerns to the manager. For example, we saw that a person was given an unsuitable diet. The manager was very responsive to our concerns and took immediate action to resolve any concerns that we raised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The service now completed regular surveys with staff and relatives to get their feedback on care received. We saw that while there were still some negative responses, the responses to the surveys had been increasingly positive each month. This showed that people were increasingly positive about the service provided

● People's diverse needs were now thoroughly recorded in care plans for staff to follow. For example, a person's routine with having a face shave on certain days of the week and for certain occasions were followed.

Continuous learning and improving care

● During the inspection, we highlighted some ongoing concerns (these are listed in the report). The manager was responsive to these concerns and advised how they would alter their oversight to make these improvements.

● Whilst some improvements were still needed, we identified that lots of positive changes had already occurred at the service. This was due to a new management team and a comprehensive action plan.

Working in partnership with others

● Where people required referrals to health and social care professionals, these referrals were made promptly. Advice was then recorded in care plans for staff to follow.

● After our last inspection, the local authority contracts team had increased involvement at the service. We received feedback that the management team had worked positively with this team to improve the care provided.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured people were not effectively supported in line with the mental capacity act

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure robust systems were in place, and that required improvements were made to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to follow safe recruitment checks to ensure that newly recruited staff were of good character