Hadley Place Limited

Hadley Place Residential Home

Inspection report

301-303 Anlaby Road
Hull
Humberside
HU3 2SB

Tel: 01482212444

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10 July 2020
15 July 2020

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14 September 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hadley Place Residential Home is a care home providing accommodation and personal care for up to 29 older people, some of whom may live with a mental health condition or dementia. At the time of our inspection 25 people lived at the service.

People's experience of using this service
Records were not up to date and checks in place to monitor the quality of care being provided had not identified or addressed the concerns found. Improvements had not been made since the last inspection in relation to governance and oversight.

Risks to people were not always identified and managed. Processes in place to ensure the health and safety of the building were not being clearly recorded to provide assurance to the manager that the building and equipment were safe. Medicines processes did not always follow best practice.

One area of the recruitment process required improvement to ensure safe and robust recruitment of new staff.

Accidents and incidents were not effectively monitored to consider lessons learnt and reduce the risk to people. There were a number of incidents that should have been notified to Care Quality Commission (CQC) and the local safeguarding authority but this had not been done.

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 requires improvement (published 18 November 2019) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of this regulation and more breaches were found.

Why we inspected
We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same as the last inspection, requires improvement. This includes the findings at this inspection.

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

Enforcement
We have identified breaches in relation to record keeping, safeguarding, the management of risks and monitoring of improvements and the notification of serious incidents and safeguarding matters to CQC.

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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Hadley Place Residential 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 Care Act 2014.

Inspection team
One inspector carried out the inspection on both days.

Service and service type
Hadley Place Residential Home 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. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced from the car park of the service on the first day of inspection. We did this to discuss the safety of people, staff and inspectors with reference to Covid-19. We told the manager we would be returning on the second day.

What we did before the inspection
We reviewed information available to us about this service. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority. We used the

information the provider sent us in the provider information return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the manager via telephone as he was not present during both days of the inspection. We spoke with two senior carers during the site visit and one carer via telephone. We spoke with two people who lived at the service. We looked at two people's care records in full and five people's records in part. We also looked at people's medication administration records and a selection of documentation about the management and running of the service. We looked at recruitment information for one member of staff.

After the inspection
We emailed the manager for further health and safety information which we could not locate during the inspection. We held a telephone call with the manager to discuss the concerns we identified during the inspection on 17 July 2020.

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated 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

- People were placed at increased risk as risk assessments and care plans lacked detail and guidance for staff to respond to risk effectively.
- People's health related risks were not safely managed. Assessments in relation to specific medical conditions were not in place. Staff were not provided with up to date records to support people or respond to risk.
- People were at risk in the event of a fire as no fire evacuations had been completed to ensure staff had confidence to act effectively in the event of a fire.
- Incidents, such as behaviours the service found difficult to manage, were not always recorded and monitored, to check whether these incidents were being dealt with effectively and to prevent reoccurrence.
- People were exposed to health and safety risks. The gas safety certificate had expired and it was not clear what electrical work had been completed following an unsatisfactory electrical report.

Whilst we found no evidence people had been harmed, people had been placed at risk of harm as a result of the issues we found. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines arrangements were not always safe. Some protocols to guide staff when 'as and when required' medicines should be given were not in place. When protocols were in place, they lacked detail to provide adequate assurances that medication would be administered as required.
- People could not be assured that their medicines were being maintained at the correct temperature, as temperature checks of the room and fridge which stored medicines were not being completed.

We found no evidence people had been harmed. However, medicines were not being effectively managed, and this placed people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Some equipment and furniture was unable to be cleaned them effectively due to being worn and would not prevent the spread of healthcare related infections.
- Best practice was not always followed in relation to infection control. This included the use of Personal Protective Equipment and wearing jewellery.

We found no evidence that people had been harmed. However, infection control was not being effectively managed and, this placed people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not always safeguarded from the risk of abuse. We identified a number of incidents which should have been reported to the local authority safeguarding team but had not.

We found systems were not in place to prevent and protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff recruitment processes were in place; more detail regarding previous employment history was needed to ensure safe recruitment practices.

Inadequate

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to implement systems to monitor and improve the quality of the service and mitigate health and safety risks, which meant people were at risk of harm and of receiving a poor service. This was a breach of regulation 17 (Good Governance) 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 17.

● The manager lacked oversight of records and processes to ensure the service was being run safely. Audits in place did not drive forward improvements. Governance systems had failed to identify the concerns we found during the inspection.
● Systems in place for identifying and capturing risks and issues were ineffective. Oversight and analysis of accidents and incidents remained ineffective.
● Records were not up to date to support people's holistic needs and keep them safe from risk.
● Records to mitigate health and safety risks were poor. Regular monthly checks on equipment and the building had not been clearly documented since 2019 and safety certificates had expired.
● Checks in place to mitigate risks in the event of a fire were not being effectively recorded. Oversight systems had failed to identify that no practiced evacuations had taken place.

Failing to have up to date records and have robust systems in place to identify concerns and act on these was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager had failed to notify the CQC of notifiable incidents that happened in the home. This included allegations of abuse and serious injuries.

This was a breach of Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of the inspection process in relation to this matter.

● There was no registered manager in post. The manager of this service told us they were in the process of

submitting their application to us.

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 provider had not been open and honest with the local authority safeguarding team and CQC when accidents and incident occurred in the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were no records of any further surveys or engagement with people and families since the last inspection. No records were provided during the inspection to show that previous survey results had now been analysed and used to improve the home.
- Staff we spoke with felt that the manager was approachable and supportive.
- People we spoke with told us they were happy at the service, they were listened to and staff looked after them well.

Working in partnership with others

- The service worked with key organisations such as the local district nurses and frailty team.
- Further development of working in partnership with key organisations including safeguarding teams was required to ensure good outcomes for people.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to effectively assess and mitigate risk, ensure health and safety checks and systems were in place and have robust medication procedures, put people at increased risk of harm. Reg 12 (2) (a) (b) (d) (e) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to safeguard people from the risk of abuse through non reporting of incidents. Reg 13 (1) (2) (3).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Continued failure to have effective governance systems and poor record keeping exposed people to risks.

The enforcement action we took:

Warning Notice.