Hawthorne Care Limited

Highbury Residential Home

Inspection report

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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
Highbury Residential Home is a care home providing personal and nursing care to 24 people aged 65 and over at the time of the inspection. The service can support up to 27 people.

Highbury Residential Home provides accommodation to people in one adapted building. People had their own bedroom with en-suite toilet and sink. There was a shared lounge, dining area and garden people living at the service can access.

People's experience of using this service and what we found
The service was not well-led. There were continued concerns about the governance of the service as there had been a number of changes to management and there was not a registered manager in post at the time of inspection. Staff failed to consistently wear personal protective equipment (PPE) at all times when supporting people in accordance with government guidelines.

People did not always receive safe care. Care plans and risk assessments were not always reviewed frequently, and the quality of information available to staff was not always of a good standard.

Some improvements had been made to medicines management, but audits were still not being completed and monitored appropriately.

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 11 May 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. At the last inspection there were multiple breaches of regulation. At this inspection enough improvement had not been made/sustained and the provider was still in breach of regulations.

Why we inspected
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 received concerns in relation to how people were being cared for and the environment being in a unsafe condition in some areas of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained the same. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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 Highbury Residential Home 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 staff failing to wear PPE in accordance with government guidance and regarding how the service is managed at this inspection.
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 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? People were not always safe.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Highbury 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.

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 carried out by one inspector.
An Expert by Experience completed telephone calls to relatives of people living at the service.
An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Highbury 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. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this

inspection. 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. We took this into account when we inspected the service and made the judgements in this report.
We used all of this information to plan our inspection.

During the inspection
We spoke with nine members of staff including the provider, deputy manager, senior care workers, care workers, housekeeper, chef and maintenance worker. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and requested further records and documents. The Expert by Experience spoke with 11 relatives of people living at the service.

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 Requires Improvement. At this inspection this key question has now remained the same.

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.

Preventing and controlling infection

● Staff did not always wear PPE in accordance with government guidance. Some staff members were observed not wearing any PPE when providing direct care to people, and when moving around the service. This meant people and staff living at the service were unnecessarily exposed to the risk of contracting and transmitting COVID-19.

● Cleaning schedules did not evidence high touch points were regularly cleaned. Due to staffing shortages there was an occasion when there was no housekeeping staff available at the weekend to maintain hygiene and infection prevention and control practices at the service

● Not all equipment was maintained. We found a hoist that had broken foam which was cellotaped up in an upstairs area of the service. A staff member told us there was not any people that needed hoisting in that area of the home, but it was the hoist that would be used. The damaged foam was an infection risk as it could not be sanitised appropriately.

The provider failed to ensure staff followed government guidance on safe PPE use; and failed to ensure cleaning of the service occurred at all times. This exposed people to unnecessary risk of harm and 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

At our last inspection the provider had failed to ensure people received medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection in relation to the management of medicines, but the provider was still in breach of regulation 12 due to staff failing to safely wear PPE in accordance with government guidelines.

●Medicine audits were not always completed. Medicine audits had only been completed for two months since the start of the year for all people living at the service which meant systems to monitor how medicines were managed were not always in place. Opportunities to identify errors or concerns and implement positive changes were missed.

● People received their medicines. A staff member described how they supported people to take their

medicines and what they did if people refused to take them. The staff member told us the GP was contacted for advice if people consistently refused to take medicines.
● Medication Administration Records (MARs) were completed. Staff were completing MARs as they administered medicines to people. Body maps to instruct staff about when and how to apply topical creams were also in place.
● Medicines were stored appropriately. Senior staff trained to administer medicines told us they were responsible for counting stock at each medicine round. This was done by two members of staff to minimise the risk of errors occurring.

Systems and processes to safeguard people from the risk of abuse
● People's relatives felt they were safe at the service. One relative told us, "We know [person] is safe here, [person] is looked after, they care for [person's] needs." Staff told us they would raise concerns with the senior and deputy manager if it was necessary.
● A safeguarding policy was in place, and the service made referrals to the local authority if there were safeguarding concerns. Staff had received safeguarding training, but at the time of inspection refresher training was overdue for 11 out of 19 staff.

Assessing risk, safety monitoring and management
● People's needs and risks were assessed, but the quality and presentation of information varied. We reviewed three people's care plans and risk assessments and found different documents had been introduced by different managers who had been at the service . This meant there was not a consistent or clear process in place to assess each person's needs.
● Care plans and risk assessments were not always reviewed consistently. We found a person's continence care plan had been written in February 2021 but not reviewed until June 2021. We also found a person's medicine care plan had been written in March 2021, but not reviewed until May 2021. While there was no evidence people had been exposed to harm, there was a risk staff were not always following up to date information and ensuring people's care needs were met safely.
● Daily records were kept. Records regarding people's daily care needs were kept but were task orientated rather than being person centred. Information was documented if people's health needs changed and contacts with the GP and health and social care professionals were maintained.
● Staff did not always ensure the environment was safe. During inspection a gate at the bottom of a staircase which people could access was left open. This was raised with staff who closed the gate to minimise the risk of people accessing the stairs and being exposed to the risk of harm.

Staffing and recruitment
● There was not always enough domestic staff. There were short falls in the housekeeping, laundry and kitchen teams which impacted upon staff in these roles. Staff were moved around regularly and taken from their usual roles to ensure someone was available to work in the kitchen or to undertake housekeeping. During the inspection, the deputy manager also had to step away from their role and responsibilities to assist in the kitchen. The registered person was aware there were not enough staff in these areas and was actively recruiting to fill the positions.
● Training was offered but not all staff had completed all training. For example, six out of 19 staff had not completed hand hygiene or infection prevention and control training. This meant not all staff had received all training relevant to their roles.
● Staff were recruited safely. Staff records were viewed, and relevant checks had been completed before staff commenced work.

Learning lessons when things go wrong

● Lessons were not always learnt. An action plan was in place, but it had not been fully completed which did not evidence how improvements had been made to the service.
● A lessons learned log was provided for June 2021 with limited analysis of the situation. It was not clear how this information was shared amongst staff to minimise the risk of the situation occurring again.

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 now 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.

At our last inspection the provider had failed to ensure systems and processes were robust to demonstrate the service was effectively managed. 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.

● There was not a registered manager at the service. Since the last inspection there had been several people appointed but none had remained in post. Inconsistency in management impacted detrimentally upon how the service was being led.
● Processes and systems continued to not be followed. Policies and procedures were in place, but lack of leadership and consistency meant they were not followed and implemented at all times. For example, there was no oversight to identify medicines were not audited consistently on a monthly basis . There was no oversight regarding inconsistencies in care plans and risk assessments. There was no mechanism in place to review staff training or to monitor the deployment of staff. There was also not a system in place to monitor and ensure staff were wearing PPE in accordance with government guidance.
● Staff morale was low. Staff were unclear of how they should undertake their duties as previous managers had changed practice and protocols. A staff member told us, "It's been really difficult, each manager has a different way of doing things and its difficult knowing what to follow. It is really confusing sometimes." Another staff member told us, "Changes in management have been really hard, it's not been the best time."
● Team meetings and supervisions had not been regularly carried out. The deputy manager advised staff had not received supervisions consistently. Team meetings had also not been completed consistently. The deputy manager was aware of the importance of these tasks occurring frequently moving forwards.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● It was not clear how staff and people were always involved in shaping the service. A quality assurance policy and procedure was in place but it was not always clear this this was achieved consistently.

● People and their relatives were not always involved in planning their care. Three relatives told us they had not seen any care plans for their family members and were not aware always of how care was provided.

Continuous learning and improving care

● Evidence was requested regarding continuous learning and improving care, but the provider was not able to produce this information. Assurances were not provided regarding how the service achieved this.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Not all people were included in shaping their care. Some people and their relatives had not been involved in planning their care, while others had. This meant opportunities to always improve every person's outcomes may have been missed.

● People's relative's felt staff were kind. Staff were described as" very friendly", and "really lovely people." The deputy manager told us they were "very proud of their staff" and felt they knew people living at the service. The deputy manager gave an example of how a person who was anxious to mix with others living at the service was supported to do so.

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 communicated with people. Relatives told us if their family members were unwell or fell they were informed. One relative told us "[Person's name] did have a fall but they [staff] were responsive and were quickly on it and informed us." Another relative told us, "They [staff] let us know all the time how [person's name] is doing or when [person's name] has been poorly straight away, yes they keep us informed."

● Relatives felt the deputy manager was approachable and helpful. Relatives told us they were able to speak with the deputy manager easily, but many relatives shared their concerns about the "high turnover" of managers at the service.

Working in partnership with others

● The service worked collaboratively with health and social care professionals. The service had a weekly telephone call with the GP and raise concerns about people's health as required.