D Roche (Holdings) Limited

Hartlands Rest 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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Hartlands Rest Home is a residential home providing accommodation and personal care to 18 people aged 65 and over at the time of the inspection, some of whom were living with dementia. The service can support up to 21 people.

People's experience of using this service and what we found
People were not always safe as the physical environment did not always support the safe provision of care and accommodation. The provider did not have effective infection prevention and control procedures in place and people did not always receive their medicines as prescribed. Missed medicines or recording errors were not identified, investigated or corrected effectively. The provider did not have effective quality checks in place to ensure people received safe care.

People were supported by enough staff who were available to assist them in a timely way. People were protected from the risks of ill-treatment and abuse as staff had been trained to recognise potential signs of abuse and understood what to do if they suspected harm or abuse. The provider had assessed the risks associated with people's personal care and support. Staff members were knowledgeable about these risks and knew what to do to minimise the potential for harm.

People were supported to have maximum choice and control of their lives and the provider supported them in the least restrictive way possible and in their best interests; the application of the policies and systems supported good practice.

The provider and management team had good links with the local communities within which people lived.

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

Rating at last inspection
The last rating for this service was good (published 24 September 2019). The rating has changed to requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about the safe moving and handling techniques used by staff and people's increased risk of falls. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

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.

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

Enforcement and Recommendations
We have identified breaches in relation to keeping people safe and how the Hartlands Rest Home 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.

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

Follow up
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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Hartlands Rest 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 1 inspector.

Service and service type
Hartlands Rest 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. Hartlands Rest Home is a care home without 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 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 asked the local authority and Healthwatch for any information they had which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 1 relative about their experience of the care provided. Additionally, we spoke with 5 staff members including the registered manager, senior carer, 2 carers and the provider.

We reviewed a range of records. This included 3 people's care plans and multiple records of medicines administration. We looked at a variety of documents relating to the management of the service, including quality monitoring checks. We confirmed the safe recruitment of 2 staff members.

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

- People were not always protected from the risk of harm. Fire escape routes had been blocked by locked doors. The fire doors at the bottom of both sets of stairs had combination locks. These locks did not disengage when the fire alarms were activated putting people at the risk of harm in the event of an emergency. Firefighting equipment had been blocked by cleaning equipment and furniture. Not all areas of the home had appropriate signage in place to direct people to the nearest exit, putting them at risk in the event of an emergency.
- People were at risk of sustaining injury from contact with hot surfaces. Not all radiators, or the pipes leading to the radiators, had been covered. Putting people at the risk of burns. Portable radiators were in place in people's rooms. These had not been covered or risk assessed to ensure they were safe for people. This put people at the risk of harm from burns.
- Not all substances hazardous to health were secured. We saw cleaning products were left unattended in the lounge. Later we saw these products had been moved to the corridor and were still unattended. People had unrestricted access to these cleaning products putting them at the risk of harm from accidental or intentional ingestion.

Using medicines safely

- The provider failed to ensure people received their medicines as prescribed. Prescribed creams were not recorded when or where they were used. We could not be assured people were receiving their medicated creams as prescribed putting people at risk of deteriorating health. One medicine administration record (MAR) chart directed staff to apply a medicated cream once per day. Records indicated this cream had not been applied throughout the 20 days prior to our inspection.
- There were gaps in people's (MAR) charts, therefore we were not assured people received their medicines as prescribed. For example, one person was prescribed eye drops 4 times per day. This was only recorded on 3 occasions over 7 days before it was discontinued.
- When people received their medicines through a patch called a transdermal patch, the application was not in accordance with the instructions. We asked one staff member about this and they confirmed they had not read the accompanying information sheet on the safe administration of this medicine. The record of medicines did not identify what the medicine was, who it was for or how to safely administer the medicine. The recording indicated inconsistent application of the patches. This put people at risk of skin irritation as the sites of administration did not have sufficient time between doses to recover.
- When people were prescribed food supplements to maintain their wellbeing, this was inconsistently provided. We saw on 4 occasions in the 20 days prior to this inspection gaps in the administration record of this prescribed supplement. This put people at an increased risk of malnutrition.

● The provider did not have systems in place to ensure people received medicines which were safe or effective. One set of eye drops had passed its disposal date. We confirmed with a staff member these drops were still being used and they hadn't noticed the date for disposal had passed. This put people at risk of receiving medicines which were potentially ineffective.
● The provider did not have effective systems in place to identify or investigate medicine errors. We found multiple incidences of missed medicines which should have been investigated further by the provider. The provider failed to identify or investigate these recording errors.

Preventing and controlling infection
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. We saw some items of equipment were rusted, there was exposed wood on door frames and handrails and mould around the sealant of a shower tray. There was evidence of poor cleaning practices throughout the building including excessive dust and debris on windows and unknown substances on the stair bannister. Some doors had sticky residue from items which had been removed and chairs were worn and, in some instances, torn. These issues hampered effective cleaning practice and put people at the risk of harm from communicable illnesses.
● We were not assured the provider was preventing visitors from catching and spreading infections. Visitors were not routinely asked if they were experiencing any adverse health conditions prior to entering the communal areas of the building putting people at the risk of infectious illnesses.
● We were not assured the provider's infection prevention and control policy was up to date. This was because staff practice was not in accordance with best practice.

We found no evidence people had been harmed. However, systems were not robust enough to demonstrate safety or medicines was effectively managed. This placed people at risk of harm. These issues constitute a breach of Regulation 12 (Safe Care and Treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They contacted Shropshire Fire and Rescue and sought advice. We later confirmed this contact. They told us they had disabled the locks and risk assessed the potential hazards. The registered manager told us they would review the medicines administration as a matter of priority.

● Despite our findings people told us they received their medicines when they needed them. One person said, "I do get a bit of a cocktail of tablets, but I get then when I expect them."
● Guidelines were in place for staff to safely support people with 'when required' medicines including the maximum dosage within a 24-hour period to keep people safe. Staff members were aware of these guidelines.
● People were supported to identify and mitigate risks associated with their care and support. One person said, "I do feel quite safe here. I can come and go as I please and there is someone there to help if I want it." The provider assessed risks to people and supported them to lead the lives they wanted whilst keeping the risk of harm to a minimum.
● We saw assessments of risks associated with people's care had been completed. These included risks related to people's mobility, diet and nutrition.
● Staff members knew the risks associated with people's care and support and knew how to keep people safe from avoidable harm. One staff member said, "If there is a risk of falling, we support the person the safest way possible including walking alongside them and making sure they have their frame available if needed." We saw staff members appropriately and safely supporting people.
● Staff members had received training in infection prevention and control. This included updated training in

response to the COVID-19 pandemic. Staff understood how to recognise and respond to signs and symptoms of infection.
● We were somewhat assured the provider was supporting people living at the service to minimise the spread of infection. However, staff expressed it was difficult to support those living with dementia to maintain safe distances or practices to minimise the spread of infection.
● Staff members had access to personal protection equipment which they used appropriately when supporting people.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.

Visiting in care homes
● The provider was supporting visits in line with the Governments guidance. However, staff did not consistently question visitor's health for infectious symptoms prior to them entering the building.

Learning lessons when things go wrong
● The provider did not have systems in place to identify or learn from errors regarding their medicine administrations. However, they reviewed any incidents or accidents to see if any further action was needed and to minimise the risk of reoccurrence. For example, any incidents where people had fallen were responded to promptly and if necessary, referrals to additional healthcare services for reassessment was requested in a timely way.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risks of abuse and ill treatment. A relative told us, "All the staff are just fine, there are no problems and I certainly have not seen anything I was worried about. I think people are safe."
● People were protected from the risk of abuse and ill treatment as staff members had received training on how to recognise and respond to concerns.
● Information was available to people, staff and relatives on how to report any concerns.
● The provider had systems in place to share information about any concerns with the appropriate agency. For example, the local authority, in order to keep people safe.

Staffing and recruitment
● People were supported by enough staff. One person said, "I think there are enough staff about. I don't tend to wait for much." There were enough staff to respond to people in a timely way without any unnecessary delay.
● The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). The Disclosure and Barring Service (DBS) checks and provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The provider had systems in place to address any unsafe staff behaviour including disciplinary processes and re-training if needed.
● The provider told us they had measures in place to mitigate the risks associated with COVID-19 related staff pressures.

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.

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

- The provider did not have effective quality monitoring systems in place to ensure improvements were identified and sustained. For example, their monitoring systems failed to identify and rectify the locked fire doors, exposed radiators and pipework. Their systems had failed to identify risks from the use of portable radiators or unsafe staff practices when using portable appliances or cleaning products.
- The provider failed to ensure effective infection prevention and control practices were maintained throughout Hartlands Rest Home.
- The provider completed checks of people's medicines administration. However, this was ineffective as it failed to identify the multiple recording errors or unsafe provision of medicines. For example, use of eye drops past the date of disposal.

Managerial oversite and environmental assessments were not robust enough to demonstrate their quality monitoring was effective. These issues constitute a breach of Regulation 17 (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A registered manager was in post and was present throughout this inspection. The manager, and provider, had appropriately submitted notifications to the CQC. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. The last rated inspection was displayed at Hartlands Rest Home in accordance with the law.

Continuous learning and improving care

- The registered manager kept themselves up to date with developments and best practice in health and social care to ensure people received positive outcomes. This included regular updates from local authorities, a provider representative organisation, the CQC and Government agencies involved in adult social care. However, they needed to apply this knowledge towards the application of safe care and use this learning to ensure their quality systems were updated and effective.

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

- People had a positive relationship with the registered manager. People and families told us they found the registered manager to be kind, helpful and approachable. One relative said, "I can talk with [registered

manager's name] whenever I want. They always make time for you and you never feel like you are in the way."

● The provider asked for people's feedback on their experiences of care. One person told us they were recently asked for their opinion on the home and if they had any recommendations for improvement. They said, "I couldn't think of any way things needed to be changed. I am quite happy with the care I receive."

● Staff members told us they found the registered manager supportive and their opinions were welcomed and valued. One staff member said, "[Registered manager's name] is open and I can go to them when I need. I think they are supportive."

● Staff members understood the policies and procedures that informed their practice including the whistleblowing policy. They were confident they would be supported by the provider should they ever need to raise such a concern. One staff member said, "If I didn't think the managers were listening to me, I would go to social services."

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 registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

Working in partnership with others

● The management team had established and maintained good links with the local communities within which people lived. This included regular contact with local healthcare professionals which people benefited from. For example, GP practices and district nurses.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure systems were in place to keep people safe.

The enforcement action we took:

We issued the provider with a warning notice giving a date by which to be compliant with the law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality systems in place to ensure the safe provision of care or medicines.

The enforcement action we took:

We issued the provider with a warning notice giving a date by which to be compliant with the law.