Hart Care Limited

Hart Care Nursing & Residential Home

Inspection report

Old Crapstone Road
Yelverton
Devon
PL20 6BT

Tel: 01822853491
Website: www.hartcarelimited.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Hart Care Nursing and Residential Home provided personal and nursing care to 49 people aged 65 and over at the time of the inspection. The service can support up to 54 people.

People's experience of using this service and what we found

Systems and processes to monitor the safety and quality of the service were not effective.
Risks in relation to people's health and care needs, such as skin breakdown, catheter care and diet were not always identified, assessed or understood by staff delivering care. Where guidance was in place for staff to monitor and reduce risks these were not always being followed consistently. People's monitoring charts were not being completed consistently, such as charts monitoring food and fluid intake and re-positioning to prevent skin breakdown.

Care plans did not contain sufficient information about people's specific needs to ensure staff knew how to deliver appropriate care. Where information was recorded this was not always accurate, up to date and did not provide evidence of staff interactions.

Medicines were not managed safely, and we were not assured people received their medicines as needed and as prescribed. When mistakes were made in relation to medicines these were not always escalated appropriately, and action was not always taken to ensure mistakes did not happen again.

People were not safeguarded from the risk of abuse. Staff did not always recognise potential safeguarding concerns and when concerns were reported these were not always appropriately escalated and actioned to ensure people were safe. The provider had not learned from previous safeguarding concerns, which had meant people continued to be at risk of poor practice and potential abuse occurring again.

Accidents and incidents were not appropriately managed and there was no effective system in place to learn from accidents and prevent re-occurrence.

Staff were not always sufficiently trained to provide safe and effective care. The service had a training plan for staff, however training was not in all cases up to date and did not address gaps in staff skills and knowledge that had been identified.

Staffing levels and the organisation of staff were not sufficient to meet people's need and to keep them safe. Staff told us they did not always have time or there were insufficient numbers of staff to meet people's needs and complete daily tasks.

People were not protected by infection control practices in the home. Staff had not undertaken sufficient training and did not have the information they needed to ensure people were fully protected from the risks of infection.

Quality checking processes and audits were either not completed or were ineffective across all areas of care. This meant people were at risk of receiving poor care because the risks to their safety and wellbeing were not mitigated or managed effectively to protect them from harm.

On the second day of the inspection we escalated the most serious concerns found to the local authority and requested assurances from the provider that they would take immediate action to ensure people were safe. The provider responded promptly and since the inspection has worked with the local authority and other agencies to ensure people became safe and have their needs met. The provider has recruited a consultancy company to assist them with these improvements.

On the second day of the inspection we were informed by the provider that the registered manager was no longer working in the service. Since the inspection an interim manager has been appointed to assist with the running of the service.

We have made a recommendation in relation to recruitment records.

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 16.01.2019)

Why we inspected
We received concerns in relation to people's nursing needs, the management of medicines and the escalation and management of incidents. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Enforcement
We have identified breaches in relation to the management of risks, safeguarding, medicines management, staffing and the governance of the service at this inspection.
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 as and to hold providers to account where it is necessary for us to do so.
For 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 overall rating for this service is 'Inadequate' and the service is therefore 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.
If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Hart Care Nursing & 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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was undertaken by three inspectors. One of the inspectors was a specialist pharmacy inspector and looked specifically at the management of medicines.

Service and service type
Hart Care Residential and Nursing 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 had a manager registered with the Care Quality Commission. This means that they 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
We gave the service 48 hours' notice of the inspection. We needed to ensure the provider could consider any risks in relation to COVID-19 and to ensure the inspection was carried out safely.

What we did before the inspection

We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We had not requested the provider send us a provider information return. This is information providers are required to send us with key information about the service, what they do well, and improvements they plan to make.

At the time of the inspection Devon County Council were in the process of investigating some safeguarding concerns, which also related to these areas of concern. We did not specifically look at these individual safeguarding concerns but were mindful of them in the overall planning and inspection of the service.

We used all this information to help plan our inspection.

During the inspection-
We spoke with 10 members of the staff team. This included, the registered provider, registered manager, clinical lead, nurses, and care staff. We observed staff as they supported people and went about their designated tasks within the home. Due to risks associated with COVID-19 we did not meet and talk with people separately, but we did observe and speak to people informally about their care and experiences as they were being supported by staff.

We reviewed a range of records relating to people's care and the running of the service. This included care plans, twelve medicines administration records (MARS), 3 staff recruitment records and quality audits including fire safety and maintenance records.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We requested further records relating to people's care arrangements, such as care plans. We requested records relating to incident reports, training and specific policies and procedures we had not been able to review on site.

We spoke with the registered provider and local authority to seek clarity about the immediate plans in place to ensure people's on-going safety and well-being.

Inadequate

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 now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse. Lessons learned when things go wrong
● People were not protected from the risks of abuse. Management of potential safeguarding concerns was not robust or effective. For example, thoughstaff had used the homes incident reporting process to report concerns of potential abuse and neglect. Reports we looked at did not include information about any action that had been taken to safeguard the people concerned.
• The registered manager told us they had responsibility for overseeing incidents and allegations of potential abuse in the service. However, the registered manager was not aware of all incidents that had been reported and was not able to confirm that appropriate action had been taken to safeguard people.The registered manager had not always taken action when incidents of potential abuse were reported to them.
• Staff told us they had raised concerns about people's care, but that their concerns had not always been listened to, escalated or acted on.
• Prior to the inspection the registered manager had been informed by the local authority safeguarding team about serious concerns raised about the service and people's care. This information had not been used effectively to review systems in the service and to prevent re-occurrence and safeguard people. For example, one person had sustained a minor scald to their hand due to being given a hot drink in bed. At this inspection we found risk assessments and care plans had not been sufficiently updated to ensure risks for this person were minimised. Safeguarding concerns had also been reported to the home in relation to a person with skin damage. At this inspection we saw a further incident had been reported about the failure of staff to meet the person's daily personal care needs and the risk of further skin damage.
• Due to the absence of a robust system to report and escalate safeguarding concerns and the number of concerns we saw had been reported but not acted on, we raised an immediate alert with Devon County Council during the inspection.
• A meeting was held with the provider and the local authority to formulate an immediate plan to ensure people were made safe.

People were not safeguarded from the risks of 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.

Assessing risk, safety monitoring and management
• People were placed at increased risk as risks were not adequately assessed or managed.
• Care plans and risk assessments lacked detail and guidance for staff to respond effectively to people's needs. One person was being supported with their continence needs and had a catheter in situ. We saw from records this person had experienced infections in the past. The care plan for the person was not specific to this area of need and did not contain guidance for staff to recognise and prevent complications of

infection. This meant the person may be at risk of recurrent infections and associated complications.
• Where people were at risk of pressure sores, care plans instructed staff about what action was required to mitigate risks, such as how often the person needed to be re-positioned. However, monitoring records such as re-positioning charts did not evidence that this care happened in practice. For example, one person's records stated the person should be supported to change their position every two to four hours. The persons monitoring charts showed this was not being adhered to and we saw from records that there were long periods of time where their position had not been changed, such as overnight.
• Some people were receiving treatment and care of existing pressure ulcers. Although care plans identified that they had a pressure ulcer and where they were on the body, there were no specific care plans in place that gave detailed information. For example, there was no information about the type of dressing, frequency of application, the size and shape of the pressure damage or any specific creams required to promote healing and prevent further damage.
• Some people had been assessed as needing pressure relieving equipment to assist with the prevention of skin damage. Although equipment was in place, these were not being used effectively. For example, we checked six people's mattress settings and found five pressure mattresses were not set correctly for their weight. There was no guidance in care plans or risk assessments to instruct staff on what pressure the mattress should be set at and there was no checking system in place to ensure mattresses were set correctly. We reviewed the records of one person who had been assessed as having fragile skin and had a pressure wound. The person's mattress was not set correctly for their weight. We raised concern in relation to this person at the time of the inspection.
• People with particular dietary needs were not in all cases being supported safely. Where people were at risk of dehydration, charts and electronic monitoring was used to record what people had drunk and how much. However, we found staff were not consistently recording fluid intake or acting appropriately when a person's daily intake was insufficient.
• Where people were living with long- term health needs, records did not always contain enough information about how people needed to be supported to reduce risks and maintain their safety. For example, one person was living with a condition, which caused seizures. Their care plan did not contain detail about what staff should look out for, how to monitor the person's condition or when it might be necessary to seek medical support. We found care plans did not support staff to deliver effective care for people living with diabetes. There was no guidance for staff about how to identify high or low blood sugar levels or information about specific dietary needs and other important health checks.
• People with risks associated with their mental health did not have plans in place to manage and mitigate the risks appropriately. One person had been assessed by the specialist mental health services and recommendations made to ensure they had stimulation and for staff to keep a record of activities. Records did not demonstrate these guidelines had been followed and staff said they did not have time to do activities with people.
• When people had been assessed as being at risk of falls plans were not in all cases in place to describe the actions needed to reduce these risks. One person had a pressure mat in place to alert staff when they were moving, but the leads from the mat were trailing along the floor area of the person's bedroom creating a potential tripping hazard. Incident reports detailed a high number of unwitnessed falls, particularly in people's bedrooms.
• We were told that a number of people in the home were at risk of wandering. Incident reports detailed incidents of people found by staff outside of the building and wandering into other people's bedrooms. We saw one person wandering into the food preparation area, where items of food supplements were stored. Staff we spoke with were not aware of this person's whereaboutsbut did know they were at risk of wandering. Care plans we looked at did not describe these risks or plans in place to keep people safe.

Using medicines safely
• Medicines were stored in locked rooms, cupboards and trollies. However, during the inspection, a dose of a

liquid medicine had been left out unattended on a trolley. A member of staff removed it as soon as it was noticed. Two medicines trollies were kept in a corridor outside a dining room. These were locked when not in use, however they were not secured to the wall.
• There were suitable arrangements for storing medicines requiring extra security. However, when unwanted supplies were sent to be destroyed, they were not signed out of the register, although their destruction was recorded on disposal records.
• We checked a sample of people's medicine administration record (MAR) charts. These showed that people did not always receive their medicines in the way prescribed for them. For example, one person was prescribed an antibiotic three times a day, where the dose was signed as given only once a day. Another person was prescribed an antibiotic where more doses were signed as given, than those recorded as having been received into the home. We saw two people's records where a dose of one tablet had been prescribed, but two tablets had been signed as given on several occasions. Two people had two charts in use covering the same date when a dose of the same medicine had been signed on each chart for the same time.
• When MAR charts were handwritten, we saw that these were not always clearly or legibly written or signed by staff. There was no system for double checking these charts to ensure they were clear and accurate.
• There were not always suitable details available when people were prescribed medicines 'when required'. Charts to record administration of these medicines were available but there was not always person-centred information to support staff when it would be appropriate to administer a dose. For example, one person prescribed a medicine to be given only when required had been given a dose every night on their current MAR chart. Care records did not show any reason for the doses being needed. The medicines policy did not contain guidance for staff on managing 'when required' medicines.
• There had been some issues of medicines running out of stock between ordering cycles, for example one person missed two days of regular medication part way through the month because insufficient supplies were received at the start of the cycle. This had not been identified in a timely way. We were told that new systems were being introduced to ensure that when medicines were received at the start of each cycle, quantities would be checked to make sure supplies would not run out.
• We checked records for one person who sometimes received medicines covertly. There was some evidence that this had been discussed with the GP and family, however there was no documented mental capacity assessment and best interest decision, and no record of pharmacy advice on how to safely administer the medicines.
• When any medicines errors or incidents were identified these were reported to management. However, records of any actions taken were not always followed up or recorded.
• Staff told us they received medicines training, however there were no recorded competency checks to make sure they gave medicines safely. This is not in line with current best practice guidance.

This demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• A new system had been introduced for the recording of creams and other external preparations. Directions were available so staff knew how to apply them. Records showed that staff recorded each preparation when applied.
• If people were supported to look after their own medicines, we saw that a risk assessment had been completed to make sure this was safe for them.
• Storage temperatures were monitored to make sure medicines would be safe and effective.

Preventing and controlling infection
• Best practice was not always followed in relation to infection control. Staff were not all wearing appropriate PPE in line with current guidance.
• We observed the registered manager and provider and some staff wearing masks that were not fluid

resistant. Some staff were wearing their masks under their chins or below their noses. We observed staff constantly touching the outside of their masks to adjust them.
• Staff told us they had not received infection control training, training on how to put on and take off PPE or specific Covid-19 training, to help them understand the risks and adhere to infection control processes in line with guidance. The service had not attended infection prevention and control training offered by the local authority.
• There was no signage displayed around the service to advise staff on handwashing technique or donning and doffing PPE.
• We were not assured that the provider was promoting safety through hygiene practices at the service. The service did not always look clean and some areas were cluttered. Domestic staff were employed within the service and completed regular cleaning tasks. However, they told us they only had time to bleach clean frequently touched surfaces once a day. This was not in line with current guidance.
• The service was not free from malodours. We noted one area smelt strongly of urine.
• People were not always supported to socially distance whilst in communal areas of the home. Seating arrangements in some communal areas did not enable people to maintain the minimum distance from each other when sitting down, in line with Public Health England's current guidelines. This placed people at risk from the spread of Covid19.
• Individual risk assessments had not been completed to identify and manage people at higher risk from Covid 19.
• We asked the registered manager to send us the service's Covid 19 infection procedures and policies prior to the second day of the inspection. The information sent to us was downloaded from the internet and was not personalised to the service.

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.

• PPE was available around the building, for example masks, gloves and aprons.
• People were not admitted to the service unless they had been tested as negative for Covid-19. Newly admitted people were isolated in their rooms to further ensure people were protected from the risk of cross-infection.
• Visitors to the service were limited to two visitors at a time and had no contact with other residents and minimal contact with staff. There was a booking system in place to stagger visitors and visiting times to minimise visitor numbers.

Staffing and recruitment
● Staffing levels and skills of the staff team were not sufficient to meet people's needs and to keep them safe.
• Staff told us they did not always have time or sufficient numbers of staff to meet people's needs and complete daily tasks. A staff member said one person had remained in bed as there were not enough staff available to keep them safe. One staff member said, "We don't have time to just sit and spend time with people".
• Staff had reported incidents of when there had not been enough staff available to get people up and to do tasks, such as changing people's pads, or monitoring people who may wander. We asked the registered manager about the reports and what action had been taken to address the concerns raised. The registered manager was not able to provide this information.
• The registered provider said they used a tool to calculate the number of staff needed to meet people's needs. However, they said they were not aware of the concerns raised by staff in relation to staffing levels and had not been aware of recent incidents, such as falls and people wandering, to take into consideration

when planning staffing levels.
• The service had a training plan for staff, however training was not in all cases up to date and did not address gaps in staff skills and knowledge that had been identified. For example, incident reports detailed a number of recent medicines errors. No action had been taken in relation to these incidents to ensure staff competencies were assessed and monitored.
• Other agencies expressed concern that training programmes were not always taken up by the service and staff engagement in training sessions had been poor. The registered manager said they were aware that all areas of training were out of date and that they planned to address this issue as a matter of priority.

Staffing levels and skills of the staff team were not sufficient to meet people's needs and to keep them safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Good. 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. Continuous learning and improving care.

• The registered provider did not demonstrate they had sufficient oversight of the service to ensure people received the care and support they needed that promoted their well-being and protected them from harm. For example, the provider did not know about incidents and safeguarding concerns that had been raised about the service or that action had not in all cases been taken to safeguard people.

• Quality checking processes and audits were either not completed or were ineffective across all areas of care. This meant people were at risk of receiving poor care because the risks to their safety and wellbeing were not mitigated or managed effectively to protect them from harm.

● Records were not always accurate and had not always been updated to reflect changes in people's needs.

● People could not be assured of safe care and treatment as this was not being effectively monitored. There was a lack of monitoring and oversight of daily care records to ensure people's needs were met. For example, in relation to people's food and fluid intake and skin integrity. Where risks to people had been highlighted, it was not clear from records that staff were following the systems in place to reduce this risk.

• The home did not have effective systems in place to assess or to monitor staff competence and/or skills to carry out the role required of them. This meant the provider could not be assured staff had the necessary skills and knowledge to meet people's assessed needs in a safe way.

• People could not be assured that allegations of potential abuse would be acted on and escalated appropriately. When reports of potential abuse had been reported to management these had not always been acted on immediately to safeguard people or to prevent re-occurrence.

• Quality checking processes were not effective in assuring that incidents that happened in the home were reported to other agencies as required.

● Opportunities to learn from incidents, address poor performance and improve practice had been missed. A lack of robust auditing and managerial oversight meant the service did not pick up on concerns when they occurred, meaning they could not learn from them or improve care for people.

● There was a lack of understanding of best practice guidance, and oversight of risks to people to ensure safe care and treatment. Staff had not received the appropriate training or competency checks on their practice to ensure they were able to provide care to meet specific needs.

● Whilst staffing levels were being assessed this was not effective as the planning of staff rotas did not take into account risks, incidents and concerns raised by staff.

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

• The lack of effective leadership did not promote and ensure a positive and person-centred culture in the home.
• The lack of up to date training and insufficient numbers of staff meant people's needs were not always met in a way that promoted and respected their rights and dignity.

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 and provider told us they understood the duty of candour and their responsibility to be open and honest when things went wrong. However, their lack of oversight meant they weren't always aware when things went wrong, and therefore did not always consider and fulfil this responsibility.
• Staff told us they knew how to 'whistleblow' and to raise concerns with the local authority and the Care Quality Commission. However, we found evidence of poor practice that had been raised by staff within the service to senior management but had not been escalated further when no action had been taken.

Working in partnership with others
• The registered manager had been working with representatives from the local authority safeguarding and quality team following concerns identified to make improvements needed. However, other agencies told us that information requested was not made available in a timely manner and records were often of a poor-quality making investigations difficult to conclude.
• During the inspection the registered provider told us they had recognised information and liaison with other agencies had not in all cases provided a prompt and accurate reflection of people's needs. During the inspection they told us they were committed to working closely with all key agencies to ensure people's needs were appropriately and safely met.

Systems were either not in place or not robust enough to manage the safety and quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

• The suitability of staff to work with people was checked as part of the recruitment process. These checks included obtaining proof of identity and a disclosure and barring (police) check to ensure that staff did not have criminal cautions or convictions that could impact on the role they had applied for.
● However, a full work history and an explanation for gaps in employment history had not been obtained for some newly employed staff.

We recommend the provider seeks advice and guidance from a reputable source about maintaining robust records in relation to recruitment.
• The service had a Registered manager responsible for the day to day running of the service. The registered manager was available on the first day of the inspection. On the second day of the inspection the registered provider informed us the registered manager had left and was no longer overseeing the running of the service.
• We spoke with the registered provider who was open and honest throughout the inspection and said they recognised they had lost oversight of the service. The registered provider was staying at the service and told us they would continue to do so until they were assured people's needs were being met safely. They had recruited a consultancy firm to support the service and to have oversight of quality and safety. A representative of the consultancy firm spoke with us and confirmed their plans to support the service and to review all areas of care including, staffing, risk, care planning and auditing.