Yunicorn Limited

Hawthorns

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Hawthorns is a residential care home providing accommodation and personal care to three people with learning disabilities at the time of the inspection. The service can support up to four people. Hawthorns accommodates people in one modern domestic detached building. Bedrooms were located on the first and ground floor of the property. A communal lounge/dining room, kitchen and conservatory room were on the ground floor.

The service has been developed taking into account best practice guidance and the principles and values underpinning Registering the Right Support. The home is located close to communal facilities.

People's experience of using this service and what we found
People living at Hawthorns did not receive a safe, effective and well led service. The registered provider had not ensured oversight was in place to maintain people's safety and welfare. Shortfalls identified as part of previous inspections regarding the service were not always actioned to prevent further or similar occurrences.

People's rights were not always promoted regarding where they spent their time within their own home. Terminology used by staff when caring for people and in recording people's care was not always in line with person-cantered care.

Care plans and risk assessments did not contain up to date and accurate information to provide safe care and support people required to keep them safe. Body maps were used in the event of a person having bruising. However, no follow up action was recorded to prevent reoccurrences. Specialist nursing advice was not always sought if people's care needs changed.

The provider and registered manager had not taken appropriate action to protect people. Where people experiencing unexplained bruising, the provider had not informed key agencies with responsibilities for protecting people, to ensure investigations were undertaken and plans put in place to keep people safe.

Environmental risks were not acted upon and systems in operation failed to identify where people could be at risk of harm. Risks regarding the building were not always identified and were not always acted upon in line with the provider's procedures.

Accurate records regarding people's medicines and prescribed creams were not always maintained placing people at risk.

The dependency needs of people were not considered to establish the required staffing levels to meet these needs.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support. Terminology used in recording and while supporting people was not always in line with person-centred care.

Staff had received training in line with the provider's procedures. Staff were not always applying their skills and knowledge from the training they had received in areas such as consent and record management. Management had not provided an oversight to ensure staff training was used effectively.

The governance of the service had not ensured people received the care and support required to meet their individual need. Systems in operation had not identify shortfalls and had not driven improvements in peoples care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. Best interests decision involving appropriate people were not undertaken prior to people having tests for Covid-19. There was a lack of person-centred care for example in terms of language used by staff within records and staff actions if people did not comply with requests.

The provider had failed to notify the Care Quality Commission of certain events which had occurred within the home as required by law.

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 Requires Improvement (published 04 September 2019). There were two breaches of regulation. The provider told us what they had done after the last inspection to show how they had improved. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

The service was rated Requires Improvement at the last two consecutive inspections.

Why we inspected
We received concerns in relation to the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We were also aware of the death

of a person. This is potentially subject to a police investigation. As a result, this inspection did not examine the circumstances surrounding this.

We reviewed the information we held about the service including information supplied to us before the inspection was undertaken. We did not inspect the other key questions as part of this inspection. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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 changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

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 Hawthorns on our website at www.cqc.org.uk.

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

We have identified breaches in relation to safe care and people's treatment, staffing, personalised care, best interests decisions, safeguarding, management of a safe environment and the governance of the service.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
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 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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Hawthorns

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
The inspection team consisted of two inspectors.

Service and service type
Hawthorns is a 'care home' without nursing. People in a care home receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, both 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
This inspection was unannounced.

What we did before the inspection
We reviewed information we have received about this service since the last inspection. We received information of concern from two local authorities and other professionals who work with the service. In addition, we identified further concerns as result of the Emergency Support Framework (ESF) which was undertaken with the registered manager.

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 were unable to speak with people who use the service. We spent time to see how people were cared for by staff, before everyone went out for their planned activity for the day. We spoke with four members of staff including the registered manager who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. The other staff members spoken with were members of care staff who are also responsible for cleaning the home and cooking people's food.

We reviewed a range of records these included two peoples care records and multiple medication records. We looked at the file of a newly appointed member of staff in relation to their recruitment. We looked at a variety of records related to the management of the service including body maps, records of incidents and the management and review of people's risks as well as policies and procedures.

After the inspection
We continued to seek clarification from the registered provider to validate evidence found. We viewed the records and additional information we requested sent to us via email and held further discussions with the registered manager. We discussed our findings with other professionals so they were aware of risks at the home and the safety concerns we identified.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection; Learning lessons when things go wrong

At our last inspection the provider had failed to prevent the risk of harm to people to keep them safe. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People were not protected from the risk of harm. This required action to be taken by the registered manager and provider to ensure people were safe. Care plans were not up to date and in sufficient detail to guide staff to provide safe care to people.
- Staff had recorded incidents on body maps such as bruising, lumps, swelling and grazes. These were not always recorded within the care records or clinical records to evidence action taken. The body maps lacked any follow up action and were not linked with accident records or investigation to demonstrate what was done to reduce people's future risk, or to identify whether any other intervention was needed. The lack of action placed people at risk of further incidents and at risk of not receiving the care required to keep them safe.
- The records of one person included instruction from a specialist nurse regarding the use of pressure relieving equipment to prevent the person developing sore skin. This equipment was not used when the person was sat in the lounge. We were told the staff had found the use of equipment to be a greater risk. This was not recorded and there was no record to indicate if staff had sought additional specialist advice to inform their decision to stop using the equipment.
- Medicinal cream management placed people at risk because accurate records were not completed. In addition, one person had cream within their bedroom with no date of opening recorded. The item was dispensed in March 2018. Instructions upon the container showed it needed to be used within three months. There was no record of when this item was opened and therefore increased risk the person would be administered this cream which was not in line with NICE (National Institute for Health and Care Excellence) best practice guidance.
- Risks to people regarding water temperatures were identified as part of our previous inspection.
- We found further concerns on this occasion as temperatures outside those permissible under the providers own policy and guidance were recorded, but action had not been taken to address this risk to people.

● Risks to people were increased because action had not been taken to mitigate harm regarding infection control and environmental risks. The bath hoist seat was found to be dirty underneath as effective cleaning had not taken place. The support fixed to the floor for the over bath hoist was damaged as was the bath. Both would make effective cleaning difficult and increase the risk of people experiencing infections.
● Management had not learnt from previous inspection reports and from other stakeholders to ensure people were kept safe. There was a lack of action to ensure people were cared for safely. Patterns and trends were not identified and escalated or address.

Systems were not in place to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff confirmed they had access to Personal Protective Equipment (PPE) in line with current Public Health England (PHE) guidelines. Additional PPE was available in the event of staff requiring this.
● Staff were able to describe a range of additional infection control practices they had instigated and built upon due to the pandemic.

Systems and processes to safeguard people from the risk of abuse
● The registered manager and staff spoke about their knowledge of recognising potential abuse and about the action they would take if they believed people to be at risk. However, we raised concerns with the registered manager regarding the recording of unexplained bruises. One incident gave us cause for concern and we raised a safeguarding alert with the local authority as no alert had been raised by the provider. The registered manager stated they were not aware of the incident and no investigation had taken place regarding this or other occasions where people sustained bruising. The local authority later confirmed the information sent to them by CQC met their threshold and should have come to their attention at the time of the incident by the provider.

We found evidence of a lack of safeguarding reporting to the local authority. The provider had not taken action to report incidents of unexplained bruising. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008.

Staffing and recruitment
● The number of people living at the home had reduced since our previous inspection. As a result the provider had reduced the number of staff on duty. We asked the registered manager to provide us with information about people's dependency needs in order to determine the staffing level required. The registered manager was unable to supply this information and therefore could not demonstrate how the provider had reached a decision to reduced staffing and calculated the staffing requirement.
● Staff told us certain times of the day were busy as a result of the number of staff members on duty and this effected how they were able to meet people's needs.
● The care plan of one person stated they would need the support of two people to support them if they became anxious. This would involve the whole team during the day time and could not be achieved when only one member of staff was on shift such as night-time since the reduction in people living at the home. This meant there were insufficient staff to provide key areas of people's support, safely.
● In addition, the provider's medicines policy stated two members of staff were required to administer people's medicines. This was not always possible due to the number of staff members on shift at times.

We found no evidence that people had been harmed however, the registered manager was unable to evidence how dependency levels were considered in determining staffing levels. This placed people at risk

of harm. This was a continual breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A member of staff confirmed recruitment checks were undertaken prior to them commencing work at the home. The same person confirmed they had received shadowing opportunities with experienced members of staff prior to them providing care to people.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At 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 people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

- People living at the home had done so for several years. Regular reviews of people's assessment of needs were not evident within the care documentation.
- The provider was unable to evidence how people's health care needs had been met. We previously reported upon concerns in relation to the management of people's toileting needs and the improvement needed to evidence people's well-being. We checked current personal care records in relation to this and found similar concerns. In addition, one person's record had been completed for a date in the future.
- People's epilepsy health needs were not manged effectively. The registered manager advised us all seizure histories were up to date. Seizures people had experienced were not reflected in their seizure history. For example, one person had recently experienced a seizure, however this information was not readily available should they require specialist support. We found at least one more recent seizure had happened, which the registered manager was not aware of. This increased risks other health professionals would not know the extent of the person's health needs.
- Care records did not always show people were cared for in a person-centred way or in which people's human rights were respected. One person's records indicated a punitive system to be in place. Documents stated a person would be taken to their bedroom if they did not conform to staff instructions. One entry stated, 'Staff told (person) to be good otherwise (person) would sit in (person) room'. The registered manager assured us this was not a sanction and the person liked to go to their bedroom. There was no care plan in place which reflected this approach.
- The terminology used in people's records was not always person centred. For example, we saw reference made to a person playing with their toys and referred to people as in a, 'Good mood'. The comments lacked respect for the individual and were not conducive to working alongside an adult and highlighted a risk of psychological harm as a result of a culture within the home.

We found no evidence that people had been harmed. However, people's health care needs were not always effectively focused on them as individuals or effectively managed. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they would access emergency care if people needed it.
- Staff were aware of triggers to one person's anxiety and strategies such as working at the persons' own pace to reduce these levels and keep the person safe from potential harm.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People living at the home had recently undergone a test for Covid-19. The registered manager had not followed requirements to ensure people's rights had been respected and decisions made in their best interests. They had not ensured they consulted with relevant people prior to each person having an invasive test carried out.
● We were told decisions were made by the registered manager and the deputy manager in the event of people not being able to make informed decisions themselves. This is not in accordance with the MCA.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they had made new applications to the relevant local authority in relation to the Deprivation of Liberty Safeguards.

Adapting service, design, decoration to meet people's needs
● Shortfalls in the repair of aspects of the home were not always identified and promptly actioned to ensure the environment was safe for people.
● We brought to the attention of the deputy manager a trip hazard leading into a person's bedroom as the carpet was not secured by a suitable holder. We saw a screw protruding from a wall which could have potentially caused injury.
● In addition, we saw a broken radiator cover and shortfalls where fixtures could not be effectively cleaned. The registered manager was not able to supply us with a programme of ongoing improvement and replacement concerning the items we identified.

We found no evidence that people had been harmed. However, action to ensure effective management of the environment had not always taken place. This was a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● After the inspection the registered manager sent us a training matrix. The matrix evidenced staff members had undertaken training in line with the provider's requirements. However, we found knowledge and skills were not always put into practice.

● Staff did not escalate safeguarding concerns or apply the knowledge they had gained regarding people's safety.
● There was a lack of understanding regarding gaining people's consent and records were not accurately maintained including those relating to people' care and their medicines.
● One member of staff confirmed they had received shadowing opportunities with an experienced member of staff prior to providing care to people.

Staff working with other agencies to provide consistent, effective, timely care
● At the time of the inspection other agencies were working with the registered provider due to the concerns raised and the ongoing monitoring of the quality of care provided to people.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff were aware of people's dietary needs. Information regarding special diets people required provided by special healthcare professionals was available for staff to refer to as needed.

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

At our last inspection the provider failed to mitigate risks and assess and monitor the service effectively. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

- The registered manager and provider had continually failed to have an oversight of the service to ensure people received safe and consistently well-managed care and support.
- At the last two comprehensive inspections the provider was rated as requires improvement. The leadership of the home has failed to drive through the required improvements and the quality and safety of the care and support provided has deteriorated further.
- No effective systems were in place to ensure the provider and registered manager were aware of incidents such as people experiencing unexplained bruising. Effective action was not taken when these incidents occurred, and systems were not in place to identify any emerging patterns.
- The registered manager had recorded checks they had made. Areas covered water temperatures, fire and medicines. These were not always effective in identifying shortfalls in the level of service provided to people. People's weights were not monitored as part of the audits as they showed the task to be delegated to other staff members meaning there was no effective system to ensure this was done.
- We previously highlighted concerns regarding the management of people's toileting needs. No systems were in place to provide oversight people had received the support they needed with their bowel health or epilepsy management.
- There were no checks made by the provider for them to assure themselves the service was safe. As a result, they had failed to identify any concerns or safeguarding incidents regarding the quality of the care provided.
- Systems operated by the provider and registered manager failed to identify concerns and shortfalls in relation to people's care records and the lack of consistent record keeping. In addition, checks had not identified or acted to address staff not using their knowledge and skills. This was needed in order to ensure people received safe care and support and did not place them at risk of not having their needs recognised and met.

● The provider did not have a system in place to assess the dependency needs of people living at the home and therefore to establish the staffing levels required to be able to meet these needs.

We found no evidence that people had been harmed however, systems in place to assess, monitor, mitigate and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had not recognised a safeguarding incident and had therefore failed to submit a notification to the Care Quality Commission in a timely way as required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The registered manager was at the time of the inspection dividing their time between two registered locations. They had a deputy manager working at each of these.

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; Working in partnership with others
● At the time of our inspection the local authority and other agencies were working alongside the provider and registered manager following the number of concerns raised by different organisations regarding the standard of the service provided.
● There was not always evidence to show consistent working with specialist nurses regarding the use of equipment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Due to the small staff team no formal staff meetings had taken place. The registered manager assured us they operated an open-door policy if staff wished to speak with the regarding their role or any aspect of the running of the home.
● We were informed regular contact had been maintained with people's family members due the current pandemic during which time visiting had not been possible. Contact had been made with people using technology such as video calls.