The Hermitage Charity Care Trust

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Inspection report

66 Holly Road
Uttoxeter
Staffordshire
ST14 7DU

Tel: 01889562040
Website: www.uttoxeterhermitage.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Hermitage Charity Care Trust is a residential care home providing personal care to 30 females aged 65 and over in one adapted building. At the time of the inspection 26 people were receiving care and support.

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

Medicines were not always managed in a safe way. People were not protected from risk as incidents that had occurred had not been identified as safeguarding issues and had not been properly investigated.

Known risks to people's health had not always been assessed and planned for.

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 to ensure they supported people in the least restrictive way possible and in their best interests.

The provider had failed to make any improvements since the last inspection. There was a lack of systems in place to monitor the safety and quality of care being provided. Notifications of incidents we should have been notified of had not been sent to us or the local safeguarding team. Lessons were not always learned when things went wrong.

People and their relatives told us they felt well supported. The environment was clean and tidy and was adapted for the people living there. Staff were recruited safely.

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 27 January 2020)

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection improvements had not been made and the provider was still in breach of regulations. The last rating for this service was requires improvement (27 January 2020). The service has now deteriorated to inadequate. This service has been rated less than good for the past two consecutive inspections. This will be the third consecutive time the provider has failed to achieve a good rating overall.

Why we inspected
We had concerns in relation to some complaints reported to us. As a result, we undertook a focused

inspection to review the key questions of safe, effective and well-led.

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 have found evidence that the provider needs to make improvements. Please see the safe, effective 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 The Hermitage charity Care Trust 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 multiple breaches in relation to the safe care and treatment of people, safeguarding people from abuse, notifying the CQC of particular incidents and the lack of quality monitoring systems in place.

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?

Requires Improvement

The service was not always 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.

The Hermitage Charity Care Trust

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 following complaints received. 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 two inspectors.

Service and service type
Hermitage charity Care trust 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
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 local authority made us aware of some support that had been provided to the service. 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 five people who used the service and three relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager, deputy manager and care workers.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. We also viewed records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at daily care notes and risk assessments.

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

Using medicines safely

●Medicines were not managed safely. Stock control systems were not in place and medicine administration records (MAR) had gaps in recording. For example, one person did not have their medicine for a period of five days as there was no stock. Another person did not have their medicines signed for on five occasions. This meant we could not be assured the people had received their prescribed medicines and this presented a potential risk to their continued well-being.

●At the last two inspections we asked the provider to ensure there were protocols in place for people that needed 'as required' (PRN) medicines. At this inspection the provider had failed to put these in place. Some people needed their medicines during periods of distressed behaviours. There was no guidance available for staff to assess when to give these medicines. This meant people were at risk of not getting additional medication prescribed to alleviate distress when needed.

●One person was prescribed medicated patches that needed to be applied to a different area of the body to avoid skin damage. There was no guidance for staff to follow to ensure the patch was applied in a different area. This meant the person was at risk of harm as we could not be assured the patches had been applied in line with the manufacturer's guidance.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from abuse.

● Where accidents or incidents had occurred, these had not been reported to the CQC or the local authority safeguarding team. This is further discussed in the well led domain

● We found instances where serious incidents had occurred and these had been recorded in people's daily notes but had not been safeguarded, investigated or any actions taken to mitigate the risk of these incidents happening again.

● One person who displayed distressed behaviours had been physically and verbally abusive to people and staff multiple times and this had not been escalated as a safeguarding concern. This meant other people were at risk of this type of incident.

● Following the inspection, we had to report some incidents of potential abuse to the safeguarding authority as these had not been recognised by the provider.

The above concerns constitute a continued 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; Learning lessons when things go wrong

●People's known risks were not always assessed or planned for and information was not always included or

updated in people's care plans. Some people displayed distressed behaviours and there were no specific plans in place to inform staff how to respond on these occasions. Staff told us they knew some strategies to help calm people, but these were not recorded in care plans.
●Some people had specific health conditions that required monitoring by staff. Professional advice had been sought in some instances but this had not been recorded in care files. These people's care plans or risk assessments did not contain detail for staff to follow or signs to look out for if the person became unwell.
●Where people required their food and fluids to be monitored, this was not done consistently. Recording charts were not always completed and did not contain the fluid totals the person needed to remain hydrated. This meant people were at risk of becoming dehydrated and at risk of pressure damage.
●Some people were being cared for in bed. These people were not monitored for weight changes or been assessed via other appropriate methods used to monitor weight for an extended period of time. This meant any significant weight loss was not potentially identified, which may have been an indicator of malnourishment.
●Some people required regular repositioning in bed to prevent pressure areas forming. We could not be assured this had always been done as recording charts had not been consistently completed, or the agreed timescales had not been adhered to. This meant people were at risk of skin damage.
●Changes to people's care needs following health professionals' input or following accidents, or incidents had not been properly recorded. There was minimal information regarding people's care and support needs such as managing distressed behaviours, skin integrity and mobility. This meant people were at risk of unsafe care because comprehensive and up to date information was not available to staff.

The above concerns constitute a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People told us they felt safe. One person said, "I do feel safe here, I wouldn't stay if I didn't. Everyone here is caring, and they look after us well."
●We observed people being supported with their mobility needs by staff who knew the correct techniques to ensure this was done safely with positive interactions between staff and people.

Staffing and recruitment
●People told us there were enough staff to support them. One person said, "Yes there's always staff around, and they do get to you quickly if you need them."
●Staff commented that night shifts were busy and there were not enough staff. We raised this with the registered manager who stated they wanted to recruit new night staff and had at times used agency staff. The registered manager told us they were awaiting for approval to recruit more staff.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

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 remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.

● At the last inspection we told the provider to make changes to people's care files in regard to MCA. At this inspection we found these changes had not been made.
●Assessments regarding people's capacity to make decisions had not been undertaken meaning people's rights were not being protected through effective use of the MCA. One person required needed to eat a specific diet due to a choking risk. Care records showed that this person may lack capacity to make a decision about this but no evidence of a formal assessment or best interest meeting was available.
●One person had a pressure sensitive mat in their room to reduce the risk of falls. There was no evidence of a mental capacity assessment being undertaken or best interest meeting being held in line with the requirements of the MCA.

The provider did not have effective systems in place to ensure they were working in line with the Mental Capacity Act 2005. This placed people at risk of harm. This was a continued breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● A Staff training matrix could not be located during the inspection and the registered manager confirmed no training had taken place for an extended period of time. Staff told us that they had not received any refresher training and had not received any supervisions or meetings in more than a year. One staff member said. "Sometimes the seniors get told things from the manager but that's not always passed onto everyone,

as the manager is usually in the office some of us find it hard to approach them with issues."
● People and their relatives told us they felt the staff had the necessary skills to support them. One person said, "Yes, the staff always seem to know what they are doing, I've never had any issues." A relative said, "I think [relatives name] is very well care for here, the staff do seem to know what they are doing."

Supporting people to eat and drink enough to maintain a balanced diet
●People told us they enjoyed the food, there was plenty of it and they were given choices. One person said, "The food is always nice, it's always nice and hot and we get to choose what we want. If we don't want what's on the menu we can have something else it's never an issue."
●We observed people being supported to eat and drink where needed, however records of how much people actually ate had not been accurately recorded.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●There was evidence of people having access to other health and social care professionals, however advice from these visits were not always updated in care plans.
●Updates to people's health and wellbeing wasn't consistently documented and was handed over verbally during shift changes. This meant people were at risk as this information was not always documented and may not as a result have been known to staff so they could act upon it.

Adapting service, design, decoration to meet people's needs
●The service was suitable for the people who used the service. People were able to personalise their bedrooms and communal areas were bright, clean and tidy.
●Bathrooms had been adapted to allow for easier access for people with mobility issues, all areas were kept clutter free and there were grab rails in place to assist people with support when walking.

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
There had been no improvements been made following our last two inspections, therefore the provider continued to be in breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure adequate systems were in place to monitor the quality of care being provided for the last three consecutive inspections. People were at risk of receiving unsafe or poor quality care.
● There were no systems in place to properly monitor the administration of people's medicines. For example, some people had gone several days without their prescribed medication due to unsafe stock control practices, PRN protocols were not in place despite this being raised as an issue at previous inspections and medication audits had not been completed. The registered manager was not aware these issues had occurred which meant people had been placed at continued and significant risk of harm.
● Care records and risk assessments were not always kept up to date and did not always reflect people's current level of need. The electronic recording system in place was difficult to use and it was hard to get an overview of a person's health and well-being.
●The provider did not have systems in place to ensure staff carried out care to individuals in line with external health professional's guidance following identified health risks and needs. For example, following incidents and accidents.
●The provider lacked oversight of the service and had failed to put any systems in place to monitor the quality of the service or the performance of the registered manager. This meant no improvements had been made following our two previous inspections and meant people had been at risk of continued unsafe care with a continuation of breaches in Regulations.

Continuous learning and improving care
●The provider continually failed to improve. The service had not achieved a rating of good for the past two inspections and had failed to put systems in place to try to improve the quality of care received by the people using the service.

The above constitutes a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Notifications had not been submitted to us (CQC) as required by law. We found safeguarding incidents the local safeguarding team had not been notified of. The rating from our previous inspection was not on display, however this was rectified on the day of the inspection.

The above constitutes a continued breach of Regulation 18 (notice of other incidents) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

●The registered manager did not have systems in place to ensure staff had the opportunity to discuss any concerns, improvements for the service or to discuss their own developmental needs. Staff told us and the registered manager confirmed staff supervisions had not been undertaken for an extended period and no staff meetings had been arranged. " One staff member said, "We had our initial training but not had anything since and I've not had any supervisions with the manager for over a year now, it's been hard through Covid and lack of support has made it feel worse."

●Relatives told us that they had been kept informed about their relative's health by staff and the registered manager. One relative told us, "The staff and the manager were very good at keeping us informed, especially during the Covid lockdown. We had phone and video calls and did have a couple of visits to see [relatives name] through the window which was nice."

Working in partnership with others

●The registered manager had links with other professionals, however advice that was given by some of these professionals had not always been followed to ensure people were kept safe.