

Parkside Residential Homes Ltd

Hawthorn House

Inspection report

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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

About the service

Hawthorn House provides accommodation and support with personal care for up to 22 older people, some of whom may be living with dementia. At the time of this inspection there were 18 people using the service.

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

The service was not well led. People's safety and welfare was compromised, and governance arrangements continued to be ineffective and could not demonstrate how people were safe. This was the third consecutive inspection where the provider had not achieved a rating of good.

Risks to people were not effectively identified and mitigated. Work was required to ensure current government guidance for working safely in care homes during the COVID-19 pandemic was implemented, adhered to, and appropriately monitored. Good infection control practice had not been effectively implemented.

Work was required to improve the administration, recording and auditing of medicines. We have made a recommendation about the management of some medicines.

Where incidents and accidents had happened it was not clear that lessons had been learnt and action to reduce future risk had been taken.

Systems for oversight and checks of environmental and equipment related risk management were not being identified and documented and there were a number of shortfalls identified over the course of the inspection.

Systems to ensure people's needs were met were not effective as records were not always accurate.

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

For more details, please see the full report which is on the Care Quality Commission's (CQC) website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 9 November 2020). There were breaches of regulations 11 (Need for consent), 12 (Safe care and treatment), and 17 (Good governance).

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

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

At a previous inspection published on 9 November 2020 we recommended the provider reviewed their systems and processes in line with current legislation and guidance for determining safe staffing levels and training. The provider had made improvements.

Why we inspected

We carried out an announced focused inspection of this service on 6 October 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve Need for consent, Safe care and treatment, and Good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions of safe, and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hawthorn House 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 treatment and governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Hawthorn House

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 was completed by two inspectors.

Service and service type

Hawthorn House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was announced. We gave the service short notice of the inspection on our arrival on the first day. This was because we had to gather information on the services current COVID-19 status and the provider's procedures for visiting professionals. We informed the management we would be returning for a second day.

What we did before inspection

We reviewed 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. The provider was asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with four people who used the service, and one person's relative about their experience of the care provided. We spoke with eight members of staff including the manager, deputy manager, three senior care workers, two care workers, and an activity worker.

We looked around the environment to review the facilities available for people and the cleanliness of the service.

We reviewed a range of records. This included four people's care records, and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to review evidence that was sent remotely as well as seeking clarification from the manager to validate evidence found.

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.

At the last inspection systems were not in place to robustly assess risks relating to the health safety and welfare of people. 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 and the provider continued to be in breach of regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people were not always identified, assessed and mitigated.
- People were exposed to the risk of harm in the event of an emergency as risk was not appropriately managed. Information stored at the service to support people in the event of an emergency was missing.
- Environmental and equipment related risk management was inconsistent and risks were not always identified and addressed. Windows in four people's rooms were opening in excess of the Health and Safety Executives guidance.
- Consideration of the risks posed to people by pull cords hanging from the ceilings on the first floor, a water leak, and the use of portable heaters around the home had not been identified or assessed.
- There was no portable appliance testing (PAT) records to show the portable heaters had been tested as safe to use. One extension lead, in use in the main office, had a PAT retest sticker on it for October 2020. This had not been completed.
- Accident and incident forms were poorly completed. These were not routinely reviewed to prevent reoccurrence or identify any trends or themes.

Whilst we found no evidence people had been harmed, people had been placed at risk of harm as the provider had failed to ensure systems were in place to robustly assess risks relating to the health safety and welfare of people. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We raised the immediate risks from window safety and equipment related risks with the manager, following which some action was taken to address the concerns and ensure people's safety.
- Action was taken by the manager to ensure people's safety in the event of an emergency. All missing fire risk assessments and emergency evacuation plans were implemented and made accessible to staff in a 'grab pack.'

Preventing and controlling infection

- People were not being protected from the risk of infection. The provider did not have suitable systems of oversight of infection control within the home.

- We observed some staff were not wearing face coverings in line with government guidance. Not all staff we spoke with were able to demonstrate the correct procedure for putting on and taking off personal protective equipment (PPE). We were unable to see that staff had completed any training, or had their competencies checked in this area.
- The provider was not able to demonstrate they were following the current guidance regarding staff testing for COVID-19. We saw one staff member had not completed a lateral flow test prior to starting work on the second day of our visit.
- There were no recorded pre-entry checks of visitors entering the service despite visits going ahead during both days of our inspection. No pre-entry checks were taken of both CQC staff entering the building on the second day until prompted by CQC.
- A used continence aid had been disposed of in a waste bin with no lid and used PPE had been disposed of in a non-clinical waste bin in a downstairs office. There were no designated areas for staff to take off and dispose of compromised PPE.
- Some carpets and flooring were stained. The flooring outside of the kitchen had gaps in it, and carpet outside of one room was damaged. The dining room carpet was stained and not secured to the edges of the room. This meant appropriate standards of cleanliness and hygiene were not maintained, and some flooring was unable to be cleaned effectively.

Whilst we found no evidence people had been harmed, people had been placed at risk of harm by the failure to effectively manage infection control risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following this inspection the manager and provider offered assurance that action would be taken to improve infection prevention and control practice. New carpets and flooring had been ordered for fitting, and all pull cords in the building had been replaced with wipeable ones.

At the last inspection systems were not robust enough to ensure staff responsible for the management and administration of medication were suitably trained and competent. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this element of regulation 12.

Using medicines safely

- Staff had received training in the safe management of medicines.
- We identified discrepancies with the administration of topical medicines and transdermal patches. Transdermal patches are patches that adhere to the skin as a way to deliver medicines.
- Body maps did not contain guidance for staff on where to apply topical medicines and transdermal patches to people's bodies.
- There was no record where one person had a transdermal patch applied to their body. A staff member told us the patch was applied to the person's back, and that the location was alternated but not recorded. This meant we could not be sure prescribing instructions were followed.
- Another person was prescribed a topical cream. Prescribing instructions stated this should be applied to the affected area regularly. The body map section of the medicines records for 19 January to 15 February 2022 did not include any guidance where the affected area was, and how this cream should be applied.
- The last medication audit had been completed in October 2021. This meant none of the issues identified had been highlighted by the providers systems in place.

We recommend the provider consider current guidance on the management of topical medicines and transdermal patches and take action to update their practice accordingly.

At our last inspection we recommended the provider reviewed their systems and processes in line with current legislation and guidance for determining safe staffing levels and training. The provider had made improvements.

Staffing and recruitment

- There were enough staff to meet people's needs.
- The manager had begun to review staffing levels on a monthly basis in line with people's needs.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. Comments included, "If we needed help they [staff] would get it for us" and "It's lovely here."
- Staff told us they had received safeguarding training and were able to tell us how to identify and report abuse.
- Reporting systems and paperwork to show how people were kept safe were not sufficient. We have reported on this further in the well led section of this report.

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 inadequate. At this inspection this key question has remained the same. 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.

At the last inspection the provider had failed to suitably assess, monitor and improve 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.

Not enough improvement had been made and the provider continued in breach of regulation 17.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Risk management was ineffective, and regulations continued not to be met. This meant people were not always in receipt of safe care.
- There provider had not ensured that recent checks of the quality of service and audits had been completed. This meant it was not possible to determine any learning or improvements to care.
- There was no home manager registered with CQC at the time of inspection. A manager had very recently joined the service. They were supportive of the inspection and open and honest in relation to areas of concern we identified during our visits. They began to make some changes during and after the inspection.
- Organisational policies and processes had not been consistently followed in relation to medicines, window security, PPE, infection control, COVID-19 testing and governance.
- Monitoring of care plans had failed to identify an unplanned weight loss of one person since October 2021. Records relating to people's care were not always completed in line with their care plans. One person's sleep and night routine records stated they should be checked at least two hourly throughout the night. The daily log recording identified these checks were not completed as the care plan instructed.
- The provider had failed to ensure government guidelines for working safely in care homes during the COVID-19 pandemic were adhered to.
- Safeguarding processes in place were not sufficient to provide us with assurance that systems were robust.
- An effective system was not in place to monitor accidents and incidents which occurred within the service.
- Documentation to support an effective workforce had not been completed. Interview records for staff had not been completed and induction records were missing, and incomplete.
- The provider was not using systems to engage people. Surveys and other systems for feedback had not been recently completed.

We found no evidence that people had been harmed. However, the provider had failed to suitably assess,

monitor and improve the safety and quality of the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had failed to follow the principles of the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer breach of regulation 11.

- Systems were in place to ensure any restrictions to people's freedom were applied in line with the principles of the Mental Capacity Act 2005.
- People told us they were happy living at Hawthorn House. We found there was a warm and welcoming atmosphere.

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

something goes wrong; Working in partnership with others

- Staff told us they felt able to share concerns with the manager and deputy manager and they were supported in their role. Comments included, "[Deputy manager] has done a great job supporting us with all the swapping of managers. [Manager] is approachable and seems knowledgeable."
- Staff contacted other services, including primary care services that supported people. This helped to ensure people continued to receive support as they needed it.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to manage risks relating to the health, safety and welfare of people. The provider has failed to manage and assess the risk of infection. This was a breach of Regulation 12 (1) (2) (Safe Care and Treatment)

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to operate a robust quality assurance process to continually understand the quality of the service and ensure any shortfalls were addressed. The provider had not maintained accurate and complete records in relation to the service and people's care. This was a breach of Regulation 17 (1)(2)(Good governance)

The enforcement action we took:

Warning notice.