Essential Healthcare Solutions Limited

The Shrubbery Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Shrubbery Rest Home is a care home providing personal care to up to 26 people. At the time of the inspection there were 21 people living there, although three people were in hospital on the day of our visit so 18 people were in the building. The home supported older people, some of the people were living with dementia or other mental health support needs. People may also have had sensory and/or physical disabilities.

People's experience of using this service and what we found
Risks to people's health and wellbeing were not always assessed and planned for so we could not be sure people were always kept safe. Lessons had not always been learned when things went wrong. It was not always clear what action had been taken to reduce ongoing risk to people. People were not always protected from the risk of cross infection and the provider was not always following government guidance. Medicines were not always managed safely; some people had missed doses of medicines and we could not be sure they were always stored appropriately. Staff were not always effectively deployed as communal areas were often unattended and multiple incidents were unwitnessed.

Quality assurance systems were not fully effective at identifying areas for improvement as many concerns identified on inspection were not always known to the provider. Medicines audits had not been effective at identifying concerns and ensuring improvements were made. Reviews of people's care plans were not always accurate or effectively reviewed.

Whilst the provider and registered manager had an action plan to improve the service, some concerns had not been recognised so this plan this had failed to fully address the concerns we found, until we provided feedback. Once they were made aware of our concerns, they were proactive in making necessary improvements.

Staff were recruited safely and risk assessments were in place until references had been received from previous employers. Staff understood their safeguarding responsibilities and referrals were made to the local safeguarding authority.

People and staff were complimentary of the registered manager and provider. They felt they were approachable and felt supported. The registered manager was aware of their duty of candour.

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
At the last inspection we inspected the key questions of safe and well-led and the last rating for this service was good (published 19 January 2021). The service has deteriorated to requires improvement overall.

Why we inspected
We had received some anonymous concerns from people telling us they were members of staff. As a result, we undertook a focused inspection to review the key questions of safe and well-led.

The ratings from the previous comprehensive inspection for the effective, caring and responsive key questions were also used in calculating the overall rating at this inspection.

The overall rating for the service has deteriorated to requires improvement overall. This is based on the findings at this inspection.

Enforcement
We have identified a number of breaches of regulation in relation to the safe care and treatment of people, ineffective quality assurance systems and the deployment of staff.

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.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Shrubbery Rest Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
The Shrubbery Rest 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
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 concerns they had received. 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 seven people who used the service. We spoke with six members of staff including care

assistants, senior carers and a member of kitchen staff. In addition to this, we also spoke with the registered manager, nominated individual and another senior representative from the provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We made observations in communal areas to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care file and multiple medication and daily care records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including building safety records, audits and accident and incident records were also reviewed.

After the inspection
We had a virtual meeting with the registered manager after our site visit to ask further questions and discuss our findings. We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures, training records and quality assurance records.

We also spoke with four relatives over the phone to gain their views as we were unable to speak with them during our site visit. We also spoke to one more member of staff over the phone who had not been present on the day of our site visit.

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 deteriorated to inadequate. This meant people were not always safe and were at risk of avoidable harm.

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

- Risks were not always fully assessed and planned for and lessons were not always learned when there had been accidents or incidents in the home. Despite this, people felt safe and relatives felt people were safe. One relative said, "They [staff] keep my relative safe."
- Some people needed support to go to the toilet and staff needed to monitor how often they went to the toilet to ensure they did not become ill. This was not being effectively monitored or planned for, so we could not be sure people would be kept safe. Following our feedback, the registered manager did a review of people's needs in relation to this.
- Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPRs) in place so in the event of a person needing CPR, staff should not provide this. However, information for two people was incorrect in care records in respect of their DNACPRs. This placed them at risk of not being supported in line with their wishes in the event of a medical emergency. Whilst the registered manager had discussed DNACPRs with an appropriate health professional prior to our inspection, prompt action had not been taken to resolve the conflicting information. Action was taken to remedy this following our feedback.
- People had experienced incidents such as falls or periods of anxiety. This had not always prompted a review of their care plans and incidents were not always clearly recorded in their care records.
- If people had experienced falls, staff had not always recorded they had carried out checks on people following someone hitting their head during a fall. Medical attention was sought at the time of the falls. However, referrals to other health professionals to follow up about these incidents were not always made in a timely manner. Therefore, we could not be sure people were always kept safe.
- One person experienced periods of being anxious and they had been physically aggressive to other people and staff. Their care plan lacked detail as to how to support them during these times, it had not been reviewed following incidents and we found an incident had not been included in their overall review of incidents, so we could not be sure lessons would always be learned. Following the inspection, the provider showed us evidence of involvement they had with other health professionals to support the person with their mental well-being, however the person's care plans had not been updated to reflect this input.
- There was a largely newly-recruited team of staff and due to people's care plans lacking information and staff having not completed all their training yet, there was a risk staff may not always know how to support people appropriately.
- The building was appropriately maintained. A radiator in an unoccupied bedroom and some radiators in communal areas did not have full covers over them in order to protect people if they fell against them. The provider was taking action to cover all of them completely.

Preventing and controlling infection

- People were not always protected from cross contamination. Due to the COVID-19 pandemic, extra

measures were in place to keep people safe, however these extra measures were not always being followed.
● We were not always assured that the provider was promoting safety through the hygiene practices of the premises. Some areas of the home were dirty, such as skirting boards and walls and the backs of chairs were dirty. The décor was damaged in places making it more difficult to clean, such as peeling wallpaper. A plug hole and some equipment had the protective coating worn away in parts so it could not be effectively cleaned.
● We were not assured that the provider was rigorous with ensuring staff testing was consistently completed in line with government guidance. Although, we were assured the provider was accessing testing people using the service.
● One staff member said, "I forgot to do one [COVID-19 LTF test] today, nobody has asked me to do one since I arrived." Staff should have one COVID-19 test per week that gets analysed in a laboratory (known as a PCR test) and two COVID-19 tests per week, whereby the results are known within 30 minutes (known as an LTF test). Whilst the provider was recording the results of these, they were not adequately checked when they had been done. Two staff told us they had forgotten to complete their LTF test prior to starting their shift and no one had checked they had completed this. Following our feedback, the registered manager and provider took action to resolve this.
● People were not having their temperature checked twice a day in line with government guidance. A high temperature could be a symptom of COVID-19. When we asked the provider and registered manager about this, they said they only wrote down a temperature if it was of concern, however then said they had stopped checking the temperatures. Therefore, government guidance was not being followed and people were not always protected. Following our feedback, the registered manager took action to resolve this.
● We were not assured that the provider's infection prevention and control policy was up to date and being followed as guidance was not always being followed.
● We were not always assured that the provider was admitting people safely to the service as they were not checking people's temperatures.
● Staff who may be at increased risk of becoming ill if they caught COVID-19 had risk assessments completed to assess whether extra measures needed to be in place to help reduce the risk to them.
● 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 where possible, as some people would not understand needing to socially distance.
● We were assured that the provider was using PPE effectively and safely.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely
● Medicines were not managed safely.
● There were gaps in the recording of administration with no explanations and stock levels did not match. Some people had missed doses of medicine and this had not been addressed, such as seeking medical advice, at the time of the error. Therefore, people had not always received their medicine as prescribed.
● One person had medicine that had run out. There had been attempts to increase the amount delivered, however there was an occasion when it had run out and the replacement of this medicine had not been done in a timely manner.
● Medicines were not always stored appropriately; the medicines room and fridge did not have their temperature checked regularly so it had not been verified they were stored at a safe temperature. If medicines are stored outside a safe temperature range (as recommended by manufacturers), it can change their efficacy.

The above concerns constitute a breach of Regulation 12 (Safe care and treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We could not always be sure staff were deployed effectively to support people.
● Comments from people included, "They [staff] come in to see me but it is not often enough. They rush me" and, "Sometimes they can respond really quickly if I call them but other times it can be slow."
● A staff member said, "[Staffing levels] could be better. We are struggling at times. It's hard for us to give as good care as we want to give." Other staff commented they felt the staffing levels were appropriate.
● The layout of the building made it difficult for staff to adequately supervise communal areas. There were three separate communal areas and people's bedrooms were spaced over three levels.
● Incidents were frequently unwitnessed by staff in communal areas, such as falls and incidents between people. Therefore, we could not be sure people would be kept safe.

The above concerns constitute a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Checks were made on staff members suitability, such as employment history, references and criminal convictions. Several new staff had recently started. Some references had not yet been returned, but a risk assessment was in place until these had been received.

Systems and processes to safeguard people from the risk of abuse
● People felt safe living in the service, however, they were not always protected from abuse.
● The registered manager referred concerns to the local safeguarding authority. However, as people's care was not always reviewed and learned from following an incident, we could not be sure improvements to people's care would take place to protect people from further incidents. Following the inspection we were shown examples where people's needs and changes had been communicated to staff, however we could not be sure this was always consistent as people's records did not confirm this.
● Despite this, people told us they felt safe. Staff understood their safeguarding responsibilities. They were aware of different types of abuse, understood the signs to look for and knew to report their concerns, both internally and to other external organisations.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The service had not always been safe and the provider and registered manager had failed to effectively monitor the service to ensure areas for improvement and safety concerns were identified and addressed in a timely manner. Quality assurance systems had not always been effective.
- Government guidance in relation to COVID-19 was not always being followed and this had not always been realised by the registered manager or provider.
- Medicines audits had failed to identify concerns. Staff who administered medicines told us they noticed when there were gaps in recording or counts of stock levels were incorrect. However, they were unaware of the process to document and report these.
- The storage of medicines was part of the audits, but issues about lack of checks of the appropriate storage of medicines had not been identified.
- There was poor information in some people's plans about their ability to make decisions, and this had not always been assessed for people.
- The reviews of people's care files were not always regular, and reviews which had occurred were not effective at identifying omissions. Some plans lacked detail, and these had not been reviewed following accidents or incidents. The registered manager explained the plans were currently being reviewed so they could be improved. We saw an updated example of one care plan, and this was more detailed than those that had not been reviewed by the registered manager.
- Care plans contained inaccurate information, such as details of health conditions the person did not have, or they referenced other people's names, showing they were not all personalised and reviews had not identified this. However, these plans had not yet been fully reviewed by the registered manager who had recently returned to work after a period of absence.
- There was poor oversight of people's medical wishes in relation to whether they wanted chest compressions in the event of their heart stopping.
- There was poor recording of the care people received or of their health conditions, such as how often people had been to the toilet, when the person needed support with this area, and the timing of night checks on people's safety had not being recorded accurately.
- Whilst the registered manager and provider responded to feedback and made changes to improve people's care, they had not fully identified the concerns we found and were prompted to make these improvements.

Continuous learning and improving care

● The provider had failed to consistently continuously learn and improve. However, some measures were in place to ensure new staff completed their training and there was communication with staff about how to work in the home.

● When people had experienced a fall or been found on the floor, this was recorded on an accident/incident form and there was a process in place to check on people following an incident to ensure they suffered no ill effects (assuming they had not had to attend hospital due to a fall). These checks were not always recorded so we could not be sure staff were following the provider's process.

● These accident and incident forms had been reviewed by the registered manager. These reviews had repeatedly failed to identify observations of people following a fall had not been completed by staff, which could have left people at risk. Monthly reviews had also failed to double-check this and had failed to ensure timely referrals to other health professionals had always been made. We found an incident not included in the monthly reviews, so we could not be sure these were a comprehensive review of all incidents in the home.

● Some staff had not yet completed all their training as multiple new staff had recently started. However, this was being monitored by the provider and training was being booked.

● The provider and registered manager shared their overarching action plan for the home, which had not identified several concerns we found until after we provided our feedback.

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

● Whilst there had been failures in safety, the provider and registered manager had been extremely proactive in responding to feedback and making necessary improvements.

● The registered manager and provider explained that there had been a high volume of staffing changes since the last inspection. They felt this had contributed to the deterioration in care and they had the additional challenge of having to recruit multiple new staff members.

● Following our inspection, other organisations visited the home to check on people's care and they found the CQC's concerns had generally been acted upon and improvements implemented.

● The provider also shared communication they had with staff via a messaging app including instructions, photos and videos to demonstrate how to do things, as well as ongoing training.

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

● We could not be sure people's equality characteristics were always taken into consideration.

● People's plans were not always personalised and some referred to other people. Therefore, we could not be sure people's equality characteristics would always be considered and catered for. Staff received training in equality and diversity but many of the newer staff were yet to complete this training. However, no one raised any concerns with us regarding this.

● Despite this, people and staff were positive about the registered manager and provider.

● One person said, "[Registered manager] is smashing." A staff member said, "They [the registered manager and provider] are nice, I can go to them." Another staff member told us, "[The registered manager] is brilliant, they have been very supportive of me since I started."

● The staff team was largely new due to the sudden departure of previous staff. Therefore, some staff had not had supervisions yet. Despite this, staff felt supported. One staff member said, "I do feel supported, I have not had any supervisions yet although I am asked regularly informally if I am ok." Another staff member said, "I feel supported in my role, I have not had one to one or supervision yet."

● The registered manager also felt supported by the provider.
● There had not been any recent surveys or meetings, due to COVID-19 restrictions. However, 'key worker reviews' had been introduced to see what people thought about the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was aware of their responsibility around duty of candour. They said, "It means that being open and transparent if we have done something wrong, or if something has gone wrong." They also knew a letter and apology would be required.
● When incidents had occurred in the home, people's relatives were informed where necessary.
● The previous inspection rating was being displayed in the home, as required. We received notifications, as required. Notifications are events the provider is required to tell us about such as safeguarding concerns, deaths and serious injuries.

Working in partnership with others
● The provider was willing to work in partnership with other organisations. There was a regular 'ward round' with the GP.
● The provider was willing to engage with us following the inspection and kept us up to date with the action they were taking or had planned to make improvements. They responded to requests for information.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always effectively deployed to ensure people were kept safe.

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 People were not always kept safe as risks were not always assessed and planned for. Medicines were not always managed and stored safely. Guidance was not always followed to keep people safe in relation to COVID-19.

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 Quality assurance systems were not always effective at identifying areas which needed improving.

The enforcement action we took:

Warning notice