Mrs M Mather-Franks

Hawthorns Residential Care Home

Inspection report

The Hawthorns
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Rushden
Northamptonshire
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Hawthorns Residential Care Home provides personal care and accommodation for up to six people who have learning disabilities. The home is located in a residential area of Rushden.

The inspection took place on 15 June 2015.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Prior to this inspection we received information of concern in respect of the standards of hygiene and cleanliness within the service. This alleged that people were not always protected against the risks associated with infection control. In addition to this, we were also informed that equipment used to support people with manual handling and additional mobility needs, was not always clean or well maintained.

Concerns were also raised in respect of the medication systems in place which did not ensure that people always received their medication on time or in accordance with their prescriptions. It was indicated that there were some gaps and omissions within the medication administration records.

During this inspection, we found that some areas within the home remained unclean and posed a risk of cross

Summary of findings

infection to people and staff, despite evidence of on-going cleaning taking place. Although the equipment used to support people and maintain their comfort and posture, appeared visually clean and well maintained, there were no records to evidence that regular cleaning had taken place.

There were systems in place to monitor the quality of the service provided; however the audit checks that had been completed were not always effective in identifying the issues that we found or detailing the action that needed to be taken to address them.

We found that the systems and processes in place in respect of medication were not always robust, although we saw some evidence that improvements had been made since our last inspection.

We identified that the provider was not meeting regulatory requirements and was in breach of one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 always safe.

People were put at risk because the premises and equipment used to support them had not been always been adequately maintained. Robust standards of cleanliness and hygiene had not been upheld.

Systems for the management of medicines were not always safe although some improvements had been made since our last inspection.

Requires improvement

Is the service well-led?
The service was not always well-led.

People were put at risk because systems to assess and monitor the quality of care provided or to manage risks of unsafe or inappropriate treatment were not effective.

Requires improvement

Hawthorns Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 June 2015 and was unannounced.

The inspection was undertaken by one inspector.

We checked the information we held about the service and the provider and saw that some recent concerns had been raised by the local authority. We had received information about events that the provider was required to inform us about by law, for example, where safeguarding referrals had been made to the local authority to investigate and for incidents of serious injuries or events that stop the service. We contacted the local authority that commissioned the service to obtain their views.

We spoke with two people in order to gain their views about the quality of the service provided. We also spoke with one member of care staff and the deputy manager, to determine whether the service had robust quality systems in place. We reviewed the records in relation to infection control and medication and also reviewed quality monitoring and audit check systems and processes.

Requires improvement

Is the service safe?

Our findings

Prior to our inspection we had received some information of concern which alleged that the service was not maintaining a high standard of cleanliness and hygiene, both within the interior of the service and in respect of the equipment that was used to support people.

During this inspection, we found that surface areas and carpets within two people's bedrooms were not always clean; carpets had areas of staining on and tops of chests were dusty. However, people told us they were happy with the cleanliness within their bedrooms and the home itself. One person told us, "Staff help me to clean my room." Staff explained they supported some people to clean their room as part of them remaining as independent as possible.

We observed that some of the communal areas within the service were not always clean. For example, in the main lounge area, we found small amounts of debris behind the sofa and chairs, where they had not been pulled out and cleaned behind. We also found that some chairs in communal areas were not clean, with crumbs of food underneath the cushions.

In communal toilets, air vents were dusty and the flooring was sticky around the base of toilets. In one toilet, we found an area of flooring that was unsealed around the base of the toilet itself. As a result this was a potential trap for dirt and debris, and made it difficult to clean effectively. In a downstairs bathroom, there were areas of grouting around the bottom of the tiles that required resealing. During our inspection we were advised that maintenance work was being completed to address an area of grouting around the upstairs bath that required attention. We observed that this work had been commenced prior to us leaving the inspection.

Paintwork on skirting boards in some bedrooms, and along some communal corridors was dusty in places. In communal toilets and bathrooms, we found that the top of some door frames were dusty, which meant that they had not been cleaned efficiently.

People's manual handling equipment was not always clean and suitable for use. For example, the cover on one person's custom made wheelchair was covered in crumbs. The deputy manager noted this and immediately ensured it was placed in the laundry. We found that there was no schedule in place for the regular cleaning of people's wheelchairs, shower chairs or mattresses. Although mattresses were visually clean, there was no written record of whether they were cleaned or of the frequency with which it was completed. We were assured by staff that this took place on a weekly basis; however, the lack of record keeping in this respect, did not reassure us that this was always undertaken.

The deputy manager told us that a daily cleaning checklist was in place to monitor cleaning. It appeared to be a tick box exercise, and did not fully detail what action was taken if concerns were identified. The deputy manager told us that the staff on duty cleaned the home on a daily basis, in between their other duties and would then complete the cleaning schedule. There was however no evidence of a deep clean being undertaken. Staff were observed to be cleaning communal areas and bedrooms, along with hoovering carpets and cleaning floors, during our inspection. Although cleaning was taking place throughout the home, it needed to be more robust.

We found that although records indicated that daily cleaning took place, they did not identify the issues that we found. The cleaning systems and processes in place were not always effective. We discussed this with the deputy manager, who acknowledged that improvements needed to be made to the cleaning that was undertaken. They discussed a variety of new records that could be implemented across all services within the group, to document when pressure mattress and equipment cleaning took place. They assured us that this would be addressed with immediate effect.

This was in breach of Regulation 12 (1) & (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people's furniture was positioned to create space within their bedrooms; however the design of the premises did not always lend itself to easy access for some people, with the space between doors being quite tight for staff to manoeuvre wheelchairs. Recent work had been undertaken to the doors of two rooms to replace them with appropriate fire doors, following a recent inspection by the fire service. The deputy manager informed us that work was also being completed to update Personal Emergency Evacuation Plans (PEEPs) following this recent inspection and we have asked for confirmation when this has been completed.

Requires improvement

Is the service safe?

During this inspection we found that some areas of the premises were not well maintained and required attention to ensure people's safety. We observed that some of the paintwork in people's rooms required attention, with a patch of discolouration and bubbled area of ceiling in one person's room. In other rooms, we found that some drawer fronts were falling off. The deputy manager told us that a maintenance plan had been put in place, which included some general re-decoration to communal areas and some bedrooms within the service, so that these areas would be addressed in the near future

People told us they received their medicines on time and were supported by staff to take their medicines safely. One person told us, "Yes they are good at giving me my tablets." Staff told us that they administered medication to people in accordance with their prescriptions and had worked hard to make improvements since our last inspection. The deputy manager told us, "All new staff have medication training which assesses their competence. All other staff have received this as well and we make sure it is kept updated because it is important."

We observed that people received their medicines on time and saw evidence that people's medicines had been reviewed by the GP on a regular basis. Medicines were stored safely and securely, and records showed staff were administering medicines to people as prescribed. Two of the four medication administration records (MAR) charts had no photograph of the person attached to them. We discussed this with staff and were advised that they were awaiting a new folder, but they acknowledged this was no excuse for not having photographs attached. The deputy manager told us that this would be addressed with immediate effect.

Although we found one gap in the recording of medication, this was when a person had been absent from the service. Generally the records we reviewed contained no gaps and omissions and we found that staff used the correct codes, although the deputy manager acknowledged that the reverse of the MAR charts could be more effectively used. Staff had learned lessons from recent medication issues and had devised ways to reduce the risks of these occurring again; for example, the member of staff administering medication would now wear a tabard to indicate to people that they were busy administering medication. It was hoped that this would reduce the risk of further errors.

Requires improvement

Is the service well-led?

Our findings

People were not always protected against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to regularly assess and monitor the quality of the service. We saw that although quality monitoring was undertaken, it did not assess compliance with local and national standards and had not been robustly overviewed by the provider. The deputy manager told us an annual infection control audit was undertaken along with monthly medication audits and we saw records to confirm this. On reviewing these, we found that the audits in place were ineffective and there were no improvements made to the service as a result of them.

Despite monthly medication audits taking place, these had failed to identify some of the issues identified within recent safeguarding concerns, in relation to gaps and omissions on Medication Administration Records (MAR). Therefore, the systems in place were not always used as effectively as they could have been.

We spoke with the deputy manager about quality assurance systems and were shown the records for cleaning within the service. We found these did not detail when people's mattresses had been cleaned or when profiling beds or additional supporting equipment, including postural support and wheelchairs had been cleaned. Although we were told this was done on a weekly basis, there were no records to indicate that this had been completed. The deputy manager was unable to provide us with all the information we requested about safety systems and quality assurance procedures in respect of equipment, although we could visually see that hoists and wheelchairs had been maintained, there was no documentary evidence to suggest that this was the case.

This was in breach of regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Good Governance) The registered person failed to operate systems to ensure records were managed safely and effectively. Systems were not effective in terms of assessing, monitoring and improving the quality and safety of the services provided.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) & (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe and Care Treatment) There were no effective systems in place to manage and monitor the prevention and control of infection or ensure that the premises and equipment used was safe and cleaned to an appropriate standard.