

Hollyberry Care Limited

# Margaret's Rest Home

## Inspection report

30-32 Kingsley Road  
Northampton  
Northamptonshire  
NN2 7BL

Tel: 01604710544

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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** 

# Summary of findings

## Overall summary

### About the service

Margaret's Rest Home provides nursing and residential care for up to 27 older people, including people living with dementia. There were 24 people receiving care at the time of the inspection.

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

Systems and processes in place to maintain oversight of the service required improvement. Although audits were completed these did not always pick up issues or gaps in records.

People's risks were assessed, and strategies were documented to mitigate the known risks. However, not all records evidenced these strategies were completed. Referrals to external professional were made when appropriate.

Medicine management required improvement. Not all documentation had been put into place. However, staff understood people's medicine needs.

People were supported by staff who knew them well. Staff had received training to meet people's needs and understood safeguarding processes to keep people safe.

Staff had been safely recruited and received support from the registered manager and provider. Staff were positive about working at Margaret's Rest Home.

Infection control processes and procedures were in place and followed by staff. Staff wore appropriate personal protective equipment and supported people to reduce the transmission of COVID 19.

Staff and people were supported to feedback on the service delivered. We received mixed experiences from relatives regarding the sharing of information.

The registered manager was visible within the service and interacted with staff and people using the service regularly.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection

The last rating for this service was good (published 25 May 2018).

### Why we inspected

We received concerns in relation to cleanliness, oversight and information sharing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

We have found evidence that the provider needs to make improvement.

You can see what action we have asked the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Margaret's Rest Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### 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?**

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Margaret's 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.

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 one inspector.

#### Service and service type

Margaret's 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; however, we phoned the service before entering. This supported the service and us to manage any potential risks associated with Covid-19.

#### 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 and professionals who work with 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 two people who used the service about their experience of the care provided. We spoke with eight members of staff including the registered manager, maintenance person and care staff.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We had contact with four relatives about their experience of the care provided.

# 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 now deteriorated to requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Assessing risk, safety monitoring and management

- People had risk assessments in place which detailed the strategies to mitigate known risks. However, staff had not always followed the strategies to reduce harm. For example, we found people who required two hourly repositioning did not consistently have this support given. Some people could not access their call ball to summon support if needed. The registered manager agreed to investigate and rectify these concerns immediately.
- One person had been supported to change to a pureed diet. However, this need had not been assessed by a specialist such as a speech and language therapist. The registered manager had not referred the person to a dentist to investigate if there were any issues or pain associated with eating. This meant that the support being given may not be the best option for the person. The registered manager referred the person to their GP after the inspection.
- One person who was at risk of malnutrition and dehydration did not have their food and fluid recorded correctly. A dietician had made recommendations that staff offer milkshakes three times a day to promote weight gain. Records showed that staff were only offering these at most twice daily. This put people at risk of dehydration and malnutrition.
- A fire risk assessment was in place for staff to follow. Personal Emergency Evacuation Plans (PEEPs) were in place to support the evacuation of people using the service in the event of an emergency.

### Using medicines safely

- Medicine management required improvement. Staff had not always recorded the reasons for administering 'as required' [PRN] medicines. One person received PRN medicines 13 times within five days without any evidence recorded of the reasons given. This put people at risk of overuse of medicines. However, we found no evidence of harm to people.
- When staff had transcribed medicines onto people's medicines charts, there was not always enough information recorded and best practice guidance was not always followed. For example, two staff had not signed when they transcribed medicines. This put people at risk of receiving the incorrect dose of medicines.
- Staff had received training on the administration of medicines, we saw staff recognised a person's right to refuse, staff recorded this information correctly, and followed up any actions needed.

### Systems and processes to safeguard people from the risk of abuse

- Staff were trained and knowledgeable about the types of abuse and knew how to report any concerns.
- The provider had policies and procedures in place to safeguard people. There were posters within the home regarding safeguarding.

### Staffing and recruitment

- People and relatives told us staff were kind and caring and knew people well.
- On the day of the inspection we found there were enough staff available, and the appropriate levels of skilled staff were deployed to meet people's needs. However, relatives felt that staff levels required improvement. One relative said, "Staff are very stretched, they don't have time to tune in [person's name] radio." Another relative told us, "Staff are too busy, [person's name] has to wait long periods to be taken out of the bedroom."
- Safe recruitment and selection processes were followed. Staff files contained all the necessary pre-employment checks, including references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

### Preventing and controlling infection

- Systems and processes were in place to protect people from infection.
- Cleaning schedules had been completed in line with the providers policies.
- Staff wore appropriate personal protective equipment [PPE].
- People and staff were supported to access regular testing for COVID 19.

### Learning lessons when things go wrong

- Accidents and incidents are appropriately recorded and investigated. We have seen evidence of lessons learned.



# 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 remained the same. 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. Continuous learning and improving care

- The provider did not have sufficient systems in place to identify when support and care was not delivered. The registered manager had not completed audits on repositioning charts or food and fluid charts. During the inspection we found concerns related to these records.
- Medication audits completed had not identified missed signatures on the medicine administration record or the lack of PRN protocols. A PRN protocol should identify the reasons a person can be administered the specific medicine and for how long before professional advice is sought.
- The monthly audits the registered manager completed for weights, falls, care plans and pressure care only sampled a few records every month. This meant that the management oversight of issues was not always up to date. We found that one person's weight was documented differently in separate parts of their care file. The wrong weight had been imputed onto their malnutrition score chart. This could put people at risk of not receiving the appropriate care and support.
- The registered manager and the provider were open to the inspection process and immediately put actions into place to mitigate the concerns raised on inspection.
- The registered manager understood their regulatory responsibility and submitted notifications as required.

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

- Regular meetings were held to support people's and staff engagement. People and staff had the opportunity to feedback on the support they were offered.
- The provider had put plans in place to support staff to feel secure during the COVID 19 pandemic.
- People and relatives knew the registered manager and told us that they were available and visible within the service.
- Staff felt supported by the registered manager and felt they all worked well as a team. One staff member told us, "I can go to the registered manager at any time and they will listen to me. You are able to share your views."

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

- Relatives told us that they had not always been kept up to date by the staff on their loved ones needs. However, we were also told that relatives could contact the home and information was shared.
- We saw evidence of referral being made to external agencies including, doctors, speech and language therapists and the falls team.
- The registered managers understood, their duty of candour responsibility. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.