D Roche (Holdings) Limited

Hartlands Rest Home

Inspection report

57 Salop Road
Oswestry
Shropshire
SY11 2RJ

Tel: 01691658088

Date of inspection visit:
26 September 2023
28 September 2023
26 October 2023

Date of publication:
04 March 2024

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
Hartlands Rest Home is a residential home providing accommodation and personal care for up to 21 people aged 60 and over. At the time of the inspection 14 people were living there, some of whom were living with dementia.

People's experience of the service and what we found:
People were exposed to risks from the environment including fire, following our inspection we made referrals to the fire service who have taken action. Management of medicines was not safe. People were not always safeguarded from the risk of abuse. Lessons were not learned after adverse incidents. Infection prevention and control measures were not robust, and people were placed at risk of Legionella and food poisoning.

The provider did not have a clear system to ensure there were enough staff to support people safely. Staff did not receive appropriate training to ensure they could deliver safe and effective care. Staff were not always recruited safely.

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.

The provider did not have good oversight of the quality and safety of care, their governance systems were ineffective. People and relative described the registered manager as supportive. The registered manager felt unsupported by the provider and was planning on leaving their post following our inspection. There were no clear systems in place to proactively seek feedback from people, relatives and staff about the running of the service and how quality could be improved.

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 9 June 2023.
The provider completed an action plan after the last inspection to show what they would do and by when to improve.
At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, training and safety of people. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. During the inspection we found there was a concern with people being given maximum choice and control of their lives, so we widened the scope of the inspection to include effective.
You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Hartlands Rest Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the need for consent, safe care and treatment, safeguarding service users from abuse, governance of the service, staffing and training.

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.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well led. Details are in our well-led findings below.	**Inadequate**

Hartlands 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 Health and Social Care Act 2008.

Inspection team
The inspection team consisted of two inspectors on each day.

Service and service type
Hartlands Rest Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hartlands Rest Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.
At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We contacted the local authority and Healthwatch for feedback about the service.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.
We used all this information to plan our inspection.

During the inspection
We spoke with 4 people living at Hartlands Rest Home and observed care and support being given in communal areas of the home. We spoke with 5 friends and relatives. We spoke with 7 members of staff including the Nominated Individual, Registered Manager, Deputy Manager, Nurses, Care Assistants, Cleaners and Cooks. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a wide range of records, such as care plans, medication administration records, staff records, quality assurance documents, policies, and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure the physical environment was safe for people to receive a regulated activity. These issues were 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 at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management
- The provider did not always assess risks to ensure people were safe. Staff did not always take action to mitigate any identified risks.
- People could not be assured that their needs would be accurately reflected in their plans of care. One person's plan of care contained conflicting information about their dietary needs. The failure to maintain accurate plans of care for people, increased the risk of them coming to harm.
- People could not be assured that the safety of their environment would be maintained by safety checks carried out by staff. Records showed that checks were not being carried out in line with their scheduled frequency and the information recorded in the checks was not always accurate.
- People were not protected from the risk of Legionnaires disease. The provider was not following the guidance provided from the health and safety executive. This placed people at an increased risk from Legionnaires disease.
- People were not fully protected from the risk of falls from height. Window restrictors were not installed with tamper proof fixings which meant they could be removed with simple tools such as a knife.
- People were not protected from the risk of fire. Fire doors had been damaged through the fitting of locks and the provider had failed to ensure that the 30-minute protection they offered had been maintained.
- The provider had failed to fully assess people's needs should an evacuation be required. This meant people could not be assured that there would be enough staff to assist and supervise them in an emergency.
- We shared the concerns we had with fire safety with Shropshire Fire and Rescue Service who visited the property after our inspection. They have issued the provider with an enforcement notice to make improvements.

Systems were not robust enough to demonstrate safety effectively managed. This placed people at risk of harm. These issues constitute a continued breach of Regulation 12 (Safe Care and Treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
- People were not always supported to receive their medicines when they required it as the administration processes were not safe.

● We looked at medication administration records (MAR). We found handwritten MAR that had not been fully completed. For example, one person's MAR lacked information about allergies, when the medication should be administered and how many tablets had been dispensed to the home. This meant people were at an increased risk of medication errors and harm.
● Not everyone at the home had a protocol for medicines that had been prescribed as and when required. This meant staff did not have clear instructions as to when they should administer the medicines. People could therefore not be assured they would receive their medicines when they required them.
● One person had been prescribed a PRN medication for when they became anxious. Records showed that this medicine had been administered at the same time every day. Records completed by staff recorded that the person was not anxious and therefore did not require the medicine.

Systems had failed to ensure people received their medication safely and when they required it. This is a breach of Regulation 12 (Safe Care and Treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices. During the inspection we observed staff using the kitchen to access the external smoking area.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found the kitchen to be visibly dirty and records of cleaning and safety checks such as fridge temperature showed they were only being carried out sporadically. This placed people at an increased risk of food poisoning.
● After the inspection we shared our concerns with the local environmental health department and the local authority are visiting the service regularly to monitor concerns over quality and safety.

Infection control was not effectively managed in the kitchen. This placed people at risk of harm. These issues constitute a breach of Regulation 12 (Safe Care and Treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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.

Staffing and recruitment
● The provider did not ensure there were sufficient numbers of suitable staff. The provider told us that they had no formal method for deciding how many staff were required to meet people's needs. This meant people could not be assured that there would be enough staff to support them safely.
● During the inspection, people sat in the communal lounge without staff supervision including people identified in their care plans as requiring supervision as they were at risk of falls.
● We received mixed feedback from families about staffing levels. One family member told us, "There always seems to be staff around." Another family member said, "The lounge is often unsupervised, and I have had

to intervene. There are just not enough staff."
● Prior to the inspection, Shropshire Fire and Rescue Service had visited the home and were concerned about staffing levels at night. They asked the provider to carry out an urgent review of people's needs to ensure that there would be sufficient staff to evacuate them. At the time of this inspection the provider had failed to do this.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to ensure that there were sufficient staff to meet people's needs. This is a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff were not always recruited safely. We found that checks on staff's characters were not always carried out and full employment histories had not always been obtained. We found 1 member of staff working without a Disclosure and Barring Service (DBS) check prior to them commencing at the service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff told us that an agency chef had been allowed to work at the service over a weekend and sleep overnight at the service. We asked the provider to demonstrate they had made appropriate checks on the person prior to them working. The provider told us that they had not checked the persons details or DBS check with the agency.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate people were protected by the provider's recruitment procedures. This is a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
● People were not always safeguarded from abuse and avoidable harm.
● We read records of incidents where the provider should have notified the local safeguarding team but had failed to do so. This placed people at an increased risk of harm and abuse.
● We shared our concerns with the provider who sent retrospective notifications for the incidents.

Systems were either not in place or robust enough to demonstrate people were protected by the provider's safeguarding procedures. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider did not learn lessons when things had gone wrong.
● We saw records of incidents where the provider had failed to follow them up and identify ways that improvements could be made, or actions taken to prevent a re-occurrence which is what their policy stated would happen.

Visiting in Care Homes
● People were able to receive visitors without restrictions in line with best practice 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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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 MCA 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)
The provider was not always working in line with the Mental Capacity Act.
● The provider had installed CCTV throughout communal areas in the home. People were not consulted prior to the installation. Those who were unable to express a decision had not been supported through best interest meetings. Failing to document the continual surveillance was in people's best interests put them at risk of their privacy and human rights not being protected.
● The provider had fitted locks to all bedroom doors, and these were locked when people left their rooms. The provider had not consulted with people about the locks and those who were unable to express a decision had not been supported through best interest meetings. This meant people had restrictions in place which may not have been in their best interests.

Care and support were not always provided with people's consent. This was breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Staff were able to tell us about the principles of the MCA and how they used it in their day-to-day roles.
● We saw in some cases, where required people's capacity to make decisions had been assessed and decisions made for people who were unable to make decision were in their best interests.

Staff support: induction, training, skills and experience
● The service did not always make sure staff had the skills, knowledge and experience to deliver effective care and support. Training records were not available for us to see during the inspection. The registered manager told us that the training company had prevented access to their account due to a dispute over an unpaid bill. The registered manager said this had impacted on the ability to obtain training for new staff and to identify when staff required refresher training.
● Training records were sent to us after the inspection, and these showed that some staff had not completed essential training to be able to support people at the home safely.
● People were at risk from poor manual handling as staff had not been provided with any practical training

and were only completing on-line training. We asked the registered manager if this was followed up by competency assessments to see if staff had embedded the training into their working practises. They advised us that this did not take place.

Effective systems were not in place to ensure that staff had the right knowledge and skills to deliver effective care and support. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always assessed, care and support were not always delivered in line with current standards. People did not always achieve effective outcomes.
● We identified shortfalls around the management of risk, medicines management and the MCA/DoLS. Records did not always demonstrate how best practice guidance was followed.
● Information contained in people's care plans was not always clear and some information was contradictory. This placed people at risk of not having their needs met.

Adapting service, design, decoration to meet people's needs
● We saw that some areas of the home had been refurbished since our last inspection.
● We saw that people were supported to personalise their rooms.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet.
● Where people required modified diets, we saw that care was taken to ensure that it remained appetising.
● People and their families were complimentary about the food provided. One person said, "I enjoy all the meals here."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to live healthier lives, access healthcare services and support.
● Staff supported people to access health and social care services such as GPs, district nursing and speech and language therapy.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has inadequate. This meant there were 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; Continuous learning and improving care
At our last inspection, systems and processes were not effective to assess, monitor and mitigate risk or to assess, monitor and improve the quality of the service. This was a breach of regulation 17(1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.
● This is the third consecutive inspection where the provider has failed to meet the regulations. There have been repeated breaches in relation to safe care and treatment, and good governance across all these inspections.
● The governance systems in place continued to be ineffective. The provider's systems and processes were not robust, effective or embedded, with a lack of oversight that failed to identify significant gaps in the quality of the service people received.
● Audits had failed to identify shortfalls we found in relation to the safe administration of people's medicines.
● Where the provider had delegated the responsibility for conducting audits, they had failed to maintain oversight to ensure that they were being carried out effectively. This placed people at increased risk of harm through unsafe conditions not being identified and corrective action being taken.
● Audits had failed to identify that effective employment checks were not being conducted to ensure that staff were recruited safely.
● There was a lack of oversight of accidents and incidents. This meant risks to people's safety and wellbeing had not been appropriately reviewed, assessed, and learned from to reduce the risk of them happening again.
● The provider had failed to ensure that access to timely training was available, and lack of oversight had failed to ensure staff received appropriate manual handling training.
● The provider had failed to maintain fire safety at the premises or respond to instructions from Shropshire Fire and Rescue Service in a timely manner.

The failure to operate effective systems to assess, monitor and improve the service was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Everyone we spoke with was complimentary about the registered manager. During the inspection the registered manager advised us they would be leaving the service. One family member said, "I am aware that they are leaving, and I am concerned what will happen when they go."

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.

● People were not always involved in decisions about their care. For example, they were not consulted about the installation of locks on their bedroom doors or CCTV being installed at the home.

● The provider had not sought feedback from relatives. Families told us that they were consulted when their relatives moved to the home but were not asked for feedback about the care they received.

● Staff we spoke with told us that morale was low in the staff team and that they didn't feel supported or listened to by the provider. One staff member said, "(registered manager) listens and supports me and is very approachable but I think [provider] could visit more and support the manager.

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 provider understood their responsibilities in relation to the duty of candour and communication with people when things went wrong.

● Relatives told us they were informed when things went wrong. One relative said, "They do call me if anything happens or there are any changes."

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 11 HSCA RA Regulations 2014 Need for consent Care and support were not always provided with people's consent.

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not robust enough to demonstrate safety effectively managed. This placed people at risk of harm. Systems had failed to ensure people received their medication safely and when they required it. Infection control was not effectively managed in the kitchen.

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were either not in place or robust enough to demonstrate people were protected were protected from the risk of abuse.

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the service

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected by the provider's recruitment procedures.

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective systems were not in place to ensure that staff had the right knowledge and skills to deliver effective care and support. Systems were either not in place or robust enough to ensure that there were sufficient staff to meet people's needs

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration.