

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

Hawthorn House is a residential care home providing accommodation and personal care to up to 22 people, some of whom may be living with dementia. At the time of our inspection there were 16 people using the service.

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

The service was not well-led. This was the fourth consecutive inspection where the provider had failed to reach a rating of at least good.

Quality assurance systems continued to be ineffective. Lessons had not always been learned as some of the same issues remained from the previous inspections.

Shortfalls had not been identified or promptly addressed which placed people at risk of harm and of receiving a poor-quality service.

People were not always safe and were placed at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs, as well as environmental risks.

Some areas of the service were not clean, and staff and visitors did not continually follow infection control guidance to manage the risk of spread of infection.

Medicines management practice had deteriorated since the last inspection and were unsafe, which put people at risk of harm. We could not be assured people received their medicines as directed, and medicines were not always stored safely.

We could not be assured staff were suitably skilled to ensure people received appropriate care and support to meet their needs. The providers processes could not demonstrate that suitably competent staff were deployed due to a lack of recorded competency and training. Appropriate robust checks were not always completed prior to new staff commencing employment.

There had been some improvements made to the environment, some floorings and furniture had been replaced and a new kitchen had been fitted.

Staffing levels were sufficient during the inspection. Staff were kind and attentive to people. Most feedback from people and their relatives about the care provided was positive.

People were supported to have maximum choice and control of their lives and staff supported did 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 (CQC) website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was inadequate (published 23 May 2022) and there were breaches of regulation. 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

We carried out a focused inspection of this service on 8 and 10 March 2022. Breaches of legal requirements were found, and we issued warning notices for the breaches of regulations 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 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 remains inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

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.

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 have identified breaches in relation to safe care and treatment, staffing, and good governance at this inspection.

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 remaining 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 2 inspectors and an Expert by Experience.

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 had a manager registered with the Care Quality Commission.

Notice of inspection

The first day of inspection was unannounced. We informed the registered manager we would be returning for a second day, but not for the third 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 11 people who used the service, and 3 people's relatives about their experience of the care provided. We spoke with the registered provider and 9 members of staff including the registered manager,

deputy manager, and day and night care staff.

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 samples of 6 people's care records, and multiple medication records. We looked at 6 staff files in relation to recruitment and training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 Inadequate. At this inspection this key question remained the same. 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 the health and safety of people were not managed or mitigated, leaving people at risk of harm.
- Measures in relation to fire safety were not in place. For example, there was increased risk of a fire in the laundry which had not been identified. There was no fire safety evacuation procedure and the fire 'grab pack' was not accessible in the event of a fire. A grab bag contains items needed in the event of an emergency and allows the provision of relevant information of people's needs to a responding fire service.
- Environmental related risk management was inconsistent, and risks were not always identified and addressed. Consideration had not been given of the risks posed to people by external contractors working in the home.
- The provider had not learnt lessons from areas identified at the last inspection. Sufficient action had not been taken to reduce the risk posed to people by a water leak from the roof of the home, which had not been addressed since the last CQC inspection.

We found no evidence people had been harmed, however, 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 risks in relation to fire safety for the registered manager to action.
- Accident and incidents were routinely reviewed to prevent reoccurrence and to help identify any trends or themes.

At the last inspection systems were not in place 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.

Not enough improvement had been made and the provider continued to be in breach of regulation 12.

Preventing and controlling infection

- People were at risk of infection due to poor infection prevention and control practices.
- Some staff and visitors were not wearing face coverings in communal areas of the home, in line with current government guidance.
- Flooring in the conservatory which was being used as a temporary kitchen was not clean. Cooking utensils were stored on the floor and had a layer of dust on them.
- Flooring in the laundry was cracked which meant it could not be cleaned effectively. Peoples clean laundered clothes were hung to dry above a clinical waste disposal bin. These practices meant good infection control could not be achieved.
- Several people's bathroom shelves were rusty, and one person's bed bumper was perished. This meant it could not be cleaned effectively.

We found no evidence people had been harmed, however, 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.

Visiting in care homes

- The provider was facilitating visits for people living in the home in accordance with the current guidance.

At the last inspection we recommended the provider consider current guidance on the management of topical medicines and transdermal patches and take action to update their practice accordingly. The provider had not made improvements.

Using medicines safely

- Medicines were not managed safely.
- We could not be assured people's creams and topical medicines were administered as prescribed as there were inconsistencies in the records completed.
- Risk assessments were not in place for people who were prescribed paraffin-based creams which had the potential to cause harm.
- Systems and processes were ineffective. One person was prescribed a cream for use on a wound. There was no medicine record in place to direct staff when administering the cream and there were inconsistencies in the knowledge of staff on when this cream should be applied. We could not be assured the cream had been applied to the persons wound.
- A box containing a person's eye drops stated they should only be used for 5 days. Records showed these drops had been administered to the person for 14 consecutive days. This error was identified during the inspection and had not been identified through the providers own processes.

We found no evidence people had been harmed, however, people were placed at risk of harm by the failure to ensure the safe and proper management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staff were not always suitably skilled to ensure people received appropriate care and support to meet their needs. For example, one staff member had administered medicines to people without completing any medicines training, in line with the providers own policy.
- We could not be sure the provider deployed suitably competent staff due to a lack of recorded staff competency and training.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

- Recruitment was not always robust. Where appropriate checks had been completed, identified risks were not considered or followed up.
- We observed sufficient staff visible during the inspection.

Systems and processes to safeguard people from the risk of abuse

- Systems were in place in relation to safeguarding people. However, we identified concerns in relation to 2 people's safety for which we raised alerts with the local safeguarding authority.

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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
- People confirmed staff gained consent prior to providing them with care.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider continued to lack understanding of their regulatory responsibilities and roles. We found they remained in breach of regulations. They had continued to fail to take the necessary action to improve the safety and quality of the service for the last four inspections.
- We could not be assured systems were robust to ensure people were safe. Governance systems had not identified or addressed all the shortfalls found during the inspection which included fire safety, infection control and medicines. Monitoring systems had failed to identify risks associated with people's care. In addition, documentation was not always complete, or up to date, so we could not be assured people were receiving the correct care, or staff were appropriately trained.
- We could not be assured the provider and registered manager understood the importance of continuous learning and quality improvement. Improvements had not been fully embedded and sustained into the service.
- Good practice guidance was not always considered and implemented to promote good outcomes for people.
- Partnership working was inconsistent. When advice and guidance had been provided by professionals, this was not always considered and implemented in a timely manner.
- People were at risk of poor outcomes through failures in the service. People's health and wellbeing were placed at risk due to the failure to assess and monitor risks to people's health, safety and wellbeing, administer medicines safely, manage the risk of infection, and robustly recruit and train staff.

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. Governance systems were not effective in ensuring compliance with regulations. This was a continued breach of regulation 17

(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some systems were in place to gather feedback from people and staff. Meetings were held for people and staff to inform them of any changes and seek their views and experiences of the service.
- Staff had a positive attitude to their role. Staff were kind and caring and interacted positively with people. One member of staff told us, "I feel well supported in my role, all staff are very friendly." A person using the service told us, "Well the staff know what I like better than me sometimes."

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

- Staff told us they felt able to share concerns with the manager and deputy manager and they were supported in their role. Comments included, "Communication is good and everyone is friendly." Another told us, "The staff here are lovely, you can tell everyone cares. I can get raise things if I need to. I can go to [managers] at any time."

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 The provider had not ensured staff were not suitably skilled to ensure people received appropriate care and support to meet their needs. The provider could not demonstrate that deployed suitably competent staff were deployed due to a lack of recorded competency and training. 18(2)(a)