St. Matthews Limited

Hawthorne House

Inspection report

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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
Hawthorne House is a residential care home providing personal and nursing care to up to 102 adults across seven separate units. People living at Hawthorne House have various needs which include dementia, physical disabilities, mental health needs and rehabilitation for acquired brain injuries. Each of the units are adapted to meet the needs of the people living there. At the time of our inspection there were 99 people living at the service.

People's experience of using this service and what we found
Governance systems, management, and provider oversight had not been fully effective, and standards had declined in the home since our last inspection. A new manager had been in post for approximately 2 months when we completed this inspection. They acknowledged improvements were required across the service and had been, and were continuing, to work with the provider to introduce new systems to help improve the service. The service was being supported by the local Integrated Care Board (an NHS organisation) to make the necessary improvements. There was a friendly atmosphere within the service. People and relatives were generally positive in their comments about the staff team.

People told us they felt safe at the home but risks to people's health and well-being had not been consistently identified and assessed. Some of these risks were associated with unclear records, medicine management and staffing arrangements. Staff received training relevant to their roles but staff on some units felt pressured and not able to support people how they would like. People's medicines had not been managed safely consistently to ensure people received their medicines as prescribed. People had individualised care plans that supported staff to deliver their care. However, some people did not experience person centred care that always met their needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff were recruited safely in line with the providers policy. People told us staff treated them with respect. People had access to healthcare professionals to support their needs when necessary to ensure they remained well.

The prevention and control of infection was managed safely. Good infection prevention and control processes were followed.

We received concerns in relation to the management of risks related to people's care needs. As a result, 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. The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hawthorne House on our website at www.cqc.org.uk.

Rating at last inspection
The last overall rating for this service was Good (published 1 May 2021)

Why we inspected
The inspection was prompted in part due to concerns received about management of risks associated with people's care including medicine management. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing and the governance of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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.

Hawthorne 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 Health and Social Care Act 2008.

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
This inspection was carried out by 6 inspectors, a pharmacist specialist, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 20 November 2023, 5 inspectors visited the service. One inspector spoke with relatives over the telephone to gather feedback on their experience of working in the service. The Expert by Experience spoke with people living at the service. The pharmacist specialist reviewed medicines at the home.

Service and service type
Hawthorne House 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. Hawthorne house is a care home with 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 not a registered manager in post. An experienced manager had transferred from one of the provider's other care homes and had been in post for 2 months at the time of our visit. They were planning to submit an application to register with us.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 13 November 2023 and ended on 20 November 2023. We visited the home on 20 November 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. 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
During the inspection, we reviewed 17 care plans across all of the units. We reviewed 5 medicine administration records and observed a medicines administration round. We reviewed actions in progress to reduce medicine errors. We spoke to the home manager, regional manager, 4 nurses, and 8 care staff. We spoke with 13 people receiving care and 2 relatives.

Requires Improvement

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 as Requires Improvement. At this inspection the rating has remained 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

- Risks to people's health and wellbeing had been identified and assessed but improvements were required to ensure risks were managed to keep people safe.
- Records failed to show that checks detailed in people's care plans were completed in a timely manner. For example, one person was to be repositioned every 2 hours to help prevent skin damage. Records did not show this had happened. A person was to have their blood sugar levels checked weekly and the last recorded check was in August 2023. A person at risk of falling was to be checked every 15 minutes, records did not show this happened.
- Some people with complex conditions required careful and considered care planning to minimise the likelihood of distress. Where the use of physical intervention may be required, records lacked sufficient detail to ensure this required intervention was completed safely, consistently, and as a last resort.
- Risks associated with people falling were not consistently managed. For example, walking frames seen for two people had worn ferrules (rubber feet) which increased the risk of them falling. Both people were assessed to be at high risk of falls and 1 of these people had fallen on the day of the inspection.
- The service did not keep seizure diaries where people were diagnosed as epileptic. These can support staff and clinicians to make informed clinical decisions about a person's care. Since the inspection, these have been put in place.
- Fire drills were completed but staff were not clear on what the contingency plan was in the event of a fire emergency should they be unable to return to the home. One stated, "Not 100% sure what happens if we couldn't come back in, but we would do what the seniors and nurses instructed."

The failure to have good oversight of risks was a breach of Regulation 12 (Safe Care and Treatment)of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Following our feedback to the provider, they took action to address some of the immediate risks during the inspection to help keep people safe.

Using medicines safely

- Prior to our inspection, the manager had informed us about medication errors that had occurred. We found robust actions had not been taken to reduce the risks of reoccurrence. People did not always receive their medicines safely or as prescribed. Records were not sufficiently clear to show how medicines had been managed.
- There were gaps in the electronic medicines administration records (eMAR) used to show medicines administered. This had not been identified by the provider. Where a medicine was recorded as out of stock,

there were no records of actions taken to rectify this. We could not be assured people always received their medicines as prescribed.
● Two people were to have their medicines administered covertly (where a medicine is hidden in food or drink). The required paperwork for all medicines to support this practice was not in place. We could not be assured that covert medicines were administered safely.
● Some medicines were administered via a PEG (percutaneous endoscopic gastrostomy) tube (PEG). The eMAR did not record administration should be safely provided this way. The volume of flush needed between each medicine was not recorded or available to staff to help prevent any incompatibilities between the different medicines.
● Staff were not aware of some serious side effects of an antipsychotic medicine or the need to record people 's smoking status and caffeine intake. This placed people at risk of ill health. Caffeine and smoking can cause changes in levels of this type of medicine in the blood.
● Senior care staff were not trained in the use of an epilepsy rescue medicine to ensure they could respond to those people with this health condition safely.
● Ambient room and fridge temperature monitoring were not recorded in 1 of the 3 medicine rooms visited during the inspection. Daily records were sometimes incomplete. We could not be assured medicines were always being stored in line with the manufacturer's recommendations, so they maintained their effectiveness.
● Medicine stock was not always managed safely. We found mixed strengths of a medicine in a single box. This meant there was a risk an incorrect dose of a medicine could be administered to a person. Regular balance checks staff completed failed to identify this issue.

The failure to have safe systems for the management of medicines was a breach of Regulation 12 (Safe Care and Treatment)of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● The provider had undertaken a full review of medication with support from the ICB pharmacy team, GP, and local pharmacist. They recognised there were actions needed to improve and these were ongoing at the time of our inspection. Provider meetings were regularly taking place to review progress.

Staffing and recruitment
● Staff were allocated to each of the units to support people in accordance with dependencies of the people on the units. However, there were inconsistencies across the units in regards to staff availability to support people's needs.
● On the dementia care unit one person had been allocated a staff member for one to one care but the staff member was not with them. Another person required an escort to a hospital appointment which left the unit with a staff member short. The impact of this meant one person did not receive personal care until the afternoon. We saw there was no staff member to support people to a planned social activity with the activity organiser. People were observed in communal areas of the unit with no staff supervision to help maintain their safety.
● Due to staffing arrangements, we saw one person experienced a delay in receiving pain relief when they were in pain. This meant they experienced pain and discomfort longer than necessary. A person spoken with about their medicines told us "They do rush a lot and have left before I have finished swallowing it (their medicine) which was not safe practice.
● A visiting health professional stated there was an impact with the regular use of temporary staff in the home. They told us, "They are reluctant to take responsibility such as to update care plans when things change, or challenge difficult situations." They went on to state that the lack of consistency meant queries or actions often got lost and were not followed up.
● People shared mixed experiences of staff support. For example, one person said, "They are there if I need

them, they do what I ask usually," and another stated, "They do look after me, but they could be more hands on. They come in and rush things and then leave."
● Staff shared mixed views about staffing within the home with some stating there were enough staff on their unit and others stating there were not. One staff member said, "No, it's not safe, 2 (staff) can be doing personal care and you come out to get something and see [name] walking up and down. Lots of the residents are at risk of falling and walk around. They are at high risk of falling but there is no one to watch out for them. So how can they be safe" and another stating, "I'd love to talk to the residents and take them out but it's impossible. In the past we were able to spend time in the garden, resident loved it, but not anymore."

Staffing arrangements meant people some people were placed at risk of unsafe care. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff had been recruited following a number of checks to ensure they were safe to work with people. This included written references and Disclosure and Barring Service (DBS) checks. DBS 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 they were recruited safely. One staff member told us, "I had an interview and was successful but then I had to wait for my references and DBS to come back before I could start and then every 3 years, they re-new my DBS.
● The provider has an ongoing recruitment campaign to help ensure each of the units can be sufficiently staffed primarily by permanent staff. Temporary staff usage within the home has reduced to help support consistency.

Systems and processes to safeguard people from the risk of abuse
● Systems and process to safeguard people from abuse were in place but inconsistent risk management placed people at risk of harm.
● There were a number of people with unexplained injuries. The manager was aware of this and explained challenges they had faced in investigating them. We saw in some cases there was a lack of information in records or issues with staff recall of events. Actions were in progress to introduce preventative measures to help reduce these incidents.
● Staff understood the need to report any safeguarding concerns. One staff member said, "Safeguarding is all about protecting the residents. If there was any incident, if I saw any abuse, if I saw carers neglecting people's needs, then I would report to nurse or senior depending on which is here. I have had a positive experience when I reported some concerns."

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. Conditions related to DoLS authorisations

were being met.
● Mental capacity assessments had been completed and were available on people's care plans to support staff where needed.
● DoLS applications had been completed and authorisations were available to view on care plan files. Staff knew which people had DoLS in place and the reasons for this. Best interest decisions had been made where needed and files contained information about family members who had lasting power of attorney for health and finances where their support was needed in decision making.

Preventing and controlling infection
● Staff understood and followed good infection control processes. The provider supported people living at the home to minimise the spread of infection and staff wore appropriate personal protective equipment when needed.
● Staff were observed transporting clinical waste in sealed bags and disposing of this safely.
● Infection, prevention, and control policies were available to support staff. One staff member told us, "I did the training on my induction. It is important to wear gloves and aprons when doing personal care to stop the spread of infection. We don't always wear masks, but they are there when we need them."
● Personal protective equipment was available to staff such as gloves and aprons when they needed them.

Visiting in care homes
● People received visits from family members and the provider had suitable processes in place to ensure visiting arrangements were safe

Learning lessons when things go wrong
● Learning from things that had gone wrong was not always addressed in a timely way. There had been some reoccurring incidents and work was underway to help guide staff to prevent these. The new manager was working through areas of improvement needed.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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 provider's systems and processes to monitor the quality of the service provided were not always effective. Where issues were identified, timely action had not aways been taken to keep people safe. Where quality checks were delegated to care staff, there had not been effective oversight by management staff.
- Audit checks showed walking frames were all in good working order when we had identified worn ferrules (rubber feet) increasing the risk of the person falling. The manager told us, "This will stem a complete turnover of the current system. It shows you can't go off what the seniors are saying. I am very disappointed but it's learning."
- Audit checks had been ineffective in identifying an item of nursing equipment used for checking blood glucose levels had not been calibrated as required to ensure accurate blood sugar monitoring was taking place and appropriate doses of insulin medication was administered to people as needed. Calibration is a term that refers to the process of comparing a measurement device or system with a known standard of accuracy.
- Whilst the manager had recognised improvements were needed to medicine management, we found areas of risk that had not been identified and acted upon in a timely way.
- The provider's systems to check staffing arrangements were safe had not ensured people's needs were met in a timely manner.
- Systems to manage safeguarding incidents were not fully effective as there were people with unexplained injuries and unclear records to enable these to be concluded.

The failure to ensure effective oversight of the service to identify and manage risk in a timely manner was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The provider acknowledged action was needed to reduce the number of safeguarding incidents. A safeguarding committee had been set up to discuss the outcomes of investigations. Changes implemented included increased staff training and competency checks. Two new clinical deputies had been recruited since the last inspection to help support improvement. Actions were ongoing to evidence learning from safeguarding investigations was being put into practice.
- Although the new manager was not registered with us, those people who knew the manager were positive in their comments. One person told us, "I know [manager] she's amazing." Another said, "It seems to run well here, I can't complain."

Working in partnership with others

● The service had regular contact with other health professionals including the Local Integrated Care Board who had been supporting and visiting the provider to instigate improvement of the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always assessed, identified and mitigated. Staff did not always have the information they needed to provide safe care and prevent avoidable harm or risk of harm. Medicines were not always managed and administered safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance Systems were not operated effectively consistently to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not always available to ensure people received safe care that met their needs.