Regal Care Trading Ltd

Hawthorn Lodge Care Home

Inspection report

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Date of inspection visit:
24 July 2023
25 July 2023
02 August 2023

Date of publication:
07 December 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Hawthorn Lodge is a residential care home providing accommodation and personal care. The service is registered for up to 60 people. The service provides support to people aged 65 and over. The building is on two floors containing people's rooms and flats as well as a shared dining room and several lounge areas. At the time of inspection the service was supporting 42 people.

People's experience of using this service and what we found
Governance systems and processes had failed to make sustained improvements since the last inspection. Quality assurance systems failed to identify and mitigate risks and left people at risk of harm.

People were not protected from environmental risks. Risks to people were not documented or mitigated effectively. The provider took action to mitigate risks highlighted once raised by inspectors.

Medicines were not managed in line with best practice. People who smoked and were prescribed flammable creams were not protected from the risk of severe burns or fatal harm. Action was taken by the provider to mitigate risks to these people once raised by inspectors.

People were not protected from the risk of infection. Areas of the service were not clean, had damage and wear and required repair.

Professional advice was not always sought or followed in a timely manner.

Potential safeguarding incidents were not consistently documented or reported to the local safeguarding authority for further review. Action was taken to improve these processes following discussion with the inspector and local authority.

People were not always supported to have maximum choice and control of their lives as they were not always supported in the least restrictive way possible and in their best interests. Systems in the service did not always support this practice. Relevant legal authorisations for Deprivations of Liberty for people were in place where required.

Most relatives felt engaged by staff and the registered manager. Staff felt the registered manager was approachable and felt able to raise concerns.

People and relatives we spoke with felt the service was safe. Staffing levels were in line with dependency levels. Staff were recruited safely.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 07 October 2022)

Why we inspected
We received concerns in relation to infection control, safeguarding and medicines management. 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 requires improvement to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end 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 Lodge on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people's health and safety, and 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 continue to monitor information we receive about the service, which will help inform when we next inspect. We will work with the 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 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 of their 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Hawthorn Lodge Care 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.

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 2 inspectors 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.

Service and service type
Hawthorn Lodge 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. Hawthorn Lodge s 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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last 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 also reviewed information shared with us by the local authority. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people and 13 relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 7 staff members. This included kitchen, housekeeping, maintenance, and care staff. We spoke with three external professionals visiting the service. We also spoke with the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We completed observations of people being supported by staff and the service environment. We reviewed a range of documentation including people's care plans, medicine records, staff recruitment files, training records and manager audits.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Environmental risks were not mitigated safely. Hot water taps were not always within safe temperature guidelines. Three hot water taps, including 2 in people's bedrooms, were over 44 degrees Celsius and presented a scalding risk. The Health and Safety Executive recommends taps are limited to 44 degrees Celsius to reduce the risk of scalding to people in care homes. This was raised with the registered manager by inspectors and temperatures were adjusted within safe limitations.
- The bacteria legionella was found in the water system in June 2023 and a re-test was required. Although this posed a small risk to people, the provider was advised this risk could increase quickly should water conditions change. While the provider ordered re-testing equipment initially, they failed to chase the delivery of this to ensure a prompt retest and this meant people were exposed to an increased risk of harm. We highlighted this to the provider and following the inspection the water system was found to be clear of legionella.
- Items which were hazardous if consumed were accessible to people who may not have understood their contents. Loose hand sanitiser, nail polish, solvent hair mousse and slug pellets were all accessible to residents and had not been locked away. This meant people were at an increased risk of poisoning. Following concerns being raised by inspectors, the registered manager informed staff of the need to securely store potentially hazardous items.
- Fire risks were not always mitigated. Two sets of fire doors were found to not be sealing correctly when closed. Fire doors are in place to slow the spread of flames and smoke. This left people at risk in the event of a fire. Personal Emergency Evacuation Plans (PEEPs) had been completed to inform staff of the evacuation needs of people, but these were only available on the online system and had not been made available in paper format in the emergency grab bag. This meant the provider had failed to ensure staff could access information quickly to support a safe evacuation of people. Once raised by inspectors, the provider acted to mitigate these risks.
- Risks to people were not always identified and mitigated. A person was observed to not have access to a call bell despite being unable to independently mobilise from bed. They were observed to be calling out for support to use the toilet and have a drink. This left them at risk of not receiving timely support. Once raised by inspectors, a portable call bell was put in place.
- Care records did not always show where people at risk of pressure sores had been repositioned, in line with their care plans. This left them at risk of skin breakdown. Once raised by inspectors, the provider took action to ensure staff were aware of how repositioning should be recorded safely and put a new system in place to check these records regularly.
- Incidents and associated risks were not always documented appropriately. For example, an incident observed by an inspector between 2 people was not documented by staff. The registered manager confirmed this was a known risk between these people, but this had not been documented in either

person's care plan or risk assessments. In another recorded incident, a person had expressed they were attempting to self-harm, but this had not been documented in their care plans or risk assessments to inform staff how best to mitigate this risk or support the person at these times. The provider took action to ensure this risk was included in care plans and risk assessments once raised by inspectors.

Using medicines safely

● Medicines were not always managed safely and in line with best practice.

● Fire risks associated with flammable skin creams were not mitigated. We identified 3 people who were prescribed flammable creams were smokers. The provider had failed to mitigate the risk of severe and fatal burns. We discussed this with the provider who sought GP advice during the inspection and risk assessments and care plans were produced with measures in place to mitigate risk.

● 'As required' (PRN) medicines did not always have relevant protocols in place for staff guidance. It is best practice to ensure PRN protocols outline when PRN medicines should be given, signs and symptoms to look out for and whether people can ask for this medicine. This left people at risk of not receiving medicines when needed. Following this being raised by inspectors, the registered manager put PRN protocols in place.

● Prescribed creams were not always stored and recorded in line with best practice. Three people's medicine records for creams failed to be recorded consistently so it was not clear if they were having creams applied as prescribed. This may have left people's skin integrity at risk. Prescribed creams were also found to be opened without a date of opening recorded. It was unclear if these creams were still in date according to manufacturer's guidelines.

Preventing and controlling infection

● People were not always protected from the risk of infection. Discarded personal protective equipment (PPE) was found on 2 occasions not in an appropriate contaminated waste bin. This left people at risk of infection if they came into contact with these items.

● Areas of the service were visibly dirty. For example, a wheelchair stored in the dining area was heavily soiled. The laundry room was unclean and there was damage to flooring, increasing the risk of bacteria being harboured. This meant that people were at an increased risk of infection.

● Numerous furnishings around the service had wear and damage to them and made them more likely to harbour bacteria as they were more difficult to clean. One person's bath had a large crack in the bath panel and had heavy wear to it.

● Food items did not always have dates of opening on them and were not always stored safely. Cereals and breakfast items were stored in a cupboard which was visibly dirty, and this risked contamination. It was not clear when some of these items had been opened and whether they were still consumable within manufacturers guidelines. This meant people were at an increased risk of food poisoning.

Systems and processes were not effective in ensuring care and treatment was provided in a safe way. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● People were supported to receive visits from their relatives. Visits occurred within people's rooms and in communal areas of the service.

Systems and processes to safeguard people from the risk of abuse

● There was evidence of safeguarding referrals being made to the local safeguarding authority, however,

this was not always fully documented in the relevant safeguarding folder.
● Concerns were raised by the local authority that not all incidents which met safeguarding thresholds, such as falls, were being reported to them for further review. Following a meeting with the local authority, action was taken to ensure a clear understanding and process for reporting these incidents.
● Staff we spoke with understood safeguarding and whistleblowing.
● People and relatives told us they felt the service was safe.

Staffing and recruitment
● A dependency tool was used to determine staffing levels. The registered manager told us they stayed above safe staffing levels prescribed by this tool and agency staff were used when required.
● Relatives we spoke with had mixed views on staffing. One relative said, "I always see enough staff around, they are very friendly and helpful." Another relative told us, "There are not always enough staff on duty, I hear residents ask for the toilet but have to wait to be taken and then I have seen them have an accident. I do sometimes go and find a member of staff for the resident."
● There were occasions observed where call bells were sounding for prolonged periods. This included an occasion where an inspector prompted the registered manager to ask staff to attend to a person's call bell.
● Staff were recruited safely with relevant checks in place. Staff files we reviewed included up to date Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 not always working within the principles of the MCA. However, if needed, appropriate legal authorisations were in place to deprive a person of their liberty. As referenced under the assessing risk section above, a person was not being supported to request support from staff as they did not have access to a call bell.
● Staff we spoke with understood the MCA and the need to support people with decisions making where required and had recorded training in place.

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 changed to inadequate. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to make significant improvements to their rating over consecutive inspections. Over the last 4 inspections, the service has been in breach of regulations on 3 occasions and has failed to achieve a rating greater than requires improvement. This has included an inspection with an inadequate rating. At this inspection there was again a failure to comply with the fundamental standards expected of services.
- Quality assurance systems failed to effectively assess, monitor and mitigate risk. For example, there was a failure to ensure processes to mitigate the risk of legionella were being completed and recorded accurately, such as flushing water outlets. There was also a lack of an effective system to complete internal fire door checks to ensure doors were working safely. This left people at risk of harm in a fire emergency.
- The provider failed to follow their own policies to ensure regulatory compliance. For example, the smoking policy and procedure stated that a risk assessment should be in place for people who smoked and were prescribed emollients. These risks, however, had not been assessed and left people at risk of burns and harm.
- Systems to ensure the upkeep and cleanliness of the building were not effective. As outlined under the safe key question, several areas of the service required cleaning and repair. This included several communal areas and within people's rooms to help improve infection control. Despite this, there failed to be a refurbishment plan in place to detail planned works, when they would be completed, and by whom. This left people at risk of infection from dirty and damaged areas of the premises.
- The provider had failed to ensure systems and processes for medicines followed professional advice and best practice. For example, an external professional medicines review had taken place in May 2023. This review made recommendations, including for the fridge and overstock cabinet to be kept locked, medicine returns to be locked in a cabinet and PRN protocols to be in place. Despite this, none of these recommended actions had taken place. Governance processes had therefore failed to ensure best practice. Once raised by the inspector, the provider took action to ensure locks were in place for medicine storage.
- There was a failure to always keep a clear and accurate record of care and treatment. For example, there was a safeguarding folder in place with an overview document to list safeguarding incidents. This document did not outline all relevant incidents referred to the local authority and therefore the relevant process in place was not being followed. Details of each individual safeguarding incident, including their outcomes, were also not evident in this folder. This meant there was no complete documented oversight of safeguarding at the service.

Systems and processes failed to assess, monitor and improve the quality and safety of the service provided. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most relatives and people we spoke with felt care was person centred, however some relatives raised concerns about how well agency staff and night staff supported people. For example, a relative told us, "The staff do appear happy and appear to have a good rapport with the residents. It's the agency staff who don't know the residents." The provider told us they use a consistent agency to supply staff to support these staff members building rapport with people. Agency staff were also used sparingly compared to permanent staff.

Working in partnership with others

● Professionals were not always contacted proactively. For example, in one incident, a person was discharged to the service from hospital without a discharge summary and the wrong medicines. Staff did not follow up the lack of discharge summary and hence did not recognise these were the wrong medicines. The person subsequently received the wrong medicines for approximately 27 days, until this was identified during ordering of medicines stocks through the GP. Action was taken following this incident to ensure discharge paperwork was checked for all people being discharged to the service.

● There were concerns raised by professionals that they were not always contacted in a timely manner. Three professionals we spoke with raised concerns about the timeliness of referrals for concerns such as people's pressure areas. Despite this, there was evidence of referrals being made and professionals having input at the service. The registered manager told us they had constant input from professionals and previous concerns around delayed referrals had been learned from.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider and registered manager failed to understand their responsibilities to act in an open and honest way and without delay if something went wrong. We found during the inspection we were not informed of significant events at the service. The registered person has a legal requirement to send statutory notifications showing how different events had been managed. This will be followed up after the inspection.

● There were mixed views from relatives around how they were engaged by the service. Some relatives felt they were kept up to date by staff and the registered manager, whereas others did not. One relative told us, "They update me regularly on everything and I feel I have a good bond with them. I know the manager well and she takes time to talk to me." Another relative said, "I don't get any updates unless I phone the home."

● People, their relatives, and staff we spoke with felt the registered manager was approachable and they felt able to raise any concerns with the service. There was evidence of concerns being followed up by the registered manager.

● The registered manager and nominated individual were candid throughout the inspection where concerns were raised. The nominated individual also put a service improvement plan in place which they updated weekly and sent to the inspector.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people's heath and safety were mitigated.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes failed to assess, monitor and mitigate risks to the health, safety and welfare of people using the service.

The enforcement action we took:

We served a warning notice.