A.N.I. Health Care Services Limited

Hazelford Residential Home

Inspection report

The Hazelford Care Home
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Date of inspection visit:
04 November 2020
05 November 2020
11 November 2020
16 November 2020
17 November 2020

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23 April 2021

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
Hazelford Residential Home is a residential care home providing personal care to 17 people aged 65 and over at the time of the inspection, some of whom were living with dementia. The service can support up to 36 people across two floors.

People's experience of using this service and what we found
People living in the service were not safe and were placed at risk of harm. Risk management and poor infection control process at the service put people at increased risk. Medicines management and administration were not safe. Records relating to people's care did not always contain sufficient information and guidance to enable staff to provide the safe care and support people required.

The service lacked oversight and leadership which led to poor outcomes for people using the service. There were very limited quality monitoring and auditing processes in place which left people at risk.

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 (published 6 July 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
As part of CQC's response to care homes with outbreaks of coronavirus, we are conducting reviews to ensure that the Infection Prevention and Control (IPC) practices were safe and the service was compliant with IPC measures. A targeted inspection looking at the IPC practices the provider had in place took place on 4 November 2020 and was unannounced.

During this targeted inspection a number of concerns were found around infection control and governance which prompted a focussed inspection to take place on 5 November 2020 and 11 November 2020.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. The provider has taken action to mitigate some of the risks identified.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection control, risk management and leadership 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.

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?

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.

Hazelford Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
Hazelford Residential Home is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. 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
On 5 November 2020 we spoke with eight members of staff including the care home manager, senior carer, care workers, cook, laundry assistant, maintenance staff and the administrator. We reviewed a range of records including multiple medicine records and quality assurance records.

Following this we sent a letter to the provider outlining the concerns we found during the first day of inspection, which they responded to with details of their action to ensure people's safety at the service.

We carried out a second visit to the service on the 11 November 2020. On this day we spoke with seven members of staff including the provider, care home manager, senior carer, care workers, domestic assistant and the administrator.

We sought further information from the provider to inform our inspection judgements. This included care records, staff training data and policies. We also sought additional feedback from healthcare professionals and the local authority.

On 16 November 2020 we made phone calls to three relatives to ask about their experience of the service. On 16 and 17 November 2020 we made phone calls to five further staff to ask them about how they cared for people and their experience of working at Hazelford Residential Home.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection
At our last inspection the provider had failed to ensure robust systems were in place to demonstrate infection prevention and control was safely managed. This resulted in a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- People were not protected from the risk of infection due to cross contamination and poor infection control practices.
- There was no adequate cleaning taking place throughout the home, which meant the home was visibly dirty and increased the risk of infection. For example, a used needle had been left in unlocked bedrooms and beds had been made over food crumbs.
- Personal protective equipment (PPE) was available but the provider was using the wrong type of face masks for a healthcare setting. There were also not enough areas around the home where staff could safely don, doff and dispose of their PPE. This was raised with the provider following the inspection and they have addressed these urgent concerns.
- Government guidelines in relation to COVID-19 were not being effectively followed. Infection control measures in place were not enough to prevent the spread of COVID-19 which placed people at significant risk.

The provider failed to ensure that people received care and treatment in a safe way and protect them from the risk of harm. This is a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure systems were in place to demonstrate risks were effectively manged. This resulted in a breach of Regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- People's risks in relation to their health needs were not being assessed, mitigated or managed effectively in order to keep people safe.
- People who had specific risks identified did not have sufficient plans in place to guide staff to support them safely. For example, around catheter care, records did not contain information about when and by whom the catheter and bag should be changed. Care plans also contained statements which could lead to

unsafe practice, for example "staff to give as much fluid as possible".
● We observed poor moving and handling practices. People were incorrectly assisted to stand from sitting positions and unsafe techniques were used to assist people. There was incorrect use of mobility equipment. This placed people at increased risk of injury or harm.
● Environmental risks were not managed adequately to ensure the safety of people. Checks, such as water temperatures, that should take place on a regular basis we not carried out consistently. Fire safety was not being managed appropriately. There were no recorded fire drills and plans for people's safety in the event of a fire were not all stored in the 'grab bag'. This meant in an emergency plans were not accessible to staff in order to evacuate people safely.
● People were at increased risk of harm due to the poor risk management in the service.

The provider failed to ensure that people received care and treatment in a safe way and protect them from the risk of harm. This is 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
At our last inspection the provider had failed to ensure systems were robust enough to demonstrate medicines were safely managed. This resulted in a breach of regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not always managed effectively to ensure they were being administered to people safely.
● People were prescribed "as and when" medicines, such as painkillers or medicines to help with anxiety or agitation. However, we found protocols for these medicines did not guide staff to administer them safely or effectively.
● Medicines were not always stored safely. For example, they were not always stored at the right temperature, this meant there was a risk they were not effective for people receiving them.

The provider failed to ensure that people received care and treatment in a safe way and protect them from the risk of harm. This is a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels and recruitment were not managed in a safe way.
● Staff had not always had the appropriate employment checks prior to commencing duties. The provider did not always ensure they had the proper assurances that people were being supported by appropriate staff, this placed people at increased risk.

The provider failed to ensure that new staff were recruited safely, and their recruitment procedures followed schedule 3. This is a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not use a dependency tool or have a system in place to calculate how many staff were required on each shift or to ensure there was the right skill mix. This meant people were at risk of not being supported in a timely manner or by appropriately trained and experienced staff.
● Staff told us due to staff shortages they had worked high numbers of consecutive days in a row and felt under pressure to do so.

This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- The provider did not have adequate systems in place to safeguard people from the risk of abuse.
- Staff had not all completed safeguarding training. This meant safeguarding concerns may have been missed. We found reportable concerns during the inspection which we escalated to the safeguarding team.
- The provider did not ensure safeguarding concerns were always recognised, recorded or reported on appropriately.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Learning lessons when things go wrong

- The provider did not have a system in place to effectively monitor and learn from accidents and incidents.
- There was very limited analysis on incidents which meant there was very limited opportunity for learning. For example, the system in place to track falls did not identify people at risk due to lack of detail on when and where falls occurred and how many falls each person had.
- The care home manager was unable to provide any examples of when lessons had been identified and shared with the staff.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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.

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 we found quality assurance and audit processes had not always been effective in identifying and addressing areas for improvement at the service. This resulted in a breach of Regulation 17 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

- There was no provider oversight at this service, which meant they were unaware of the risks, concerns and issues we identified.
- The registered manager was no longer present in the service. The newly appointment care home manager had been left without effective support or guidance on their duties and responsibilities.
- There were inadequate systems in place to ensure safe care is delivered. This was demonstrated by the poor recruitment practices, lack of staff training and the substandard risk assessments and care plans.
- There were no robust systems in place to monitor the quality of the service. Audits were limited and inconsistently recorded. Where some had been completed, they were not effective enough to pick up the concerns and risks throughout the service. For example, although a medicines audit had taken place it had not identified the insufficient PRN protocols. No action plans had been implemented to improve care provided or to mitigate risks.
- Due to the lack of oversight and governance, where incidents had been recorded, investigations were very limited. There was no evidence of analysis or lessons learnt.
- The provider had a business continuity plan but there was no evidence this had been followed and it did not specifically guide the service on what to do in the event of a COVID-19 outbreak.
- The provider did not meet all their regulatory requirements, including notifying CQC of certain incidents and displaying the previous CQC rating within the service.

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 majority of staff spoke highly of the current manager but recognised the lack of support from the provider. Although staff said overall there was a good team morale, some did say recent weeks had been overwhelming and they felt overworked. This was reflected in the hours and days some staff were working without sufficient rest days.
- Relatives we spoke with said there was poor communication and were unaware of the management

structure or who to approach with any concerns they may have. A relative said, "They do need to do something to support relatives and keep them updated".

● Relatives who had tried to raise concerns had not been responded to. A relative said, "It would be nice to get a response or some sort of contact, as it's such a worrying time." We did not find any system in the service to record or respond to complaints.

● Engagement with people was very limited and there had only been one resident meeting this year. The manager had started to put in place some feedback questionnaires for relatives and people.

● We observed very limited interaction with people throughout the inspection days, with some staff ignoring and speaking about them in an undignified way. We also observed confidential information being left in communal areas.

● The provider was not encouraging a positive person-centred culture.

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 lack of detailed internal investigations following incidents, the poor communication reported by relatives, and the lack of understanding around reportable incidents indicated the provider was not fully aware of their responsibilities under the duty of candour.

The provider failed to ensure that their systems and processes operated effectively to improve the quality and safety of the service they provided to people. All of the above evidence was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure there were adequate safeguarding processes and systems in place to safeguard people from the risk of abuse and harm. The provider did not ensure all staff were trained in safeguarding.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure they conducted required recruitment checks to ensure the suitability of employed staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was adequate staff with the right skills to meet peoples needs.

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 People were at significant risk of harm from poor risk management, their environment and poor recruitment practices. Medicines management was poor. Infection control practices were not in line with guidance leaving people at significant risk of infection during the pandemic. Reg 12 (a) (b) (c) (d) (e) (g) (h)

The enforcement action we took:

We imposed urgent conditions to restrict admissions and for the provider to address to most urgent risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service lacked the oversight and leadership to effectively manage risk leaving people at risk of harm. Reg 17 (2) (a) (b) (c) (d) (e) (f)

The enforcement action we took:

We imposed urgent conditions to restrict admissions and for the provider to address to most urgent risks.