Hawksyard Priory Nursing Home Limited

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Inspection report

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Date of inspection visit: 3 November 2014
Date of publication: 13/04/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected this service on 03 November 2014. The inspection was unannounced. At our previous inspection in July 2013, the service was meeting the legal requirements.

The service provides nursing and personal care for up to 106 older people who may have dementia. There were 101 people living at the home on the day of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who were living at the service told us they felt safe. Medicines were administered and recorded correctly.

The recruitment processes were not consistently applied to provide assurance that suitable checks had been completed for staff prior to recruitment.

The human rights of some people who used the service were not being respected because staff had not fully understood their responsibilities under the Mental Capacity Act (MCA) 2005.

Staff received training which was linked to people's needs and specific to staff requirements. Staff told us they received supervision and they felt supported to fulfil their roles.

We observed people being given day to day choices. People we spoke with told us they had not been given the choice to take part in reviews of their care.

People had differing views about the quality and choice of the food they received and some people had chosen to cater for themselves.

We observed that people were relaxed being with and talking to staff although some staff did not interact with people or show understanding of people living with dementia.

People we spoke with told us staff knew what they liked and how they wanted their care provided.

There were arrangements in place to involve people in hobbies, pastimes and outings which interested them.

People and their relatives told us they would feel comfortable raising complaints or concerns with staff or the registered manager and felt they would be listened to.

The provider had arrangements in place to listen to the views of people and their relatives through the provision of meetings however we could not see what actions had been taken in response to people's comments.

The provider was assessing the quality of their service through an audit programme. The information captured was not used to identify trends which could affect people's care.

Some of the records we viewed did not provide accurate and up to date information about people or the staff.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond with breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what actions we told the provider to take at the back of the full version of this report.

Summary of findings

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 consistently safe. Some people's risks had not been assessed thoroughly or in a timely manner. People received their medicines safely and at the time prescribed. The staffing levels were based on the needs of people who used the service.

Requires Improvement

Is the service effective?
The service was not consistently effective. The provider was not adhering to the principles of the MCA which meant some people's movements were unlawfully restricted. People were supported by staff who had the skills and knowledge to care for them.

Requires Improvement

Is the service caring?
The service was not consistently caring. The care needs of some people living with dementia were not always recognised by staff. Staff respected people's privacy and supported them to maintain their dignity. People were encouraged to maintain their independence.

Requires Improvement

Is the service responsive?
The service was not consistently responsive. People's care plans were reviewed regularly but people told us they had not been offered the opportunity to be involved. People were supported to take part in hobbies and pastimes. People who used the service and their relatives felt supported to raise any concerns or complaints directly with staff or the registered manager.

Requires Improvement

Is the service well-led?
The service was not consistently well-led. Some of the information we viewed did not provide accurate records for the people who used the service or the staff working there. People and their relatives were given the opportunity to voice their opinions about the service they received but the registered manager had not taken action on the issues people had raised. The provider was monitoring the quality of the service through audit. There was no analysis of trends identified during audit which might highlight changes in the care provided.

Requires Improvement

Hawksyard Priory Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 November 2014 and was unannounced. There were four inspectors and an expert by experience present. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience supporting this inspection had a special interest and experience of people living with dementia.

Before the inspection the provider completed a Provider Information Return (PIR) which gives the provider the opportunity to share information with us about the service, what they feel they do well and what improvements to care and management they plan to make.

We reviewed the information we held about the service, information from the local authority and the statutory notifications the service had submitted to us. A statutory notification is information about important events which the provider is required to send us by law. We also contacted the local authority quality monitoring officer for the service and the service commissioners.

We spoke with 20 people who lived in the home and four relatives. We also spoke with eight members of staff, the registered manager and the deputy manager. We observed the care and support being delivered in communal areas of the home and observed people's lunchtime experience to see if people received appropriate support to eat and drink.

Some people were unable to speak with us about the care and support they received. We used our short observational framework tool (SOFI) to help us understand, by specific observation, their experience of care.

We reviewed 11 people's care plans to see if care was planned and delivered in the way they preferred. We reviewed five staff files to see if staff were recruited safely and received sufficient training and support to provide care which met people's needs. We looked at the ways the management of the home measured the quality of the service they provided and how they identified areas which needed to be improved.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe living at Hawksyard Priory. One person said, "Oh, I'm quite safe here". Another person said, "I feel safe". A relative told us, "My [the person who used the service] is much safer than they were before".

Staff we spoke with could explain the different categories of abuse, were clear about their individual responsibilities to keep people safe and the process for making a safeguarding referral. Staff told us they had received training in safeguarding and were knowledgeable about the types of abuse people might be subjected to. A member of staff told us, "I know what I need to do if I'm worried about someone".

Staff told us they understood their rights to share concerns about the home. They were aware what whistleblowing meant and what to do if they were worried about anything they witnessed. A whistle-blower is a person who exposes concerns about poor care or practice in an organisation. Staff told us they would feel comfortable informing their managers, the local authority or CQC if they were worried about anything they witnessed which they felt could cause harm. This meant staff felt supported to raise concerns to protect people in receipt of care, from potential harm.

Some of the records did not provide accurate and up to date information about risks or the care of people living in the home. Some people who used the service had safety gates in place across their bedroom doors. People we spoke with told us they had asked staff to do this to stop other people wandering into their rooms. A gate was also in use to restrict the access of people into one of the offices. There were no risk assessments in place for the use of the gates and we raised concerns with the manager that the gates could be a trip hazard for people.

We looked at two care plans for people who had been living in the home for a few weeks. One person had a medical condition which could require an urgent response from staff. The person came into the home with a risk assessment in place but this had not been reviewed to ensure it was still relevant or effective. Staff we spoke with were uncertain how they would support the person. It was recorded in another person's care plan that they sometimes displayed behaviour that challenged their safety and that of others. In the person's care plan it was documented that the person did not like noisy environments. There was no management plan in place to offer staff guidance on how to care for this person. The person was sitting in a lounge area with music playing and people shouting. We observed this person showing signs of distress by becoming increasingly agitated and the staff we spoke with were unaware that they had placed the person in an area which might upset them.

The manager told us that they based the number of staff on people's level of need. Staff confirmed that two members of staff started their shift earlier in the morning so more staff were available to help people get up in the morning. People we spoke with told us they received care when they needed it. One person told us, "We don't have to wait for help". Another person said, "We don't wait for someone to come. There's plenty of staff around". A relative told us, "There always seem to be staff available. A member of staff said, "We have enough staff to meet people's needs".

We looked at the processes in place to ensure medicines were managed safely. Medicines were being stored securely and at the correct temperature to maintain their efficiency. We observed medicines being administered and recorded on the medication administration charts and saw these processes were completed correctly. One member of staff who had previously worked in a pharmacy was responsible for ensuring that medicines which were surplus to requirements were destroyed in the correct manner. People we spoke with told us they received their medicines when they expected to.

There were no written protocols for medicines given on an 'as and when required basis', known as PRN medicine. We saw that a person was given anti-anxiety PRN medication when they became distressed at lunch time. There was no protocol for this medication and no reasons or outcomes recorded for its use.

We spoke to staff about their recruitment into the service and looked at the process recorded in five staff records. Staff told us about the documentation they had to provide before starting work. Staff explained that they did not start work until they had received clearance from the Disclosure and Barring service (DBS) which was confirmed in the files we reviewed. The DBS provides employers with information if potential staff have a criminal record and would not be suitable to work with people. Three of the recruitment files

Requires Improvement

Is the service safe?

we viewed did not contain sufficient or appropriate references and on two occasions references addressed to 'Whom it may concern' which were undated and therefore their validity could not be confirmed.

Requires Improvement

Is the service effective?

Our findings

We saw people being offered some choices throughout the day about where they would like to sit or if they wanted to participate in hobby and leisure activities. A member of staff said to a person who used the service, "Would you like to sit in the armchair for a while or would you rather go back to bed for a rest?" We did not see, in the care plans we looked at, that people had been asked to sign to indicate their consent to care and treatment.

Some people who used the service were unable to make decisions about their care, support and safety for themselves. The Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements, when people lack capacity, to ensure appropriate decisions are made in their best interests. Some capacity assessments had been recorded but we saw these had not been reviewed for specific decisions and did not reflect changes in people's level of capacity. This meant the information in people's care plans was not always up to date.

Staff we spoke with demonstrated a mixed and inconsistent understanding of mental capacity and DoLS. One of the units we visited, for people who were living with advanced dementia, had several locked doors. We saw people walking around trying to get out of the unit, or go into their bedrooms but these doors had been locked with access managed by staff, which meant people's movements were restricted. The MCA and DoLS require providers, when a person lacks capacity, to submit applications to a supervisory body for permission to deprive them of their liberty however this had not been done for everyone who might fall into this category. This meant people's human rights were not being protected. The manager confirmed to us that they would refer the people affected to the local authority, as required, for assessment.

We reviewed information we held about the service and noted that there had been a higher number of expected deaths reported than we would have expected. The registered manager told us this was due to the number of people who chose to come into Hawksyard Priory for their end of life care. We saw, in some of the care plans we looked at, that some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place. This document is completed in advance when people have decided they do not want to be resuscitated. Some of the DNACPR forms had been completed by a GP and some by a qualified nurse working at Hawksyard Priory. We could not see a record of discussions, as required, with people or their relatives to support the decision making process which had been used to implement the DNARCPR. This meant that people wishes may not have been considered.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked people if the staff understood how to care for them. One person who used the service told us, "The staff look after me more than nicely because they've had the experience and training". Another person said, "I don't know who trains them or where they're trained but they're very good".

Staff told us they had access to training and could ask for additional training if a need was identified. One member of staff told us about the training they had received for the care of people living with dementia and said, "It explained the reality of living with dementia". Another member of staff told us, "We had a person admitted who needed specialist care. I asked for an update and the training was provided for all the staff".

One member of staff spoke with us about the induction training they received when they started working at the home, they said, "I had a booklet of training that I worked through with a senior member of staff and then had support from other staff before I was ready to work alone". This meant the provider recognised the need to provide staff with training and support.

There were arrangements in place to provide staff with regular supervision during which they could reflect on their practice and discuss any personal problems or training requirements. Staff told us they could discuss anything during their supervision sessions. One member of staff said, "If you have a problem, the supervision sessions help you to sort it".

We saw people's weight was recorded and monitored on a regular basis. Staff we spoke with told us they regarding people's weight as an indication of their health and wellbeing. We saw that whenever there were concerns about people's weight loss they were prescribed supplements to support their food intake. We saw that

people were not observed whilst they were having their lunch. One person had been prescribed food supplements to be given if they did not eat a sufficient amount. We noted the person was not encouraged by staff to eat their meal and the amount they had eaten was not recorded. This meant the staff had no record to refer to and we did not see that the person received the supplement prescribed for them.

People who used the service were provided with a choice of food. We received mixed comments about the food; some people told us they enjoyed the meals. One person said, “I can’t grumble at the food”. Another person said, “It’s not always what I like but it’s good food”. Other people told us they did not like the meals. One person said, “The food isn’t good, it’s adequate”. Some people had chosen to buy their own food which they stored in fridges in their rooms because the choices available to them did not meet their preferences. On the day of our inspection people were asked which of the two options available they would like. For those people requiring a soft diet there was only a choice of fish on that day. We saw one person tell staff they did not like fish but agreed to eat it after staff said there was no other choice. The person said, “Okay I’ll eat it this time but don’t give me fish again, I don’t like it”. This meant some people were not supported to have food they enjoyed.

People told us they saw healthcare professionals such as the doctor or optician whenever they needed to. The care plans we looked at showed there were regular reviews by the GP and referrals for specialist advice were made as required. We saw that referrals had been made to podiatrists, the dentist and dieticians and speech and language professionals for people who developed problems with weight loss or swallowing difficulties.

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Requires Improvement

Is the service caring?

Our findings

We observed some kind communication between staff and people who used the service. People looked comfortable and relaxed in the company of staff however we observed that some people were not always treated with consideration and understanding.

We saw one person was left sitting alone in the dining room after lunch and we observed several members of staff who came in for their own lunch break did not acknowledge this person or make any effort to interact with them. Another person became distressed when staff answered their request to go home by saying, "You can't go home, you live here now". Another person who was trying to get into an office was told 'to go back to their room'.

During lunchtime we saw that once food was served people were left without supervision by staff. We saw people, once they had finished their food shouting for assistance to leave the room. Although staff walked through the room to and from the kitchen no attempt was made to assist people. We had to intervene when one person who had asked staff to help them became frustrated by the lack of response from staff. They attempted to mobilise independently and almost tripped on the footplate of a wheelchair. Some people who were sitting in a small lounge were not provided with a meal. We had to ask staff to serve them lunch as they had been overlooked.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they were welcome to visit at any time and stay as long as they wanted. Staff encouraged relatives to maintain contact with their loved ones by inviting them to stay for a meal or join in social activities. One relative said, "If I wanted to I could stop and have a meal with them [the person who used the service]".

People told us they were well cared for and staff were kind and caring. One person said, "They're nice, we can't grumble". Another person said, "They're very good, very obliging". A relative told us, "I'm so happy they are here. They [the staff] seem very nice".

Most of the people we spoke with told us the staff treated them with dignity and respected their right to privacy. We saw requests for personal care were responded to in a discreet and timely manner. One person told us, "They [the staff] do respect our dignity and respect".

Staff supported people to retain and maintain their independence. People told us staff helped them when they needed it but respected their right to be independent. One person who used the service told us, "I'll do anything to help myself but if you need help they're here to help you". Another person said, "If I say I can manage they let me do things for myself".

Requires Improvement

Is the service responsive?

Our findings

People were supported by a staff to participate in their hobbies and any social activities that interested them. On the day of our inspection we saw people taking part in a game of darts. A person who used the service told us, "If I can manage it I always join in. They always welcome me and help me". Another person said, "We do things in the afternoon. There's a girl who's very good at organising quizzes and sing-a-longs". A relative told us they received information monthly about forthcoming social arrangements that their loved ones would have the opportunity to participate and meant they could attend as well, if they wanted.

There were links with the community through social events and the people who worshiped at the priory adjacent to the service. One relative told us, "There's an outing to the local pub which people enjoy. Relatives can go too". This meant people were supported to remain in touch with the community.

We looked at the care plans for eight people and saw they provided information about each person's needs. The information included how people would like to be supported and their individual health and social care needs. Information about people's preferences was also displayed inside the wardrobe door in their bedroom to prompt staff about people's likes and dislikes. A relative told us, "We were asked to provide information about our [the person who used the service] when they first moved in here". Another relative told us, "The staff remember what people like, even if it's just how much sugar they like in their tea". We did not see that people had been given the choice to be involved in reviewing the care they received. One person said, "I can't remember them showing me a care plan". We asked another person if they had a care plan and they said, "If I have it's a secret to me".

Staff told us they completed 'daily records' which included the personal care people received, notes about their general well-being and information, when appropriate about people's nutrition and fluid intake and output however one of the records we looked at did not accurately reflect the care the person had received that day. Information recorded in the daily notes was communicated between staff at each shift handover and gaps in recording meant staff might not receive up to date information about people.

People we spoke with told us they would happily raise any complaints or grumbles with the staff or directly to the manager. One person said, "You can talk to any of the nurses and they will listen" whilst another person said, "I'd tell the matron [manager] if I was unhappy". A relative told us, "I've never had a reason to complain but I'd go straight to the manager, you can talk to her alright". We looked at the complaints which had been received since out last inspection and saw these had been investigated appropriately and responded to within a timely manner.

Requires Improvement

Is the service well-led?

Our findings

We looked at records relating to the management of the home. We saw there were inconsistencies in the quality of information in people's care plans across the three floors in the home. Care plans for one floor provided staff with information on how to meet people's care needs and manage the risks identified. On the other floors the information was brief and lacked detail. There were no management processes in place to ensure consistency of information throughout the home.

One person was looking after their own medicines. Their ability to manage their own medicines safely and self-medicate had been risk assessed. We saw the medicines were not stored securely and staff were unaware of the amount of medicine this person may have taken as no check was kept of the stock.

Qualified nurses are required to renew their registration annually and if they fail to do so are not entitled to work as a trained nurse. The annual registration process ensures that staff are working legally. Staff we spoke with told us they renewed their registration as required however the files we looked at did not provide information on the current registration status of the nurses working within the service. This meant the provider did not have an appropriate system to check that trained nurses working within the home were professionally entitled to do so.

The service had arrangements in place to listen to the views of the people who used the service and their relatives. We saw minutes of meetings and saw some people had voiced negative comments about the food however we could not see that the registered manager had taken steps to address their comments.

There was a service quality audit programme in place to monitor the standard of the service people received. Information was collected on a range of topics. However, we could not see the information was used to inform future care through the analysis of trends.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a well-defined management structure in place with a manager in charge of each unit, one of whom also acting as the deputy manager. Staff we spoke with told us they understood their roles and responsibilities and felt supported by the management arrangements. One member of staff said, "The manager always finds time to see you. We can talk to her about absolutely anything". The registered manager was meeting their registration requirements by notifying us about any significant events which occurred in the service

People and relatives spoke positively about the way the home was managed. A relative said, "Matron's door is always open" We observed a person who used the service sit with the registered manager to discuss some personal issues which were worrying them and they told us, "I have confidence in matron [the registered manager]. She is always available".

The provider's vision for care was set out in their statement of purpose and this was also in the PIR they completed and forwarded to us. Senior staff were encouraged to become lead nurses for specific areas of care. On the day of our inspection one manager was due to represent the service at the local infection control group meeting.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider was not acting in accordance with the Mental Capacity Act 2005.** **Regulation (1)-(3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider was not ensuring service users needs were met or making reasonable adjustments to enable the service user to receive their care and treatment.** **Regulation 9(3)(b)-(h)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.** **Regulation 17 (1)-(2)-(b)**