Hawksyard Priory Nursing Home Limited

Hawksyard Priory Nursing Home

Inspection report

Armitage Lane
Armitage
Rugeley
Staffordshire
WS15 1PT
Tel: 01543 490112

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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?	Good
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on 22 July 2015. At our last inspection in November 2014 we found the provider was breaching the legal requirements associated with consent, person centred care and the management of the service. The provider sent us an action plan demonstrating how they would improve the service. At this inspection we found some improvements had been made. However, we found other breaches of the Health and Social Care Act Regulations 2014 in respect of safeguarding people from harm, the management of medicines and the accuracy of records.

Hawksyard Priory provides nursing and personal care for up to 106 people some of whom may be living with dementia. At the time of our inspection there were 92 people living in the home.

Summary of findings

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 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.

Staff did not know how to report incidents of alleged abuse to the local authority and we identified some incidents involving people which had not been reported for investigation as required.

Risks associated with people's care such as safe moving and handling had been assessed but there was a lack of review following incidents which meant people did not always receive safe care.

We found that people's medicines were not managed safely. Some of the records relating to the administration of medicines were not accurate. There was no guidance in place to ensure staff understood when to give people 'as and when' required medicines for pain or to help settle them when they were distressed.

People were supported by sufficient numbers of suitably recruited staff. Newly recruited staff were provided with an effective induction period which supported them to understand people's needs. Staff had access to training and demonstrated some of the skills required to care for people. However, staff did not understand the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards which meant some people's legal rights were not respected.

Some people's right to dignity and privacy was not recognised by staff. People's care plans did not provide an accurate description of their care as staff did not understand the importance of keeping detailed records.

People were provided with food and drinks which met their individual requirements. Staff understood how to support people with specific dietary needs. However staff were not always recording if people had lost or gained weight. People were referred to their doctor and specialist health care professionals when additional support was required to maintain their health and wellbeing.

Staff were kind and considerate to people. Staff encouraged and reassured people. People were able to choose how they spent their time and their decisions were respected by staff. There were opportunities for people to socialise together or be supported independently to take part in games or activities which interested them. People were encouraged and supported to achieve experiences they wanted to do. Relatives were able to visit whenever they wanted and they were encouraged to be involved in social gatherings.

The registered manager was monitoring the quality of the service and listening to people's views to improve their experience of care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the 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. Staff did not know how to report safeguarding concerns as required to the relevant external agencies. People's medicines were not being managed in a safe manner. Some risks to people had not been reviewed in response to incidents. There were sufficient, suitably recruited staff available to care for people.

Requires improvement

Is the service effective?
The service was not consistently effective. Staff did not understand the scope of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People received a choice of nutritious food and drinks provided in the way they required to meet their needs. There were arrangements in place to refer people for specialist health care support.

Requires improvement

Is the service caring?
The service was not consistently caring. Some people's privacy and dignity was not supported. Staff treated people with kindness and compassion. People could receive visits from their families and friends at any time.

Requires improvement

Is the service responsive?
The service was responsive. People were provided with care that met their preferences. There were opportunities for people to have social support on an individual or group basis. People were supported to realise their 'wish list' hopes. People and their relatives felt supported to raise concerns and complaints if necessary.

Good

Is the service well-led?
The service was not consistently well-led. People's records did not provide accurate and comprehensive information about their care. People were listened to when they shared their views of the service. There were arrangements in place to monitor the quality of the service however the audit system did not always identify concerns that we highlighted.

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 was planned to check 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.

The inspection took place on 22 July 2015 and was unannounced. The inspection was carried out by five 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.

We looked at the information we held about the service and the provider, including the notifications they had sent us about significant events at the home. We spoke with 14 people who used the service, 12 relatives, 12 members of the care staff and the registered manager. We did this to gain views about the care and to ensure that the required standards were being met.

Some of the people living in the home were unable to speak with us about the care and support they received. We observed the care in communal areas to understand people's experience of care. We looked at the care records for nine people to see if they accurately reflected the way people were cared for. We also looked at records relating to the management of the service, including quality checks, training records and staff rotas.

Requires improvement

Is the service safe?

Our findings

At our last inspection in November 2014 we found that some environmental risks for people had not been identified. At this inspection we saw that actions had been taken to reduce the risks for people associated with the home. We saw that there were assessments of risk associated with people's care. The assessments provided staff with information about the level support people needed to be moved safely or to ensure they received adequate nutrition. We saw staff using a hoist to move someone and observed that this was used correctly. A member of staff told us, "We are watched using the hoist to make sure we do it properly".

We did not see that incidents prompted a review of people's risks. One person had bruising to their hands and a skin tear on their arm. Staff told us the injury had occurred when the person grabbed at a doorway when they were in their wheelchair. We saw the injury had been recorded in the person's daily records but not in their care plan. There had been no review of the person's risk assessment to protect them against this happening again.

Staff did not know how to protect people from abuse. A relative told us, "I'd be concerned about anyone that hadn't got a relative to speak up for them". We saw that several incidents of challenging behaviour had been recorded by staff. Some of these incidents met the criteria for referral to the adult safeguarding authority and should have been reported externally. We saw that only one incident had been reported as required. None of the staff we spoke with knew the contact details for the local safeguarding team. All of the staff we spoke with said they would report concerns to the registered manager. One member of the nursing staff said, "I would report anything to the registered manager if I saw or had any concerns about the safety of people. I've worked here for a few years and I've always asked matron [the registered manager] to do it". The same member of staff said, "We've got a policy. I'd have to read it to remind myself what I had to do". The agreed local safeguarding procedure states that concerns should be reported immediately. This demonstrated that staff had not recognised what constituted possible abuse and were unaware how to make immediate referrals, as required.

This evidence demonstrates a breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 13

The arrangements in place for the management of medicines were not safe. We observed a member of the nursing staff sign to show medicines had been taken without checking that they had. We saw them put people's medicines into a pot and give to another member of staff to dispense. This practice is known as secondary dispensing and is considered to be unsafe as it increases the risk of medicines being given to the wrong person.

We saw there had been changes to some people's prescription without any indication of who had made the change. For example, one person had been prescribed an inhaler to be used twice each day. We read that this had been altered to 'two puffs when required' however the nurse was unable to tell us when and why the record had been changed or who had made the alteration. This meant the person might not be receiving the correct treatment.

Some people were prescribed creams and ointments. We saw that that some of the creams in use had previously been prescribed for other people including one person who had passed away. Staff confirmed that the creams were still in use. All prescription medicines, including creams should only be used for the people they have been prescribed for to prevent inappropriate treatment.

We saw there were some gaps in the recording of people's medicines. Staff had not indicated on the MAR the reason why the person had not been given or taken their prescribed medicine. We were unable to check if the stock levels of medicines were correct as staff had not recorded the number in stock for each person. We also saw the administration of the external preparations was not recorded, as required, on the person's medicine administration record (MAR), to show that they had been applied.

Some people were receiving homely remedies. These are medicines which are available to buy 'over the counter'. We saw the way the remedies were recorded did not comply with best practice on the use of these medicines in care homes. The lack of guidance for staff meant that some people could receive these medicines inappropriately.

We looked at how medicines were stored. Staff were unable to provide us with information to show they stored medicines in the fridge safely. None of the medicines

Requires improvement

Is the service safe?

stored in the fridge were labelled with the date of opening which meant they could be used after their use by date. This could affect the condition and effectiveness of the medicines and the health of the people who used the service.

This evidence demonstrates a breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 12

At our last inspection we found there were areas of the recruitment process which needed to improve to ensure staff were suitable to work with people. At this inspection staff told us they were asked to provide evidence of their previous experience and their suitability to work before joining the staff. We looked at four recruitment records and saw they contained evidence of checks including references and disclosure and barring records (DBS). The DBS is a national agency which holds information on criminal convictions. The records demonstrated that an improved pre-employment process had been developed to protect people.

Some people presented with behaviours which challenged their safety and that of others. There were risk assessments in place and some people had specific behaviour charts to monitor incidents. We saw staff responded to a potential incident between people by successfully using distraction techniques. This protected the people from harm.

We saw that staffing was planned to reflect people's level of dependency. People we spoke with told us there were usually sufficient staff available to meet their needs. One person said, "Sometimes there's a bit of a wait at busy times but usually it's okay. The night staff always come when I call". We saw that staff were present in the communal areas and responded to people's requests for support without delay. A relative told us, "There's always staff about when we need them".

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) legislation sets out the requirements, when people lack the mental capacity, to ensure that decisions about their health, safety and welfare, are made in their best interest. At our last inspection we found there was a breach of Regulation 18 of the Health and Social Care Act (HCSA) 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the HSCA (Regulated Activities) 2014. At that time the provider was not fully complying with the requirements of the (MCA) and (DoLS). Some people living in the dementia unit were being deprived of their liberty but staff had not applied to do this legally, in line with the Act. At this inspection we found that the provider had made applications to deprive some people of their liberty and had the approvals in place. However, we found the staff still had a limited understanding of mental capacity and deprivation of liberty. A nurse who told us they were responsible for completing DoLS checklists was unable to demonstrate a full understanding of the scope of the Act. This could have an impact on the rights of people who used the service.

The mental capacity assessments we saw did not provide information about the level of people's mental capacity or demonstrate how specific decisions were made for them. Some people needed bedrails to reduce the risk of them falling from their bed. If people lacked the mental capacity to make this decision for themselves we saw relatives had been asked for their permission. Relatives can be involved in decisions made in people's best interest but the process to support the decision must be recorded. Staff had not recognised that a legal power of attorney was required, in respect of care and welfare, for relatives to make decisions independently on behalf of their loved ones. This demonstrated a lack of understanding about legal consent. We saw that there were arrangements in place to train staff on the MCA.

Staff received training to ensure they had the skills to care for people. People and their relatives told us they thought the staff were competent and knew how to care for them. One person said, "Yes, I think they know what they're doing". Staff told us that they were supported to gain nationally recognised qualifications in care and had opportunities to attend other training courses arranged by the provider. One member of staff said, "I've done first aid and fire training recently". Another member of staff explained to us what they had learnt from training on a specialist nutrition delivery system for people who are unable to have food and fluids by mouth.

Staff told us there were induction arrangements in place to support new staff and ensure they were competent to deliver care. One member of staff told us, "New staff are supported by a mentor. The induction covers all areas of care". A new member of staff told us, "I had a really good induction. I shadowed a senior member of staff until I knew what I was doing". The registered manager told us that new staff were being trained in the newly introduced care certificate and showed us their training booklets. The care certificate provides staff with a broader knowledge and skills to care for people effectively.

Staff we spoke with told us they felt well supported by the registered manager. There were arrangements in place for staff to receive supervision and appraisals. Staff told us they were able to discuss their personal development and any concerns they had about the care they provided during their individual sessions.

People were provided with a varied diet and a choice of food and drinks. We heard staff asking people what they would like to eat. Most people we spoke with told us they enjoyed the food and had plenty to eat. One person said to us, "There's adequate food. We also have biscuits and snacks if we want them. We have plenty of drinks. I have a jug of water but I could have squash if I wanted it". A relative told us, "My [Name] loves the food". Some people preferred to prepare their own food and we saw they had facilities, such as microwave ovens, in their rooms to support this.

People who needed help to eat were supported by staff. We saw staff sat with people and provided support in a patient and kind manner. Staff chatted to people during their meal; they told them what they were eating and checked that they were enjoying the food. This supported people to enjoy a pleasant mealtime experience.

People with specific dietary needs received meals that supported their health and wellbeing. We saw that people were referred for specialist support when concerns were identified about their weight or ability to swallow whole foods. Some people needed their food and drinks prepared differently and staff were knowledgeable about people's

Requires improvement

Is the service effective?

individual requirements. One member of staff told us, "[Name] has their fluid the consistency of syrup whilst [Name] needs it to be thicker, like custard because of their problems with swallowing safely".

People told us they could see their GP whenever they wanted. One person told us, "The doctor comes once a week, I can see them whenever I want to, they're very good". Staff told us there was a good working relationship with the GP surgery and they felt supported by them. One member of staff said, "If we need the doctor to visit they will often call in before their su

Requires improvement

Is the service caring?

Our findings

At our last inspection in November 2014 we found there 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 HSCA (Regulated Activities) 2014. This was because people's care and welfare did not always meet the required standard. At this inspection we saw that this had improved however some people were not supported to maintain their privacy and dignity. We saw one person had their medicine patch changed, which involved exposing their back, whilst sitting in the corridor. We observed another person being shaved whilst sitting in the lounge area with other people present. This demonstrated that staff did not always respect people's rights to privacy for personal support.

People we spoke with told us the staff were kind to them. One person told us, "The staff are very good to me". Another person said, "The staff are lovely" and another said, "They look after you and help you keep nice and clean". We saw people looked relaxed and at ease with staff. Staff chatted with people as they were delivering care and acknowledged them when they saw them in the communal areas. We observed staff encouraging and reassuring people when they assisted them. We heard staff speaking kindly and they demonstrated a caring approach with people.Some people had their hair styled by the hairdresser and we heard staff complimenting them on their appearance. Another person was asked if they would like their nails shaped and we saw staff sitting with them as they did this. The member of staff promoted the person's wellbeing by complimenting them and we saw the person reacted in a positive way to the comments they received.

People told us they could choose how to spend their time. Some people wanted to sit in the communal areas whilst others preferred to remain in their rooms. We saw that staff respected people's wishes and supported them to spend their day as they preferred. We heard staff providing people with choices for example where they would like to sit and at lunchtime, where they would prefer to have their meal.

Relatives told us they felt the staff tried hard to support people. One relative told us, "The staff are lovely. They treat [Name] well". One relative said that a member of staff had noticed that their family member had run out of an item whilst the relative was on holiday. The relative told us, "The member of staff bought it herself and wouldn't take any money for it".

People were supported to maintain the relationships which were important to them. We saw that visitors were welcomed at any time. Some people brought their dogs with them to visit and we saw people enjoyed the opportunity to speak to and pet the dogs. One person told us, "I like to watch television and have my visitors, they can come anytime". A relative we spoke with told us, "[Name] is happy here and we're very satisfied with the care. [Name] was always well dressed and liked their jewellery and they [the staff] make sure that continues".

Good

Is the service responsive?

Our findings

Staff understood how people wanted their care delivered. One person told us, “People know me well”. We saw information about people’s preferences was displayed in the wardrobes in their bedrooms. The information included their likes and dislikes, for example, we saw their drink preferences and favourite television programmes were recorded. This meant staff had prompts available to remind them about people’s individual choices.

Some people and relatives told us they had been involved in the planning and review of their care. One person told us they knew they had a care plan and recognised the plan as being theirs. A relative told us, “I’ve looked at [Name’s] care plan, I was involved to a certain degree, and I’ve seen it at least and know it’s there”.

People were supported, by an activities coordinator to participate in hobbies and pastimes which interested them. We saw some people playing dominos and cards with staff. Other people were encouraged, by staff, to participate in singing and dancing to music. There was an activity schedule displayed in the hallway. On the schedule it showed a variety of planned activities including skittle‘s and an American themed day. A visitor told us, “They do activities every day, there’s a list up in the lift so you can see what’s happening”. Another said, “We get invited to join in things all the time’.

Staff told us they tried to support people to do what they wanted. We saw there was a ‘wishing tree’ displayed on the wall which people could use to share any special requests they had. One person wished they could see and stroke a horse. We saw photographs of the person and the horse to show their ‘wish’ had been fulfilled. A member of staff told us, “Sometimes [Name] will wander towards the door. We know that means they want to go out so we go outside with them for a bit. They like to be outdoors”. We saw when people chose not to participate their views were respected. A relative told us, “My [Name] stipulated they did not want to take part in any social activities before they came here to live and the staff understand and support that”.

There were daily arrangements in place to keep staff informed about people’s needs. Staff were updated about changes to peoples care in handover. One member of staff told us, “I have never been on shift and found out something that hasn’t been handed over”.

People we spoke with told us they would happily raise any concerns or complaints. One person said, “I have no complaints to make but I feel like I could do that if I needed to.” A relative told us, “I’ve made complaints, not formally to the manager but to the senior care staff and the nurse. They have been dealt with and I’m happy with the response I received”. There was information displayed in the reception hall to advise people and their visitors how to raise a concern or complaint. We saw that when complaints had been received they had been investigated appropriately and responded to in a timely manner.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in November 2014 we found that there were inconsistencies in the quality of information in people's care plans. 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 (Regulated Activities) 2014. At this inspection we saw that further improvements were required to the way care was recorded. People were at risk of receiving inappropriate care because accurate and up to date records were still not being maintained. We asked to see a care plan for someone who had been living in the home for two months but staff were unable to find it. The registered manager told us the information was on the computer, which senior staff could access, but the care plan had not been printed off. Staff we spoke with were unable to provide information about this person or details of the care they required. This meant people might not receive the care that had been planned for them.

One person's care plan stated that they had fragile skin and were at high risk of developing skin damage from pressure. The person required support to change their position regularly to protect their skin. There were no records to indicate that this was being done. One member of staff said, "We're good at skin care here. We do the turns but we don't record it". Another person had an entry in their care plan which stated 'All skin areas intact' however the nurse told us the person was being treated for a pressure ulcer. This meant the person's care plan was not up to date and there was a risk that they would not receive the correct care.

Other people needed to have their weight recorded and tracked because of a history of weight loss. There were no monitoring charts in place to provide evidence that this was being done. A member of the nursing staff told us, "It's not physically possible to have everyone who needs them on charts. Staff are good at monitoring without recording it". We saw one person's care plan stated that they were prone to urinary infections and their fluids should be monitored however there was no recording in place. A member of the nursing staff said, "All older people are prone to urine infections. We can't record fluids; we'd never do anything else". This information demonstrates that people's care was not being accurately recorded.

This evidence demonstrates a breach of the HSCA Act 2008 (Regulated Activities) Regulations 2014 Regulation 17

At our last inspection we found that the provider did not respond to comments from people and their relatives. At this inspection we saw that improvements had been made. We read the responses the registered manager had sent to relatives regarding the comments they made in the most recent satisfaction survey. The registered manager was monitoring the quality of the service through an audit programme. Some of the audits had not identified the gaps in recording we highlighted. We saw the audits were used to identify any trends which affected people's care, for example to reduce the prevalence of falls. This demonstrated that the audit programme was not fully effective.

People we spoke with knew who the registered manager was. One person said, "The manager is [Name], she's here every day". We saw the registered manager encouraged people to sit in her office and discuss any concerns they had. Staff told us there was an open culture within the home. One member of staff told us, "I'm happy working here. There's a really positive atmosphere". Staff told us they worked well as a team and felt well supported by the management arrangements.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was not ensuring that medicines were administered accurately in line with Regulation 12 (2)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider was not ensuring that the systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse, in line with Regulation 13 (3)**

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 was not maintaining a complete and contemporaneous record in respect of each service userin line with Regulation 17 (2)(c)**