Hafod Care Organisation Limited

Hafod Nursing Home

Inspection report

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West Midlands
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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Hafod Nursing Home is a care home providing personal and nursing care for up to 29 people. The service cares for younger people and some people over the age of 65 and living with dementia. The service accommodates people across two floors in two adjoining buildings. At the time of the inspection 25 people were living there.

People's experience of using this service and what we found
The home environment was poorly maintained and some areas of the home were unsafe. We found multiple areas within and outside the home where ceilings, walls, paintwork and flooring was damaged. There were also issues with fire doors and window restrictors. Due to the fire safety concerns identified at the service, a referral was made to West Midlands Fire Service to conduct a fire safety visit.

The provider's governance systems had failed to identify the concerns we found. Whilst regular checks and audits were in place, the provider was not effective at driving improvement.

The provider had failed to maintain robust oversight of the maintenance of the service. As a result, the condition of the building and state of repairs had continued to deteriorate.

The home environment had not fully supported people's autonomy and independence. There was limited wheelchair access to the garden area and improvements to the home environment was required to meet the assessed needs of people living with dementia.

Care plans and risk assessments were in place and had been reviewed regularly.

People we spoke with told us they felt safe from the risk of abuse. Family members told us they felt their relatives were safe living at the home and spoke positively about all the staff that supported their relatives. Staff understood their responsibilities to keep people safe and safeguarding concerns were referred to the local authority.

Medicines were managed safely. Incidents and accidents were monitored for future learning.

There were enough staff on duty to meet people's needs and recruitment processes were in place to safely recruit staff. We found there was good communication with healthcare agencies. We saw kind interactions with people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff felt supported by the registered manager. Staff had received supervision to help them in their roles and training had been completed or in the process of being arranged for them.

The registered manager understood their regulatory responsibilities.

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 05 February 2020) and there were breaches of regulations. The enforcement action taken included issuing a warning notice. The provider submitted an action plan to tell us what they would do to comply with the warning notice. At this inspection we found the provider had complied with part of the warning notice. However, not enough improvement had been made to the governance processes and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
At our previous inspection we found breaches of legal requirements. The provider completed an action plan after the last inspection to show what they would do and by when to improve to meet the breaches of regulation 11 need for consent and regulation 17 good governance.

We undertook this focused inspection to check the provider had followed their action plan, met the warning notice and to confirm they now meet legal requirements.

This report only covers our findings in relation to the Key Questions safe, effective and well-led which contain those requirements. We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion, were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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.

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 with upkeep and maintenance of the building, an unsafe home environment 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.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Hafod Nursing 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 team comprised of one inspector, an assistant inspector and a specialist advisor with experience of nursing care.

Service and service type
Hafod Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or 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. A registered manager 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
The inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and two relatives. We spoke with seven members of staff including the registered manager, clinical lead, nursing, care and domestic staff.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Telephone calls were made to speak with five relatives about their experience of care provision for their family members.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was a risk that people could be put at risk of avoidable harm.

Assessing risk, safety, monitoring and management

● At this inspection, we found there were serious short falls with the fire, health and safety of the building. For example, fire resistant internal doors throughout the home were damaged. There were gaps in the doors and the fire-resistant seals around the doors were also damaged.

● We found three fire doors had combustible material (wooden blocks) affixed to them to make sure they could reach the contacts to release the door in the event of a fire.

● One fire exit was blocked with lifting equipment and privacy screens. This would block an escape route out of the home in the event of an evacuation. Due to the nature of the concerns, we made a referral to the West Midlands Fire Service to visit the service.

● A bathroom window had no window restrictors and was fully open, posing a potential risk to people living at the home who may try to leave or self-harm.

● The provider used wooden blocks nailed to the window frames as window restrictors to prevent them from opening. When checking the gaps on the opened windows they were found to exceed safe and legal limited.

● We identified windows in 11 people's bedrooms were unable to be opened or able to remain open. The service had experienced a COVID-19 outbreak and letting fresh air into indoor spaces can help remove air that contains virus particles and prevent the spread of coronavirus (COVID-19). In poorly ventilated rooms the amount of virus in the air can build up, increasing the risk of spreading COVID-19.

We found no evidence that people had been harmed however, the unsafe home environment placed people at risk of avoidable harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection and completed a fire risk assessment on 23 July 2021. A fire door specialist will be visiting the service to measure for new fire doors and replaced on a 'rolling programme'. The provider told us, the bathroom window has a window restriction in place and an 'ongoing rolling programme' in place for the remaining windows. Building checks have been increased to make sure fire safety procedures are in place, including checking fire exits are clear.

Preventing and controlling infection

● We were not assured that the provider was using PPE effectively and safely. We found four staff did not consistently wear their face mask correctly throughout the day. All staff have since undergone re-training for infection control and the frequency of regular spot checks introduced to make sure staff continue to wear their PPE correctly.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of

the premises. The building requires extensive repairs and decoration to be made to ensure it can be cleaned effectively. We shall be meeting with the provider to discuss the poor home environment.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● The home was clean and had no unpleasant odours.
● Risks to people had been assessed and the risk assessments in place had been regularly reviewed and updated when needed. For example, people at high risk of falls had been monitored and appropriately referred to agencies for example, the GP for medication review or the falls clinic. People who presented with behaviours that could be seen as challenging had been monitored and staff knew how to support people when they became anxious or upset.

Using medicines safely
● At our last inspection, we identified where people required prescribed creams to reduce risk of sore skin, body maps had not been completed to show where the cream should be applied. At this inspection we found body maps were in place and they clearly indicated where creams should be applied.
● Medicines were managed safely. Records indicated people had received their medicine as required. People we spoke with told us they received their medicines when they needed them.
● When people required medicines to be administered on an 'as and when required' basis there was guidance in place for staff to follow so they would know when to give the medicine. The medicine records we checked showed this guidance was being followed.

Systems and processes to safeguard people from the risk of abuse
● People and family members we spoke with all said they felt people were safe. One person said, "I do feel safe living here." A relative told us, "Safe, absolutely, really good carers, they are brilliant."
● Staff we spoke with explained how they would support people who became upset and may present with behaviours that could challenge. It was clear from conversations had with staff they knew people well.
● We found where safeguarding incidents had been identified, the relevant agencies had been notified and appropriate action had been taken by the provider.
● Staff we spoke with were aware of their legal duty to keep people safe from risk of abuse. They knew how and who to report concerns to.
● The registered manager explained how any learning from incidents would be shared with staff during team meetings, handovers and supervisions.

Staffing and recruitment
● There were no issues identified with the provider's recruitment processes.
● Nursing staff had their registration numbers checked to ensure they were legally registered to work as a nurse.
● Our observations during the day, indicated there was enough staff on duty to meet people's identified needs. One person we spoke with told us they would wait longer when they requested support at night. The provider has put an additional staff member on nights to try and improve this.

Learning lessons when things go wrong

● The registered manager and clinical lead had introduced action plans following reviews of incidents and accidents to identify trends and implement changes to mitigate future risks.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs
- At the last two inspections it had been identified improvements were needed to ensure the environment was adapted for people living with dementia.
- We found at this inspection all the bedroom doors were the same colour making it difficult for someone living with dementia to independently find their way back to their own bedroom without assistance so reducing their independence.
- The flooring in the conservatory was contrasting black and white tiles, this type of design can lead to confusion for people living with dementia on where to place their footing.
- There were no age-related memorabilia on display around the home to stimulate and prompt memories.
- Signage was inconsistent around the home. There was some dementia signage for areas such as laundry and hairdressers. This could make it difficult for people to navigate around the home independently.
- At the time of the inspection people living with dementia were residing at the service. Dementia is on the provider's registration. The home environment requires improvement and is not dementia friendly and did not follow current national guidance for dementia friendly environments.
- The service had nine bedrooms designated for people to share. We could see there were no privacy curtains around the beds to ensure people's privacy when they were resting or sleeping in their beds. We were told privacy screens were used when personal care was being completed, however these screens were removed once personal care was completed.
- Independent wheelchair access to the garden area from the lounges was limited due to no ramps being in place. This could make it difficult for wheelchair users to access the garden area independently

We found at this inspection the home environment did not always support people living with dementia or promote independence for wheelchair users. The premises was poorly maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to ensure the service had worked within the requirements of the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for Consent. At this inspection enough improvement had been made and the provider was no longer in breach of regulation.

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 Act 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

● The registered manager had introduced changes to mental capacity assessments. We saw they were detailed, decision specific and made in people's best interests. Where possible people and their family members had been involved in the assessment process and where there was no family members, health and social care professionals had been involved. One relative told us, "My visits have been limited but I am contacted when there has been anything to discuss about [person] care."
● Appropriate DoLS applications had been made to the Local Authority.
● People we spoke with told us staff sought their consent before supporting them. We saw staff seek people's consent before carrying out any support.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider carried out an initial assessment prior to admission to ensure they could meet people's needs.
● The care plans we looked at had been rewritten within the last six to 12 months and were comprehensive, clear and concise. They had been regularly reviewed with examples of involvement from people, where possible, their relatives and health professionals. The plans were person specific with some clear evidence of end of life planning where possible.

Staff support: induction, training, skills and experience
● We saw evidence new staff had received their induction training. The registered manager monitored training on a regular basis to make sure staff completed it promptly.
● People and family members we spoke with told us staff knew how to support people. One person told us, "I am very happy with what the staff do for me." A relative said, "Staff know [person's] behaviours and look after [person] well and show lots of empathy and care when I've been there."

Supporting people to eat and drink enough to maintain a balanced diet
● One person we spoke with did not like the food and told us they would like to have had more choice suitable to their cultural needs. We raised this with the registered manager and they told us they would speak with the person to address this.
● The remaining people we spoke with raised no concerns with the quality or choices of food. We saw people could choose to remain in their room to eat if they wished or were supported to eat in a dining area or lounges.
● People's specific dietary requirements were met. For example people at risk of choking had been referred to Speech and Language Therapist (SALT).
● People were offered snacks and drinks throughout the day.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The care plans we looked at clearly showed prompt and appropriate referrals had been made to healthcare professionals.
● The management team held daily meetings with staff to make sure updates on people's support needs and any other important information was shared.

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 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, risk and regulatory requirement; Continuous learning and improving care

At our last two inspections, we identified the provider had failed to ensure there were effective governance systems in place to identify concerns and drive timely improvements. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider has remained in breach of regulation 17.

● The provider's maintenance audit for April 2021 identified issues with a leaking roof in the dining area. There was damage to the work top and the area closed off to people living at the service. Staff continued to access the area to make people drinks. The provider's governance processes had failed to account for the impact on people being unable to access the dining area to make their own drinks. The provider had also failed to ensure repairs to the roof were made in a timely manner.
● Repairs were needed to a downstairs bathroom following a visit from a building contractor on 24 October 2020 who recommended the bathroom be closed for safety concerns due to the stability of the floor. The provider's governance processes had identified the maintenance repairs but had failed to make sure these repairs had been completed in a timely manner.
● The carpets on the ground floor hallways were worn and required replacing. People's bedrooms we were invited into, were painted the same colour as communal areas in the home. We saw paintwork around the home was chipped and part of the rear garden outside had been conned off.
● The environment was not homely. Relatives we spoke with told us, "I do think it (the home) is a bit sparse, it looks cold," [Person] bedroom is ok although the bed isn't very nice, there's bits (of the home) knocked about, it is just very basic." "I was a bit shocked with the home, it's very basic and the garden's a mess but it's clean." We found part of the rear garden had bricks and equipment in an area conned off due to unfinished repairs. There was a broken parasol being used by two people to protect them from the sun. There was no wheelchair access onto the grassy area of the large garden, limiting access to a small paved patio area.
● The provider had failed to identify equipment such as hoists were blocking a fire exit. This increased the risk of the fire exit being inaccessible in the event of an emergency.
● The provider had failed to identify the use of combustible material attached to fire doors was not good practice. This placed people's safety at risk.
● The provider had failed to identify fire resistant doors and their seals were damaged and needed replacing. This placed people's safety at risk.

● Although there were spot checks in place around the service, they had failed to address the issue of staff not wearing their facemasks consistently.
● Past inspections and the provider's own governance processes had identified the general state of repair and maintenance to the service was poor and needed to improve. There had been no provider learning from past inspections and recommendations (we had) made.
● The provider lacked oversight to make sure governance processes that had identified repairs, were completed in a timely manner. Well-led has remained requires improvement for the last four consecutive inspections since November 2014.

The provider's lack of responsiveness to make the necessary repairs, brought to their attention through their own governance systems, demonstrated a total disregard for the safety of the people living at the service. The provider had failed to ensure the building was a safely maintained and pleasant home environment for people to live in. The provider has a duty of care to make sure their systems and processes are operated effectively to monitor the quality and safety of the home and service provided to people. The provider has failed to act on repairs and they have failed to drive timely improvements. This means the provider has remained in a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

Since the inspection, the provider took steps to address the concerns we identified at the home. A fire risk assessment has been completed and fire awareness training arranged for staff. Building repairs have commenced and are ongoing with some of them now completed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Throughout the inspection we found the management team at the service were open about the issues we brought to their attention. They demonstrated an enthusiasm and commitment to making the required improvements to ensure safe and good quality care.
● Everyone we spoke with told us the service provided a good level of care and support to people. One person said, "They [staff] are very good to me, they look after me." A relative told us, "Staff are always welcoming and you're made to feel comfortable, staff are on top of things."
● People, relatives and staff spoke positively about the managers of the service. One staff member said, "[Registered manager] and [clinical lead] are great, you can go to them anytime if you have a problem."

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 registered manager understood the requirements of the duty of candour and other legal responsibilities. It is their legal duty to be open and honest about any accident or incident that caused or placed a person at risk of harm. On reviewing incident records, we saw prompt action had been taken, appropriate agencies notified and measures implemented to mitigate future risk.
● The rating of the last inspection was displayed as required to by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff received supervision and had their competencies assessed. Feedback was provided through team meetings and daily handovers.
● The people and relatives we spoke with could not recall being asked to feedback on the quality of the service, but all of them told us they could speak with the management team. One relative said, "I don't have a problem with raising things, I'm [person] eyes and mouth and if [person] isn't happy they [staff] know

about it, it's standing up for my family."
● People's relatives told us they were kept up to date of any changes with their relatives' condition.

Working in partnership with others
● The service liaised with organisations within the local community. For example, the Local Authority and the Clinical Commission Group to share information and any learning around best practice in care delivery.
● Staff we spoke with told us they all worked together as a team. One member of staff told us, "I love it here, everyone [staff] is great, and I love the residents, you can go to the managers anytime, the door is always open."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect We found at this inspection the home environment did not support the needs of people living with dementia or the autonomy and independence for people.

The enforcement action we took:

We have imposed a condition on the first Monday of each calendar month, the Registered Provider must send to the Commission a written report outlining the findings of their audits. The report should contain details of the areas identified by audit for improvement, the timescales for improvements, who will be responsible for them and what the quality assurance arrangements will be going forward to ensure that the agreed actions are completed

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 unsafe home environment placed people at risk of avoidable harm.

The enforcement action we took:

We have imposed a condition on the first Monday of each calendar month, the Registered Provider must send to the Commission a written report outlining the findings of their audits. The report should contain details of the areas identified by audit for improvement, the timescales for improvements, who will be responsible for them and what the quality assurance arrangements will be going forward to ensure that the agreed actions are completed.

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 has a duty of care to make sure their systems and processes are operated effectively to monitor the quality and safety of the home and service provided to people. Although there were some governance systems in place to identify concerns, they failed to drive timely improvements.

The enforcement action we took:

We have imposed a condition on the first Monday of each calendar month, the Registered Provider must send to the Commission a written report outlining the findings of their audits. The report should contain details of the areas identified by audit for improvement, the timescales for improvements, who will be responsible for them and what the quality assurance arrangements will be going forward to ensure that the agreed actions are completed