Derbyshire County Council

Hazelwood Care Home

Inspection report

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection visit was unannounced and took place on 2 May 2017. At our last inspection visit on 8 August 2016 we asked the provider to make improvements to the staffing numbers, medicines managements and the auditing and management of the home. The provider did not initially send us an action plan; however we did receive the plan ahead of the inspection which explained the actions they would take to make improvements. At this inspection, we found improvements had not been made. The service was registered to provide accommodation for up to 30 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 24 people were using the service.

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.

We saw that the previous rating was not displayed in line with our guidance. . The manager had not always sent us notifications relating to important events that occurred at the service. This meant we could not be sure appropriate action had been taken, in respect of these events to reduce future risks to people.

The service had not always completed assessments to reflect people's capacity relating to specific decisions. We could not be assured that when people lacked capacity their needs had been considered in line with the guidance available. . People's care plans did not always contain up to date information, so we could not be sure the care provided would be in line with the persons needs. .
Staff had not all received updated training and competency checks had not been completed to ensure training had been understood.

The provider had not completed audits to support the development of improvements or to consider peoples safety in relation to falls and management of medicines.

Risk assessments for individuals had not always been reviewed and assessments to ensure peoples ongoing safety. Staffing arrangements did not ensure people's needs were met in a timely manner. Systems to reflect the levels of staffing had not been used to consider when additional staff maybe required.

People enjoyed the food and felt they had choices of the meals they received, however we could not be sure peoples specific dietary needs had been met. People told us they felt safe and that staff knew how to recognise signs of abuse and what they needed do to protect people from abuse. Health care professionals were involved in people's on-going health needs and the staff knew how to make referrals to access additional support then required. People were able to engage in social activities.

Views from people and relatives had been sought and improvements which had been made were communicated through a notice board system. . People told us they were treated with kindness and compassion and their privacy was respected. The recruitment systems ensured that staff had the right skills, knowledge and experience and were suitable to work with people using the service. People knew how to raise any complaints or concerns and felt confident these would be dealt with in accordance with the provider's complaints procedure.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe
Staffing levels did not consistently ensure the safety of people's care. People's medicines were not managed safely or received as prescribed. Risk assessments had not always been updated to reflect the current risk for people. Staff understood how to protect people from the risk of harm and abuse. Clear recruitment processes were in place.

Is the service effective?

Requires Improvement

The service was not always effective
People had not received assessments that reflected their capacity to support their decision making. Staff had not always received updated training they required to enable them to feel confident in their role. People enjoyed the food, however we could not always be sure specialist diets had been catered for. When required support and advice around health and nutrition had been considered. Support from health professionals was requested and available when needed.

Is the service caring?

Good

The service was caring

People felt supported and felt cared for by the staff. They treated them with dignity and respect. Relationships and friendship that were important to people were maintained.

Is the service responsive?

Good

The service was responsive
People and those important to them had been involved in the development of the care plans. There was a varied programme of activities and individual interests had been supported. People felt able to raise a complaint if necessary and were aware of the complaints policy.

Is the service well-led?

Inadequate

The service was not always welled

Audits had not been used to ensure peoples safety and make improvements. Staff did not always feel supported in their role, in relation to training and receiving information about their role within the home. Records were not up to date. There had been an improvement in the recording of notifications, however not all notifications had been completed. Systems were not in place to ensure information was cascaded to meet peoples changing needs.

Hazelwood Care Home

Detailed findings

Background to this inspection

We carried out this inspection visit 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. Our inspection was unannounced and the team consisted of two 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 checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. We also spoke with the local authority who provided us with their current monitoring information. We used this information to formulate our inspection plan.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us at the inspection visit.

We spoke with 14 people who used the service and three relatives. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with people in communal areas.

We also spoke with five members of care staff, the cook, a visiting professional and the registered manager. We looked at the training records to see how staff were supported to deliver care appropriate to meet each person's needs We looked at the care records for six people to see if they were accurate and up to date. We reviewed the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in August 2016, we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that there were enough staff to support people's needs. In addition, we asked the provider to make improvements in relation to the safe administration and storage of medicines. At this inspection we found that the required improvements had not been made.

Since our last inspection visit the levels of staff had not changed. People we spoke with raised concern in relation to the number of staff available to support them. One person said, "The staff are busy, you've got to wait." Another person said, "There are not enough staff, often when I call they can't come and I have to wait." We saw that a staff member who was working in the laundry supported people with their care needs. On one occasion they responded to a call bell and on another they supported a person to the bathroom as the person had been waiting. On the day of our visit the call bell system stopped working and the manager drafted in additional staff members. The manager told us, "I have done this because people will not be able to get a response from their call bells.". However, this meant it was difficult for us to evaluate if the staffing levels were having an impact on people's needs. This was due to the number of staff being higher than the number usually planned for the service. People we spoke with said, "Staff are under pressure in the mornings." Another person said, "In the afternoon, people who required the hoist often have to wait." A visiting heath care professional told us, "Sometimes there is not enough staff especially at weekends and if not enough staff, it's hard to do everything."

Staff we spoke with said, "There is not enough staff, particularly when there is sickness. There has not been an increase in staffing, some people have changed and some staff have left so we are not better." We saw the home still had four staff vacancies which is the same number as identified in out last inspection visit. The manager told us they had recruited to one of the posts and other staff were in the process of being recruited. A visiting heath care professional told us, "Sometimes there is not enough staff especially at weekends and if not enough staff, it's hard to do everything." This meant we could not be assured there were always enough staff to support people's needs.
This meant we could not be sure there were enough staff to support people's needs.

The above issues demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's medicines were not managed safely and they did not always receive them as prescribed. Some medicine had been out of stock which meant this person was unable to access medicine prescribed to them. When we reviewed medicine records we saw that signatures had been missed from the medicines administration record (MAR). We checked the stock of medicines. We saw all five of the medicines we checked had the incorrect amount of stock . The staff member was unable to provide an explanation for these errors. This meant we could not be sure people had taken their medicine as prescribed.

We saw that some people required medicine on an as required basis (known as PRN). They received medicine on a PRN basis for their pain relief. There were no protocols to establish when or why this medicine was to be given. Some people had been prescribed topical creams, and there was no medical administration record (MAR) or a body map to show where the cream should be applied or how often. This meant we could not be sure people had received their pain relief as necessary or their cream applied correctly to support their skin care.

We saw that one person's medicine had been removed from the packaging and then replaced into the foil and re-sealed with a sticker. One member of staff we spoke with said, "I was not aware that medicine could not be handled like this." Handling the medicine in this way meant that we could not be sure of its integrity. We intervened and asked for it to be destroyed and replaced.

Risk was not always managed to meet people's current needs. For example, the records showed a one person used a Zimmer frame to mobilise. Since this person had fallen they required a wheelchair and the use of equipment for all their transfers . One other person had several falls their risk assessment had not been updated for the last 12 months. Other risk assessments had not always been updated in relation to how a person mobilises. We saw other people were being supported by staff to move part of their body to keep it mobile following a fall. No one was able to identify were the guidance had come from and records had not been updated, therefore we could not be sure the advice that was being followed was correct.

Some people were at risk of choking. These people required their drinks to be thickened. We saw one person's drink had been thickened 45 minutes before they required it. The thickener had sunk to the bottom of the glass and the fluid was not the consistency as per the guidance. Another person's drink had not initially been thickened as advised, at the start of their meal. This meant we could not be sure the guidance was being followed to support people to be safe when drinking.

The above issues demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they felt safe when they received care. One person said, "Everything's good here, they lock all the doors at night. I'm not worried about any of the staff." Another person said, "I feel safe, I came from another care home." A relative told us, "[Name] has been here a while, they are safe here, with the lay out, and the staff are nice. They notice when they are upset, when to talk to them and when to leave them." Staff had received training in safeguarding and understood the different possible signs of abuse around safeguarding and how to raise a concern. One staff member said, "I would always report it and I have done. The seniors act on it straight away."

We saw that checks had been carried out to ensure that the staff who worked at the home were suitable to work with people. These included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. One member of staff told us that they had to wait for their DBS check to come through before they started working. This demonstrated that the provider had safe recruitment practices in place.

Requires Improvement

Is the service effective?

Our findings

he Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

We checked whether the provider was working within the principles of the MCA. We saw that assessments had not always been completed when people didn't have capacity to make or understand the decision. For example, one person had been given medicines covertly. This method is used when a person is unable to understand the importance of taking their medicine. A capacity assessment had not been completed, and consequently there was no best interest decision process. We saw that other people did not have a capacity assessments completed. Some people required equipment to maintain their safety; however the correct process had not been completed to gain their permission. This meant we could not be sure people were supported with their decision making.

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. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met. We saw that the registered manager had made some DoLS applications, however for one person this was an incorrect use of this process. The person had capacity to make their own decisions and had disagreed with a decision in relation to changes of their environment. This meant we could not be sure the process regarding the DoLs applications was being managed effectively.

The above issues demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We discussed with staff about the MCA and DoLS process. The staff we spoke with had l
Some understanding but were unable to tell us which people within the home were on a DoLS or when people without capacity had been suitably supported to make their decisions.

People told us they felt supported by the staff. One person said, "They know what they're doing, they look after me well." Staff we spoke with told us they had received training in a range of areas, however not all the staff had received refresher training. For example, some staff had been waiting for an update on their moving and handling training. There had been no competency checks completed to ensure the person was still able to use the equipment in line with the latest guidance. This meant we could not be sure the staff had the skills they required for their role.

People told us they enjoyed the food. One person said, "It's lovely food." Another person said, "The food's

okay, some days are better than others. They would get me something different if I didn't like it." We observed the midday meal. Some people were not supported to maintain their independence. For example, some people had not been offered equipment to support them to manage their own meal. We saw one person struggled for five minutes, no equipment was offered to assist this person. This meant we could not be sure people received the support they required to enable them to remain independent with their meals.

Some people required specific dietary needs. We discussed these with the cook. They told us, "I don't have any written information; the staff tell me who needs what." Although the cook knew the number of people requiring a specialist meal, the records relating to individual needs and preferences had not been considered to provide a more personalised meal.

We saw that people's weight had been monitored and, when required, specialist guidance had been sought. However, some people had requested meals to support them to reduce weight. The records showed one person should receive a small plate and foods to support their weight reduction. We saw the person received a large plate of food, which was the standard choice for the day.

We saw that referrals had been made to health care professionals in a timely manner and when people had attended their appointments, however the information was not always recorded to ensure the correct guidance was followed. We saw for pressure care and wound management the staff had been responsive. A health care professional said, "Staff are on the ball here for pressure care." We saw they referred to the advisory sheets for the guidance for the person. People with skin integrity concerns had been supported to enable these areas to improve. This demonstrated people were supported to maintain their health.

There was a system in place to support people when they commenced their role at the home. One staff member told us, "I shadowed an experience member of staff for a week. It was really useful and they provided me with tips and information about people." All new people without care experience are provided training on the national care certificate which sets out common induction standards for social care staff and was introducing it for new employees.

Good

Is the service caring?

Our findings

People told us they felt supported. One person said, "Staff go out of their way to be helpful, they can't do enough to make me comfortable." We saw that people were presented well and had personal items with them. One relative said, "They usually make sure they look right, sometimes they forget to put their socks on, but the staff sort it out." Another relative said, "The staff are very good, nothing's too much trouble." A health care professional said, "The staff are great with people, they talk nicely to people and don't talk down to them."

Staff we spoke to showed a caring approach to people. One staff member said, "I love working here, the people are great." Another staff member said, "It's a great team here, everyone mucks in, so we can support the people."

People were encouraged to make choices about the daily routine. One person said, "I can do what I want within reason, if you want to go out you just have to ask. I can get up when I want." Another person said, "I'm quite content, I get up and go to bed when I want." People were encouraged to maintain their independence. For example, one person told us they made their own bed and kept their room clean. We saw people moved freely around the home as they wished.

People were encouraged to keep in touch with people who mattered to them. One person told us, "My family come every day." They added, "When it's nice we go outside, its lovely." We saw throughout the day, family members and pets visited people and were made welcome.

People told us they felt their privacy and dignity was respected. One person said, "They all treat me with respect, they're nice, helpful as well." We saw when people required assistants this was done discreetly. For example, kneeing to the persons height and speaking quietly to them.

Good

Is the service responsive?

Our findings

People told us they were involved in planning their care. We also saw that relatives and friends that were important to them had been involved in identifying their needs. Relatives could recall being involved with care planning for their family member. One said, "Staff are really approachable, they involve me in the care plan for my family member and I come to the review. I feel one hundred per cent if I had any concerns about anything I could speak to the staff."

People were supported to have their needs met effectively by a staff team who knew them. One relative told us they felt confident that staff knew how to support her family member. They said, "They notice when they are anxious. The health care people have been in, and the staff responded to their needs." Another relative said, "If staff feel [Name] is deteriorating they tell us and get us to call straight away."

People were provided with the opportunity to engage in activities and areas of interest. One person said, "Someone does some activities with us, there's enough to do." Another person said, "I enjoy the activities, there's enough to do. I've been doing gardening and I painted those benches out there." We saw that some people had been engaged in potting up seeds. The activities coordinator told us, "When people come to the home, we talked to them about the things they enjoyed before coming here. Gardening is popular especially with the gentleman. We are hoping to get a small greenhouse." A relative said, "[Name] likes to play dominoes. Staff keep them occupied. When they do trips out relatives gets invited."

We saw during the afternoon a lively music session. People were engaged and seem to enjoy the event. Other people chose to sit in the quiet lounges. One person said, "Nobody bothers you, you do your own thing, they look after you alright." We talked to the activities coordinator. They told us they had no set plan for the activities; it was dependant on the day, weather and how people felt. They said, "Not everyone likes the same thing. As long as I can engage them in something. "They also told us they provided one to one support. They said, "It's really important, to engage with the individual. Some people just like to sit and chat." We read and people told us the programme of events included entertainers and a monthly trip out. One person said, "I enjoy the trips, it's nice to get out. I like it here." This meant people were encouraged to engage in activities of interest to them

People were aware there was a complaints procedure. One person said, "I would make a complaint if I had to." Another person said, "I would go to the manager, she's very easy to talk to, she'll listen and she's there for us." Relatives told us they had not seen the complaints procedure, one said, "I'd go straight to the office if there's anything worrying me I'll go straight into the office, the staff and manager are all approachable." There had been no complaints at the home; the manager understood the complaints procedure and importance of addressing things quickly. They told us, "I have not had any formal complaints, if people speak to me with a concern we address it." This meant we could be sure complaints would be dealt with.

People and relatives had been asked their views about the service. One person said, "I think we've had a questionnaire or a survey." Relatives recalled there being a survey, relating to the home and the care for their family member. People told us they had regular meetings. One person said, "We have a residents' meeting

about once a month. If there's anything serious to talk about they're always available." Another person said, "There are residents' meetings and things do get followed through." We saw on the notice board the results from the most recent meeting and survey For example, there had been a request for new cutlery and this had been purchased.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in September 2016 we found that the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulation's 2009. The provider had not ensured we had been notified of incidents at the home. At this inspection we found that some improvements have been made, however further improvements were required.

The provider had completed notifications for some incidents; however when we checked the records relating to the number of falls resulting in a serious injury, not all of these had been reported to us. This meant we could not be sure that we had been notified of all the events that are required to be.

This is a continuing breach of Regulation 18 of the Care Quality Commission (Registration) Regulation's 2009

At our previous inspection in August 2016, we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured they used audits to develop the service to make improvements. At this inspection we saw that the necessary improvements had not been made.

Following the publication of the report for Hazelwood, we asked the provider to complete an action plan in September 2016 to tell us how they would address the concerns we raised. We had to request the action plan in February 2017, several months after the publication of the report. We received the report at the end of February 2017. We use the plan to reflect on what the provider told us they would do, to address the areas of concern from their last inspection. We saw the plan stated that all risk assessments would be up to date and completed by March 2017. On this inspection we saw that not all the risk assessments had been completed. For example, one people had fallen their risk assessments had not been revisited to reflect the level of risk for this person. .The action plan also stated that medicines audits would be completed and observations of staff competency would be reviewed on a bi monthly basis or as needed. We saw the medicine audits had been completed and they had identified that there had been missed signatures on the MAR sheets. This was in January 2017 and the action identified by the manager was to provide supervision of the staff and additional training. This had not been completed and we saw in the following three months further errors in relation to missed signatures. had been identified and no action had been taken or competency checks completed. The audits had not identified the errors in stock and therefore this had not been rectified. This meant we could not be sure the audits were effective in identifying areas of concern or that action had been taken to follow the plan which had been put in place to meet the required improvements requested in the last report.

The manager shared with us a list of audits they had planned to complete. However, not all of these had been completed correctly and we could see no evidence that these had been used to make changes to the care provided. For example, not all the falls that had occurred in the home had been recorded. There was a system in place to keep a record of the number of falls which occurred in the home. We saw that there were missed records for at least three falls from this list.. There had been 17 falls recorded since January 2017 and due to the system not being up to date, this had not been identified and any actions taken to reduce the

risks to people from further falls occurring. . None of the audits reflected the information across the different months to consider any trends or areas of the service which may be affected. The manager told us there was no administration resource to support the home, which had an impact on areas of paperwork not being completed in a timely manner. This demonstrated the audits had not supported peoples safety or to drive improvements in relation to the quality of the service.

We found the level of staffing in the home was not sufficient to always provide the support people required. At out last inspection visit we reported on this. We saw a dependency tool had been introduced, which identified individual's needs. However, some aspects of people's needs had not been reflected ,or the individual's level of need reflected when their health needs changed. For example, some people were independent in their care needs; however required support to change position on a regular basis, this level of support had not been reflected. We asked the manager if they used different information to consider their staffing levels. For example the call bells system, the dependency and the levels of falls. They told us they had not considered this as part of their staffing considerations. This meant we could not be sure the staffing was reflective of the needs of people.

Since our last visit the role of senior carers had been introduced. We saw this role held a level of responsibility to manage the staff and aspects of people's care records. There was not a full complement of senior staff and those we spoke with felt there was additional pressure on them. These staff told us they had not received any specific training or senior team meetings to support and develop their role.

Staff had not always received the support they required for their role. Staff told us they had not received regular supervisions. We discussed this with the manager and seniors who confirmed they were responsible for these. One incident had been identified by the manager as requiring a staff member to receive supervision. We discussed this with the manager, who confirmed they had only had a verbal conversation, no records had been completed. This meant there was no record to reflect back on if the incident should this occur again or to check the person now understood their role.

Records we reviewed were not always up to date. For example, one record showed a person received their personal care support in their bed. We saw this person no longer received their support this way. We saw the records had not always been updated following a discharge from hospital after an injury to include guidance of how to support the person with their recovery. We saw other records did not contain up to date information. For example, some folders contained documents of people who had since passed away or moved to other homes, other folders were missing some people's details. This meant the correct information was not always available for staff to access.

The staff had a daily handover to share information about changes in people's needs. However, the system used was not always effective and the staff told us it can be confusing and lead to errors or things not being done. For example, one person required a sample to be completed. This had not been done and had to be passed on to the next shift to be completed.

The manager told us they planned to purchase an orientation board to show the day, date and time. However, we noted that the boards that were already situated in the reception had not been updated. For example, the menu board did not display the menu for the day and the activities board showed the incorrect date and month along with activities which was not those planned for this month. This meant people were unable to access information which would support them to orientate their day or support them

to make choices.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of the report on the notice board down the corridor. The guidance for the displaying of the rating was not followed, to ensure it was not conspicuously displayed.

The above issues demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not consistently reported significant events that occurred in the home. We could not be sure of the receipt of the necessary notifications relating to important information affecting people and the management of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not considered people having consent to their care in line with legislation and guidance. People had not received an assessment or provided with the support to ensure that decisions were being made in their best interest when they were unable to make decisions themselves. Appropriate applications relating to DoLS had not always been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured systems were in place to ensure medicines were administered accurately. Stock was not maintained and administration records did not provide the assurances that people had received their medicine. Peoples safety was always reflected in the risk assessments and the guidance to staff to reduce the risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made. Risks had not been reviewed placing individuals and others at risk of harm. Staff did not always received the support they required for their roles.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs. Staffing levels had not been continuously reviewed to adapt to the changing needs of people.