Hawksyard Priory Nursing Home Limited

Hawksyard Priory Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Hawksyard Priory Nursing Home is a nursing and residential home providing personal and nursing care to up to 105 people over three different floors. There is access to a church and gardens at the service. The service provides support to people with physical and emotional needs, some of whom are living with dementia. At the time of our inspection there were 54 people using the service.

People's experience of using this service and what we found
People did not always receive safe care and treatment as action was not taken in a timely way to reduce risks following accidents and incidents. Where people were being supported on a one to one basis by staff due to risks, accidents or incident they did not always receive this. People were left for periods of time unsupported by staff placing them at risk of harm.

People who were at risk of choking were not supported by staff effectively to reduce this risk. People who required support to eat did not always receive this in line with their needs. Where people were at risk of dehydration and malnutrition this had not always been identified, and where raised by external professionals, action was not taken to reduce future risk in a timely way.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Why we inspected
The inspection was prompted in part due to concerns received about people's safe care and treatment and the management of risk. A decision was made for us to inspect and examine those risks.

We use targeted inspections to follow up concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified continued breaches in relation to people's safe care and treatment. 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.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Hawksyard Priory 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 Health and Social Care Act 2008.

This was a targeted inspection to check on a concern we had about people's safe care and treatment and the management of risk.

Inspection team
This inspection was completed by three inspectors.

Service and service type
Hawksyard Priory Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hawksyard Priory Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This 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 worked with the service.

During the inspection
We reviewed ten people's care records and one person's medicines records. We also spoke with three people and 11 staff including the nominated individual, the registered manager, two consultants, a nurse and the clinical lead and care staff. Following the inspection, we reviewed information the management team had sent us in relation to the concerns we found at this inspection and the oversight of the home.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check a concern we had about people's safe care and treatment and risk management. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and give staff clear guidance to mitigate these risks. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● At the last inspection we found one person had two episodes of choking after taking food from another person's bedroom or plated food. During the last inspection this person was unsupervised by staff whilst eating their lunch around other people who had food that could have placed them at risk of a further choking episode. At this inspection we found a further incident had occurred where the person had put tissue in their mouth. During this inspection, we saw this person continued to be at risk of harm from choking as they took food items from other peoples' bedrooms.
● At our last inspection we found people were being supported on a one to one basis by staff however staff were not always aware of why this was the case. At this inspection we found those people who were meant to be supported on a one to one basis were not always receiving this consistently. This placed these people and those around them at continued risk of harm.
● At our last inspection we found people's nutrition and hydration needs were not always being met placing people at risk of harm. For example, one person required staff support to eat and drink however staff had not recorded them receiving this support on 11 occasions. At this inspection we found this was a continued concern and staff had failed to record supporting this person on a further six occasions. This placed the person at significant and continued risk of harm.
● At our last inspection a person had experienced an incident of a sexual nature. At this inspection we found this person had been subject to a further incident of this nature. This meant insufficient action had been taken to ensure known risks were mitigated and people received consistently safe care.
● The provider had failed to take action where concerns had been raised by external professionals. For example, concerns had been raised by professionals in regard to two people at the service. However, action had not been taken to address these concerns despite being raised as urgent. This placed these people at significant and continued risk of harm.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at continued risk of harm. This was a continued breach of regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.