Ms Pauline Rodman

Hazelwood Gardens Nursing 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Hazelwood Gardens 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. Hazelwood Gardens provides accommodation with nursing and personal care for up to 36 people. At the time of our inspection 29 people were living in the home.

The registered person had registered with the Care Quality Commission to manage the service. 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.

At the last inspection on 18 May 2017, the service was rated Requires Improvement. We found breaches in the regulation relating to safe care and treatment and we served a Warning Notice. We found a further three breaches in the regulations relating to consent to care, submission of statutory notifications to the Commission and quality assurance systems. We issued requirement actions. The provider sent us an action plan telling us the actions they had taken to meet the requirements of the regulations.

We carried out a comprehensive inspection on 27 February 2018. At this inspection, whilst we found improvements had been made, we continued to find a breach of the regulations relating to quality assurance and the service has been rated Requires Improvement for the second time.

Improvements had been made to the management of people's medicines and most people received medicines when they were needed. Further improvements were needed to make sure the management of medicines was consistently safe.

Sufficient numbers of staff were deployed to provide safe care at the time of our visit. Staff performance was monitored. Staff received supervision and training to enable them to meet people's needs.

Staff demonstrated a good understanding of safeguarding and whistleblowing and knew how to report concerns.

Risk assessments and risk management plans were in place. We found improvements were needed to make sure the care plans fully reflected changes in care when the condition of a person changed.

Incidents and accidents were recorded and the records showed that actions were taken to minimise the risk of recurrences.

People were supported with food and fluids and provided with choices at mealtimes.

Staff were kind and caring. We found people were being treated with dignity and respect and people's

privacy was maintained.

Activities were provided and a vehicle had been purchased to provide opportunities for more trips out of the home. A sensory room had been introduced to provide a quiet, relaxing and calming area for people.

Systems were in place for monitoring quality and safety. Actions were taken where areas for improvement and shortfalls had been identified. However, the audits had not identified the shortfalls we found.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of this 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 has improved to requires improvement.

Further improvements were needed to make ensure consistency in management of people's medicines.

Risk assessments were completed and risk management plans were in place.

Accidents and incidents were recorded, reported and analysed. Actions were taken to minimise the risk of recurrence.

Sufficient staff were deployed during the time of the visit.

Improvements were needed to make sure staff were safely recruited.

Is the service effective?

Good

The service has improved to good.

Consent to care was being sought in line with legal requirements. Where people were being deprived of their liberty DoLS authorisations were sought from the local authority.

Staff received sufficient training to equip them to care for people living in the home.

People had access to GP's and other health professionals when needed.

Staff made sure people had enough to eat and drink.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service has improved to good.

People's needs were assessed and care plans were in place. Most

care plans were updated and reviewed on a regular basis.

An activity programme was in place and further improvements were planned.

People were able to express their views and actions were taken where needed to make improvements.

Is the service well-led?

Requires Improvement

The service remains requires improvement.

Hazelwood Gardens 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.

We undertook a comprehensive inspection of Hazelwood Gardens Nursing Home on 27 February 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by one inspector 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 notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our visit we spoke with 12 people who lived at the home and six visitors. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with the registered person and 8 staff that included care staff, housekeeping and catering staff. We observed medicines being given to people and how equipment, such as pressure relieving equipment and hoists, was being used in the home. After the inspection we received feedback from a health professional involved with the service.

We looked at three people's care records in detail and checked other care and monitoring records for specific information. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff, complaints records and other records

relating to the monitoring and management of the care home.

A quality assurance monitoring visit had been undertaken by Bristol City Council in November 2017. These visits are undertaken to make sure the service meets their contractual requirements with the council. We read the report and the areas for improvement identified at that visit.

Requires Improvement

Is the service safe?

Our findings

When we last visited the home we found people did not receive their medicines safely, risks to people's health and safety was not managed and the premises were not safely maintained. We issued a warning notice. At this inspection we found improvements had been made in each of these areas. Overall we found sufficient improvements had been made to meet the requirements of the regulation. However, we also continued to find shortfalls and that further improvements were needed.

One person did not receive their medicines when they were prescribed. The person was prescribed medicines that require additional security. These medicines are recorded when given on Medicine Administration Record (MAR) sheets and in additional recording books. The additional recording books are used to record the specific time the medicines are given, along with other checks including the amount of stock remaining. The actual time the medicine had been given had not been recorded on two occasions in January 2018 and three occasions in February 2018, including the day of our visit, in the additional recording book. The medicines had been signed for to confirm they had been given on the Medicine Administration Record (MAR) sheet. The actual times had not been recorded. The lack of recording the actual times given meant there was a risk the person may not have received the full effects of the prescribed medicine.

Where people were prescribed topical creams, to be applied onto people's skin, accurate records of administration were not always completed. Topical MAR's were kept in people's rooms for care staff to sign when creams had been applied. These were not completed. The lack of accurate recording meant people may have not have received treatments they were prescribed. We also saw, in one person's room, an unlabelled opened topical cream, and when we checked the records, this had not been prescribed for the person.

Where people had medicines prescribed 'as required' (PRN), protocols were in place. We found improvements had been made. We saw records described the types of pain the person may experience and how they expressed if they were in pain. For example, for one person it was noted they shouted to communicate when they were in pain. We found further improvements were needed to ensure this level of detail was consistently recorded. We continued to find general statements that guided staff to observe for 'verbal' and non 'verbal signs,' that did not state what actual signs staff were to look for.

Amounts of medicines received into the home were recorded on MAR sheets. There were photographs at the front of MAR sheets which meant people could be easily identified. Additional information such as allergy status and special requirements, for example, 'Likes to take with a glass of water' were recorded. Medicines were safely stored. Arrangements were in place for medicines that required cool storage and those that required additional security.

We observed medicines being given and staff spoke to people respectfully and gave people time to take their medicines. Staff clearly knew how people liked to take their medicines and people were not rushed. Where people were prescribed variable doses of medicines, the actual amounts given were recorded. Where assessed as able to do so safely, arrangements were in place for people to self-administer their medicines.

Homely remedies, medicines that can be bought without a prescription or 'over the counter' were in use in the home. This was in agreement with the GP who had agreed to these medicines being given to their patients. Accurate records were made to confirm when these medicines were given to people and stock level records were maintained.

Some people who lacked the mental capacity to understand the effects on their health by not taking their medicines received them covertly. This meant they did not know they were being given and their medicines were disguised in food or drink. A protocol was in place and the records we looked at showed the GP, pharmacist, relatives and care home staff had been consulted, involved in the decision making and had agreed it was in the person's best interests to receive their medicines this way. In addition the records for one person who received their medicines crushed showed the pharmacist had been consulted and was in agreement the medicine was safe to be given this way.

When we last visited, we found risk management plans did not fully mitigate the risks to people who were unable to use call bells to summon assistance. At this inspection, we found improvements had been made and we periodically observed and checked one person who stayed in their room throughout the day of our visit. We saw they were checked on a regular basis, and the records confirmed the times the checks had been completed.

People and relatives all told us they felt safe in the home with one person commenting, "I feel safe here. Where I lived before wasn't safe as there was no one around. I can look after myself here but I have a buzzer to get help if I need it."

Most of the people we spoke with told us that overall, staffing was sufficient. People told us they sometimes experienced delays in staff responding to their calls for support. One person told us, "I know I'm in a queue which I suppose is fair enough." We spoke with staff and the comments from one member of staff reflected the feedback we received from others. They told us, "Staffing is usually ok. Sometimes it can be hard if there's staff sickness but we can always speak to [Name of registered person] and she listens to us." Since out last visit, the registered person had introduced an electronic call bell monitoring system. They told us they checked the records on a regular basis and followed up if there were delays in people having their calls answered.

At our last visit, we found systems were not in place to fully protect people from the risks of developing pressure ulcers. Where people used pressure relieving mattresses to reduce the risks of pressure ulcers, or further skin deterioration systems were not in place to make sure the mattress pressures were set according to the weight of the person. This meant people were not receiving the pressure relief they had been assessed as needing. At this visit we found improvements had been made in that a system had been introduced and a daily checking record had been introduced to make sure the mattresses were set correctly. However, the daily checks had not been completed for the four days before our visit and we found one mattress was set incorrectly, and the recording was inaccurate. We brought this to the attention of the registered nurse on duty who corrected the error before the end of our visit.

We checked three staff recruitment files. Two files included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. One member of staff had just started in post. Their file did not contain a record of an interview having taken place and there was no photographic identification. The registered person told us the member of staff was working under supervision. They told us they would follow up as a matter of urgency and ensure the records were fully completed.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and discuss the steps they would take to protect people, including how to report any concerns. Staff had also received training and understood how they made sure people were not discriminated against and treated equally and without prejudice. A member of staff commented, "I wouldn't think twice about reporting abuse to our manager or CQC if needed. Even if it was just that I thought a resident wasn't being spoken to correctly I would report it."

Risk assessments were in place that identified specific risks to each person. These included risks associated with moving and handling, nutrition, falls and distressed or challenging behaviour. Risk management plans were recorded and regularly reviewed.

Accidents and incidents were recorded. The registered person told us they reviewed the accidents on a regular basis to make sure there were no emerging themes or trends. The follow up and management report sections were not always fully completed in the records we checked.

When we last visited, the environment was not safely maintained. At this visit, improvements had been made. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. Personal emergency evacuation plans for each person were in place. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required.

The environment was clean. We spoke with a member of the housekeeping team who described their role and responsibilities. They told us about the cleaning routines and how the housekeeping team were allocated to different floors within the home. An infection prevention and control audit was last completed by the deputy manager on 23 February 2018. The overall assessment showed the home was compliant in the areas assessed. Where shortfalls were identified an action plan was in place to make required improvements.

Good

Is the service effective?

Our findings

When we last visited, we found a breach of the regulation relating to consent to care. At this visit, actions had been taken and consent to care and treatment was generally sought in line with legislation and guidance. Throughout our visit we saw and heard staff asking people for consent with questions such as "Would you like me you?" and, "Can I just help you into the dining room now?" The records showed where best interest decisions were made. Whilst it was clear improvements had been made in recording these decisions, further improvements were needed to make sure accurate decision specific recording was completed for everyone who was unable to provide consent. For example, we found records that referred to the involvement of a 'power of attorney' when they did not. The registered person told us this wording was pre-populated on the electronic records and the wording had not always been deleted.

Staff had received training and support to carry out their roles. Staff told us they received supervisions and felt supported by each other and their manager. One member of staff commented, "We get plenty of training and [name of registered person] chases us up if we're due our mandatory training."

When new staff started in post they completed an induction programme and then shadowed more experienced colleagues. A recently employed member of staff told us about their induction programme. They spoke positively and told us the induction, training and support they received was good and helped them settle into their role with confidence. The induction programme incorporated the care certificate, a national training process introduced in April 2015. This was designed to ensure staff were suitably trained to provide a basic standard of care and support.

The registered person kept a training record that showed staff were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and food safety. Additional training was provided for registered nurses that included venepuncture and wound management and catheterisation. Training was provided for staff to support people living with dementia.

People had access and were referred to external health professionals. The records we looked at showed involvement from the GP, social workers, pharmacist and mental health team.

We observed meal service to people in the dining rooms and to people who stayed in their rooms. People chose their meals in advance and we saw staff discussing meal options with people. Feedback and comments about the food was varied. More than half the people we spoke with told us the food was good and they liked it. Two people told us their relatives brought food in for them because their individual preferences were not always catered for. Several people were not able to recall the meal they had chosen. Menus were on display in the dining room, however the writing was small and most people couldn't read the details.

Efforts were made to make the lunch service an enjoyable experience and there was gentle banter and chat between staff and people who used the service. The tables were laid with cutlery, mats, serviettes, flowers

and drinks. Staff made sure everyone was offered a choice of drinks. One of the care staff asked where the radio was and went out to look for it. They brought it in and put music that people responded positively to. The staff who served the lunch took time to present the food well on the plates. We heard staff discussing portion sizes that would meet peoples' needs and preferences such as, "Don't put too much on the plate as it's off-putting." A staff member asked one person if they could help by moving their feet under the table. The staff were aware of the needs of people who had specific dietary requirements, such as diabetic diets, and where needed, made sure appropriate food was offered and served. We did bring to the attention of staff, one person who was not managing their meal. The person said repeatedly they were unable to manage and the food was spilling onto their clothing. When alerted to the need to help the person, a staff member responded straight away and helped the person kindly and considerately, asking which part of the food they wanted to eat before giving it to them. The staff told us they were still getting to get to know the needs of the person who had just moved into the home

Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought. People were referred to the GP and prescribed supplements if needed.

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 who lack capacity can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

The registered person had submitted DoLS applications for people, and renewal requests had been made for authorisations that had expired. These applications had been submitted and had yet to be processed by the local authority. There were six people with currently authorised DoLS in place.

Good

Is the service caring?

Our findings

We received positive comments and feedback from people using the service and from relatives. People told us they felt respected and that staff were considerate, kind, friendly and compassionate. One person told us, "The staff are very nice and help me do what I want."

We saw staff caring for people with gentle and respectful approaches. Staff understood people's needs and life histories. We heard staff chatting with people about their families and daily activities. We also read entries in the care records in the 'This is me (Life Story)' section. With people's agreement, these included details of home and family life, working experiences, hobbies, interests and other information to help the staff get to know the person they were caring for. A member of staff told us they recognised one person who used to be their 'dinner lady' at school, and whilst the person wasn't able to communicate fully, and was currently staying in their room each day, the member of staff told us it was a talking point for them.

Staff spoke to people in a friendly manner and people looked relaxed and comfortable in the presence of staff. Staff were flexible in their approach with people. For example, one person preferred to stay in bed until late morning unless it was the day they attended the weekly religious service, when they preferred to get up early. Personal care was offered at the time it suited the person.

We saw no evidence of practice that could be seen as discriminatory. People's rights to a family life were respected and encouraged. Visitors and relatives were encouraged to visit at any time. One person lived in the home with their partner who did not require care but chose to live in the home so they could be together.

Staff reassured and offered support to people when needed. We heard one person being reminded it was time for breakfast. The member of staff reminded the person they were, "Just raising your bed" and, "We've got a lovely bowl of porridge for you." They explained to the person that a new member of staff would be helping them with their breakfast and introduced the member of staff to the person.

Staff spoke positively and told us they were proud of the care they gave to people. Feedback from staff included, "I love the job. It's rewarding and good to see people looking nice when we've given personal care," "It's good to work here and we do have good relationships with relatives too" and, "Yes I would recommend here and if it was needed I would be happy for someone in my family to be cared for here." The staff we spoke with were clear about the importance of providing people with privacy, dignity and respect. The care staff all gave examples of how they made sure peoples' privacy and dignity was maintained when providing personal care. They told us how they made sure doors were closed and people remained covered with towels whilst they were supported with washing or bathing. We saw staff knocking on people's doors and called to say who they were before entering the peoples' rooms.

We read recent compliment cards received in the home. They included, 'A token of our thanks and appreciation for the dedication and care given,' 'Thank you for looking after our Mum and keeping her warm and happy' and, 'Thank you for caring for Dad in such a kind and thoughtful way. Very much appreciated.'

Good

Is the service responsive?

Our findings

For most people the care and treatment plans and the delivery of care met peoples' individual needs. For one person, the care records and treatment for a person with a pressure ulcer were insufficient. The records did not provide a current description of the wound, the plan of care was not being followed and the registered nurse was unable to tell us the current grading of the wound or what the most appropriate treatment should be.

In addition, the care plan for the person did not accurately reflect their current needs. The care plan included a reference to the use of a pressure reducing foam mattress, that they may 'forget' to use the call bell and how the person was supported with their mobility. The care plan had been reviewed on 18 February 2018. The person was using an alternating pressure relief (air) mattress, they were not able to use a call bell so a call bell was not in place and they were not mobile. The changes had not been reflected in their care plan.

The care plans we looked at for other people who required support to maintain their skin condition was sufficient to meet their needs. Staff were able to tell us about the care people needed.

Daily monitoring records are used to provide regular updates and progress reports. For the above person, staff were providing the care needed. The person was being checked and supported with a change of position every two hours during the day and during the night. This was in accordance with their changed needs. The people and relatives we spoke with also told us that care met peoples' needs and they were kept updated and informed of changes

Laminated picture boards were displayed in people's rooms. On the reverse of the boards, key information headings included prompts for people's preferences such as what they wished to be called, others that were important in their lives, what staff needed to know, preferred bedding, routines and preferred drinks. These had not yet been completed for everyone in the home. Where they had been completed, the staff we spoke with told us these were useful guides and prompts, especially for new staff.

A member of administration staff was allocated to organise activities, book entertainment in the home and compile and display an activities programme. The programme included weekend activities and were supported by care staff, relatives and volunteers. Staff told us how one person was supported by a volunteer to go out of the home on a regular basis. When we asked people for their views on the activity programme we received positive feedback about the visiting animals and the regular visits of children from the local playgroup. The registered person had purchased a vehicle to provide more opportunities to take people out of the home. The vehicle was being adapted for wheelchair use and the registered person told us it would be ready to use in the summer months.

Most of the staff we spoke with told us how they were involved in day to day activity provision, reminding and supporting people with events and outings, and spending time, 'When we can' as one member of staff commented, organising activities for people. We noted there were no group activities offered on the day of

our visit. Staff were clearly aware of the need for, and benefits of, activities and engaging with people. One staff member told us, "It's important to know the residents and be able to talk to them about things they are interested in. Just everyday chatter is really important".

We heard a staff member discussing a person who was due to receive a Skype call that morning and would require support from a staff member. Another person who preferred to remain in their room had internet access via the TV so that they could pursue their interest in family history.

A sensory room designed to provide relaxation with subtle lighting offered a quiet space for people. Staff told us about the 'pamper' sessions such as manicures that took place in this area. They also told us about the 'wish tree' that had been created. In response to the wishes of one person a member of staff told us about a 1940s tea party that was planned to take place in March 2018. They told us some relatives were enthusiastic and were supported events such as this one.

We looked at the complaints file and saw that three complaints had been received since our last visit in 2017. The registered person told us they had all been resolved. They told us they spoke to people and relatives regularly and acted on comments, suggestions and feedback before people felt they needed to complain. The people and relatives we spoke with felt confident they could raise issues of concern if they needed to. Two relatives told us about occasions when they had voiced concerns. They told us they had been listened to and their concerns, which related to food options, provision of support with continence and a cancelled hospital appointment had been addressed.

Consideration had been given to people's end of life wishes. Where there were agreed 'do not attempt cardio pulmonary resuscitation' instructions, (DNACPR), these were recorded in people's care plans. Where people had expressed specific advance wishes these were also recorded. There were links with the local hospice and the registered person told us they received support, guidance, training and direction from staff at the local hospice when needed.

Requires Improvement

Is the service well-led?

Our findings

At our last visit, we found quality assurance systems were not in place to assess, monitor and mitigate risks to people's safety. At this visit, systems had been introduced that identified shortfalls. A range of audits and monitoring checks were completed by the registered person and the deputy manager. Audits and checks included infection prevention and control, health and safety, medicines audits and nutrition and hydration. Required actions were noted and checked to make sure they had been completed. For example, the action plan from the recent health and safety audit had resulted in the undertaking of fire drills during the day and at night and the introduction of a staff rota to regularly check the contents of the first aid kit and order new or replacement items when needed.

We found further improvements were needed to make sure shortfalls, such as those we reported on in previous sections of this report, were identified and acted upon. For example, the quality assurance system had not identified the shortfalls and areas of improvement we identified in the management of medicines. Systems had also failed to identify the shortfalls we found with regard to record keeping and the pressure ulcer management for one person.

The above amounted to a repeated breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we last visited, the registered person had failed to submit notifications that were legally required, to the Commission. Since our visit, the registered person demonstrated their awareness and we have received notifications. However, we had not received one notification that a person had, in November 2017, developed a Grade three pressure ulcer in the home.

People spoke positively about the management arrangements and knew who the registered person was. They told us they were able to express their views, although there had not been recent meetings and surveys had not been undertaken.

Staff understood their roles and responsibilities and told us they enjoyed working in the home. They all spoke positively about the support received from the registered person with feedback including, "Good teamwork here. Where I was before, it took time before we could see our manager. Here, there is an open door policy and we can see [name of registered person] anytime," "We get loads of support and I've found that really helpful especially when we care for people who are end of life," and, "As our manager says, 'Happy staff, happy home' and I think that's true."

Staff had the opportunity to express their views at general staff meetings. Minutes were recorded and circulated. The minutes from a recent meeting informed staff of the need to make improvements to the recording of people's day to day care and how they spent their day. There was also a reminder to make sure application of creams (topical medicines) were recorded. This was a shortfall we identified too, and reported on in the safe section of the report.

The registered person told us how they kept up to date with current practice. They told us they attended local provider forums, participated in workshop arranged by Bristol City Council, arranged clinical updates from the local hospice and attended national care shows. Policies and procedures were in place with review dates confirmed.

A business continuity plan set out the procedures to follow in the event of an incident that may cause disruption to the day to day running of the home. At the time of our visit, it started to snow and the registered person was reviewing the plan to make sure sufficient arrangements were in place to ensure sufficient staff would be available in the event of the forecasted adverse weather conditions.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not fully in place to assess, monitor and mitigate risks and make consistent improvements to the service.