Firtree Associates Limited

Hazeldene Residential Care Home

Inspection report

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Date of inspection visit:
24 September 2018

Date of publication:
20 February 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Hazeldene Residential Care Home on 24 September 2018. Hazeldene Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hazeldene Residential Care Home provides residential care for up to 26 people, some of whom are living with dementia. At the time of our inspection there were 20 people living at the service.

At the last comprehensive inspection in May 2018 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches of Regulation 12 because the risk associated with people falling was not managed safely, topical medicine records were not completed consistently and fire emergency checks were not carried out in line with the providers policy; Regulation 17 because there was a lack of effective governance processes. We also found a breach of Regulation 18 of the Care Quality Commissions (Registration) Regulations 2009 because the registered persons had not always notified CQC of significant events that happened at the home.

Following the last inspection in May 2018, we issued two warning notices requiring the provider to take action to mitigate the risks to people's health, welfare and safety and improve the systems to monitor the quality and safety of the service. The provider subsequently told us they had put measures in place to ensure the safety of people.

We undertook this focused inspection to check that they had followed their plan. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led? This is because the service was not meeting some legal requirements. No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

You can read the report from our last inspections, by selecting the 'all reports' link for 'Hazeldene Residential Care Home' on our website at www.cqc.org.uk.

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.'

At the last inspection we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks involved in the use of the stairs were not always appropriately managed. In September 2018 we received further information of concern around a

safety incident Our inspection did not examine the specifics of this incident. However, we used the information to plan areas we would inspect and to judge the safety and quality of the service

At this inspection we identified risks were still not managed safely around the use of the stairs. Risks associated with falls had not been mitigated. We also found other areas of concern in relation to risks associated with health conditions and the environment. Risk assessments lacked the guidance for staff to follow, to mitigate risks to people which meant people were placed at risk of harm.

Accidents, incidents and falls were not analysed to prevent further accidents from happening and the registered persons had not taken appropriate action in response to safety concerns.

There was not an effective quality assurance process in place. Audits to assess the quality and safety of service provision were ineffective in identifying improvements needed.

Expert advice was not sought to help make improvements in the home, however people were assisted to access health and social care professionals to maintain good health.

The provider had taken sufficient action into addressing the concerns regarding the recording of topical medicines. However, staff had not received training regarding the administration of some medicines and staff's competency to manage medicines was not regularly checked. The storage of medicines required improvement.

Staff had not always notified CQC of significant events that occurred in the home. Neither had they followed legislation that required them to act in an open and transparent way when people came to harm.

Staff were not always effectively deployed to meet people's needs or keep them safe. We have made a recommendation about the strategic oversight of the deployment of staff

Improvements had been made to staff recruitment and staff were recruited safely.

The home was visibly clean and staff used protective equipment when needed. However, because kitchen staff left personal items in food areas there was a risk of cross infection.

Staff told us the approach of the registered manager had improved and they felt able to contribute to the running of the service.

Due to the concerns identified during the inspection, a referral was made to the Local Authority to ensure the safety of people. Assurances were also sought from the provider about the immediate action they would take to address the concerns identified. Following the inspection, the provider sent us an action plan detailing how they would address the immediate risks to people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were placed at the risk of harm because risks were not suitably managed or mitigated to ensure people's safety and wellbeing.

Although arrangements were in place for reviewing and investigating incidents when things go wrong, lessons were not always learned.

The competence of staff to administer some medicines had not been suitably assessed and medicines were not always stored safely.

Staff were not always sufficiently deployed to ensure the safety and needs of people were met.

Recruitment practices had improved and ensured staff were safe to work with adults at risk.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor the quality and safety of the service remained ineffective. Quality assurance processes were not being used as an opportunity to make improvements. Audits were not effective in identifying shortfalls.

The provider had not notified CQC of all significant events. The provider did not always act in an open and transparent way when people came to harm.

Feedback was sought from people and staff told us the registered manager was approachable and listened to them.

Hazeldene Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by a notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

This inspection was unannounced and took place on 24 September 2018. Two inspectors and a specialist advisor carried out the inspection. The specialist advisor was an occupational therapist.

We reviewed information that we held about the service including previous inspection reports, action plans and notifications. A notification is information about important events which the service is required to send us by law. This information helped us to identify and address potential areas of concern.

During the inspection we spoke with two people and one relative. We also spoke with four members of staff and the registered manager. We looked at care records for six people and the medicines records for 20 people living in the home. We looked at recruitment and staff training records. We also looked at a range of records relating to the management of the service such as, incidents and accidents as well as quality audits and policies and procedures. It was not always possible to establish people's views due to the nature of their communication needs. To help us understand the experience of people who could not talk with us, we spent time observing interactions between staff and people who lived in the home.

Inadequate

Is the service safe?

Our findings

At our previous inspection in May 2018 we found concerns about the way risk was managed at the service. We had already been informed by the registered manager about a safety incident regarding the stairs resulting in a serious injury. However, we found the provider had not adequately responded to this and measures had not been taken to ensure that risks for people were minimised. This placed people at risk of harm and was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice on the provider requiring them to take action by 15 June 2018 to address our concerns.

In addition, and following that inspection, we wrote to the provider and asked them to submit an urgent action plan to tell us how they were going to reduce the risks associated with the safety incident. Their response detailed how the risks had been mitigated to keep people safe.

Following our comprehensive inspection in May 2018 and following receipt of the providers action plan we were informed by the service, in the form of a statutory notification, people continued to be at risk because another safety incident of the same nature had occurred and a further person sustained a serious injury.

At this inspection we found effective measures had not been put in place to reduce the risks associated with people falling on the stairs. We also found other concerns regarding the management of risk.

During this focused inspection we found a continued breach of Regulation 12 and this key question is now rated as inadequate.

The provider's submitted action plan stated that they implemented actions following our inspection in May 2018 to address the concerns of people falling on the stairs, including placing laser technology equipment at the top and bottom of each staircase. This was to alert staff that a person had accessed the stairs by sounding an alarm when a person walked through the laser. During the inspection, we explored the provider's action plan and use of technology to manage the risk of falls on the stairs. Staff told us that they did not think these were working. One member of staff told us, "Never known it to have so many falls, especially on stairs. The stairs are the biggest risk, the ones at the back of the house are really steep. I don't like them (talking about the lasers). They tend to set off when no one is there", this member of staff told us they felt there was a risk of staff becoming complacent because the alarms were constantly going off. They said, "Don't think they would stop people from falling because they're already on the stairs. Perhaps they should be moved". We found that the alarms did not always sound when a person passed through the laser, so staff could not be alerted when a person had accessed the stairs. When the technology equipment was working, they were placed in such a way that the alarms did not sound until someone was on the stairs. This meant that someone could fall before a staff member could assist them.

The provider told us on their action plan that they had allocated staff to the area of the stairs to monitor and assist people with using the stairs. At our inspection we found that staff were not allocated to this area. When we discussed this with the registered manager they told us they had stopped this practice once the

laser technology equipment was in place. Therefore, due to the laser technology being ineffective and the lack of staff presence, the risks of people falling on the stairs had not been reduced.

Following the last inspection in May 2018, the provider had implemented a grading system which provided guidance to staff about the level of assistance people needed when using the stairs. However, our observations on the day of the inspection raised concerns around this practice. We observed people who had been 'graded' at being of risk of falling on the stairs walking around and on the stairs without any staff assistance. On some occasions staff did not notice that people had accessed the stairs because they were busy with other tasks.

The registered manager told us that staff knew to go to the stairs as soon as the alarm sounded. However, we observed that on numerous occasions staff did not immediately respond to the alarm sounding. On one occasion, we saw a staff member walk past the stairs even though the alarm was sounding. An inspector demonstrated that they were able to walk down the stairs and up again without any staff member attending. Staff told us they found it difficult to prioritise when the alarm sounded and they were assisting another person. One staff member told us "I worry that it [the alarm] is going off all the time and that someone wants me too".

We discussed our concerns about the risks associated with the stairs with the registered manager. They acknowledged that the measures that had been put in place to reduce these risks were not effective. Additional measures were implemented during the inspection process to ensure people were safe when accessing the stairs and the registered manager increased the staffing to ensure staff were visibly present by the stairs at all times.

We identified further significant concerns in relation to risk management at the home which meant lessons had not been learnt by the provider. At the previous inspection in May 2018, it was found that a person who was at risk of falls had an alarm mat in place to alert staff when the person was mobilising. This person kept moving the alarm mat and although this was known, the provider failed to put alternative measures in place to monitor the person which meant they were at risk of harm from falling. At this inspection we continued to find this risk had not been addressed for two further people. Records demonstrated that one of these people had fallen 10 times since May 2018. We visited this person on the day of inspection and they told us an alarm mat was used so when they mobilised, staff would be made aware and provide assistance. The person told us that they often moved the alarm mat out of the way because the sound of the alarm was "annoying". The registered manager and a member of staff told us about another person who was at high risk of falls. The staff member told us, "We tried using the mat with [Name] but they move it. We did think about putting the mat under the carpet but thought it might be more of a hazard and didn't know how we would it turn off". The registered manager and the member of staff confirmed that no other measures had been put in place to mitigate these people's risk of falls. This meant these people were still at risk of falling because staff would not be aware they were mobilising. Following the inspection, the registered manager confirmed they planned to reduce these people's risk of falls by monitoring the people more frequently until they had implemented alternative falls prevention technology.

Some people lived with diabetes and the risks associated with diabetes were not clearly identified and safely managed. One person had a specific risk assessment but it was not effective and did not provide staff with the detail they needed to safely manage the risks. When a person experiences a hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar) episode, immediate action can be required to prevent a person from becoming critically unwell. There was no information on the person's risk assessment about what a safe blood sugar reading would be. When we discussed the lack of risk assessment with the registered manager, they showed us a care plan for one person which stated a blood sugar level of two-

three would indicate a hypoglycaemic episode. One staff member told us they believed a blood sugar level that would suggest a hypoglycaemic episode was anything under three. However, Diabetes UK 2017 states hypoglycaemia occurs when blood sugar levels fall below four. The lack of understanding regarding safe blood sugars put people at risk of harm. We discussed our concerns with the registered manager and following the inspection they told us they had changed the information about safe blood sugar readings to reflect best practice guidance.

Diabetes UK 2010 recommends that no member of staff perform blood sugar monitoring unless they have a sound knowledge base of diabetes, received training on blood sugar monitoring using the meter specific to their place of employment, aware of how to interpret the readings obtained and subsequent action to be taken. There was no record to demonstrate that staff had received training in diabetes and staff spoken with could not confirm they had done this. The lack of training and understanding of how to manage the risks associated with diabetes placed people at risk of potential harm. We discussed our concerns with the registered manager and they told us following the inspection that they had organised training for staff to ensure they could safely manage the risks associated with diabetes.

Some care staff were administering insulin where this was prescribed, however there was no record they had received training to do this or that they had been assessed as being competent to understand diabetes and the administration of insulin. The registered manager told us they trained the care staff but was unable to demonstrate any record confirming their competency to do this. They showed us a certificate of diabetes training dated 2010 but this did not include insulin administration. One member of staff told us they would administer insulin if blood sugar levels indicated they were in a hypo (low blood sugars). Insulin helps blood sugars to lower and as such it would be unsafe to administer this to a person suffering a hypo without professional medical advice. We discussed our concerns with the registered manager and following the inspection they told us that they had arranged training regarding this medicine from a nurse who would then determine if staff were competent.

One person was at risk of a severe allergic reaction that could be life threatening. There was no risk assessment in place about this. This meant there was no guidance available to staff about what signs to look out for or what action to take if the person experienced an allergic reaction. One member of staff told us they were not aware of this allergy. The lack of risk assessment put the person at risk of harm because staff did not have guidance to follow in the event of the person having an allergic reaction. We discussed our concerns with the registered manager and they told us they would put a risk assessment in place about this.

One person was prescribed medicines in the event of a severe allergic reaction. One of the medicines was an EpiPen which was used in an emergency. Not all staff knew the EpiPen was available and could not locate it when asked. There was no evidence that staff had been trained to administer the EpiPen. There was also no information to guide staff to the use of this in the person's medicines care plan. The person was additionally prescribed another medicine to manage the allergic reaction but this could not be found. This meant that the persons condition may not be appropriately managed in the event of an emergency. We discussed our concerns with the registered manager and they told us they would provide staff with training and update the medicines care plans to ensure staff were confident to take the right action. The Epipen was located during the inspection and the registered manager told us they would ensure the other medicine to manage the allergic reaction was available.

At the last inspection in May 2018 concerns were identified around the completion of Topical Medication Administration Records (TMAR). At this inspection we found improvements in TMARs had been made. These contained clear directions for their use and no identified gaps in the recording of the administration of these were noted. However, we found other concerns with the management of medicines.

Staff had received training regarding medicine management. They had their competency checked by the registered manager when they first commenced employment and before they were able to administer people's medicines. However, we found that staff's competency was not checked at any other time. One staff member had not had their competency checked since 2010 and another since 2013. This meant the provider could not be assured staff members were still competent to safely administer medicines.

Storage of medicines were mostly safe but some area's required improvement. For example, medicines trolleys were locked in a room but the door on one medicine trolley did not consistently lock. In addition, the registered manager was unable to confirm that the controlled drugs cupboard was secured in line with the Misuse of Drugs (Safe Custody) Regulations 1973. The temperature of the medicine storage was monitored daily and maintained at appropriate levels.

Records demonstrated that people had experienced unwitnessed falls in the service. The National Institute of Clinical Excellence (NICE) guidance states medical advice should be sought if staff are not clinically trained to undertake neurological observations themselves. This is to ensure appropriate action is taken if an actual or potential head injury had occurred. The staff and registered manager were not clinically trained to undertake neurological observations and they confirmed they did not always request a medical review for people when they had experienced an unwitnessed fall, even if they could not determine whether a person had hit their head. This meant people were at risk of harm caused by a lack of medical advice following an unwitnessed fall. When we discussed our concerns with the registered manager they told us they would review this practice.

Although the provider had a system of monitoring all accidents and incidents in the home, we found they did not always put suitable control measures in place to mitigate the risk or potential risk of harm for people using the service. There was little evidence of learning from events or action taken to improve safety.

At the last inspection in May 2018 we identified that fire emergency checks were not carried out in line with the providers policy. At this inspection we found the provider had addressed this and fire checks were being carried out in line with their policy. However, we found other concerns relating to the management of fire risks.

The provider had assessed the premises for risks from fire in December 2017. We reviewed the recommendations from this assessment and associated action plan. This had not been fully completed to evidence the actions required had been taken. For example, new fire signage was planned to be put up in June 2018 but this had not been done on the day of our inspection. These recommendations are made to reduce the risks to people from fire. We discussed our concerns with the registered manager and they told us all the outstanding actions were being completed the day after the inspection. The registered manager sent us confirmation following inspection this had been done.

Records demonstrated that staff received fire training and took part in regular fire drills. However, when we spoke to staff they told us they had not practised using the evacuation aids in the home during the drills and would therefore not be confident on how to use them. This could cause a significant delay in evacuating people safely.

We identified areas in the home that were not secure and presented risk to people. Records demonstrated that staff had raised concerns in April 2018 that people could leave the building unnoticed through an unsecure door. This door had a push bar which people could push open without anyone noticing. People could access the outside of the home through this door and onto the busy road. This presented risks to people with dementia who may not have an understanding of hazards. This door was planned to be made

secure in June 2018 but the work had not been carried out on the day of our inspection. This action was also on the fire risk action plan because it was a fire door. Following our inspection, the registered manager told us the door had been made secure when the remaining works from the fire risk assessment had been completed.

Other doors had signs on stating 'Keep shut/locked'. However, we found that not all these doors were shut or locked. One door led to a storage area, this contained walking aids and moving and handling equipment. The external door to this room was also open and people had access to the exterior of the home without the knowledge of staff. Other storage areas were similarly unlocked, one storage cupboard contained cleaning fluid which could be a risk to people with dementia. The premises were not always managed to support people to stay safe and prevent the potential for harm.

The failure to ensure risks were assessed and effective plans implemented to mitigate these; to ensure staff had the skills, knowledge and competence to manage risks; and a failure to ensure safe management of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine profiles were in place. These included photographs of people, their preferences in relation to how they liked to take their medicines and a record of any allergies. Records demonstrated that people had their medicines as prescribed. One person received the medicines covertly and the service had engaged a pharmacist in best interests' decisions to ensure this was done safely.

Other health and safety checks were conducted such as regular testing of electrical equipment and legionella. Essential equipment such as moving and handling equipment was checked and maintained on a regular basis to ensure it was fit for purpose.

We checked to see if there were sufficient numbers of staff deployed in the home to keep people safe and meet their needs. Each person's needs were calculated using a 'dependency score'. This information was used to help determine staffing levels in the service. Although rotas demonstrated that there were more staff hours used that the tool determined was needed, we observed that staff were not always appropriately deployed to keep people safe.

We observed there were periods of time during the afternoon of the inspection where there was a lack of staff presence in communal areas. For example, on one occasion we observed a period of approximately 30 minutes where there was no staff in the lounge and dining areas. They were busy with other tasks and this time had not been organised in such a way that a staff member was available to support the people in these areas. During this time, one person seated in the lounge was distressed and repeatedly attempting to stand. The inspector intervened and requested staff to support this person. Another person constantly sought reassurance, this led to other people expressing their irritation with them. Staff were not present to diffuse the situation and an inspector needed to provide support. Another person was crying and an inspector needed to reassure them until staff entered the room. This meant that people were at risk of not getting their needs met in a timely manner due to the deployment of staff throughout the home.

On a different occasion, we saw one person who was at high risk of falls and had recently fallen and injured themselves walking without any staff support or their walking frame. We also observed throughout the inspection that when the alarm sounded to alert staff that people had accessed the stairs there was frequently a delay in them attending because they were busy with other tasks. We were therefore concerned that people at risk of falls were not always sufficiently monitored by staff.

Staff had mixed views on staffing levels. One member of staff told us "There is generally enough" while another told us, "There is not always enough staff on duty". We asked the registered manager if they felt there was enough staff to keep people safe and they told us "We can look at the rota". They went on to say they had thought about changing some working times so there were more staff available in the evenings, however, this had not yet been implemented.

Following the inspection, we received notifications about unwitnessed falls and altercations between people. This demonstrated that staff were not effectively deployed to manage these incidents.

It is recommended that the provider seeks guidance from a reputable source about using a systematic approach to ensure sufficient staff are deployed throughout the day.

At the last inspection we found staff were not always recruited safely because the provider had not investigated gaps in their employment. At this inspection we found improvements had been made and staff were safely recruited. We looked at the recruitment record for a new staff member and found the provider had implemented a checklist at the front of the file to ensure gaps in employment were investigated. Application forms had been completed and recorded the applicant's employment history with a written explanation of any gaps. Suitable references were obtained and a Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions.

We checked that the home was protecting people from the risk of infection. We found that care staff were following safe infection control procedures when carrying out their care tasks. There were hand washing facilities, gloves and aprons available throughout the home and we saw staff used them. The service was clean with no malodours. However, we did see that kitchen staff members were storing their outdoor clothes and shoes in the food cupboard in the kitchen. This could cause cross infection. We discussed our concerns with the registered manager and they told us they would ensure that the food cupboard would only store food items in future.

The staff training information provided to us showed staff employed at the service had received up-to-date safeguarding training. Staff demonstrated a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. They told us they would report any signs of poor care or abuse to the registered manager and felt it would be dealt with effectively.

Inadequate

Is the service well-led?

Our findings

At each of our most recent comprehensive inspections of the home in February 2017 and May 2018, we identified concerns with the monitoring of the safety and quality of the service. We found a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at both of these inspections. After out inspection in May 2018 we served a warning notice requiring the provider to take action to address our concerns. Following the last inspection, the provider submitted an urgent action plan in response to our concerns.

During this focused inspection we found a continued breach of Regulation 17 and this key question is now rated as inadequate.

At this inspection we found actions had been undertaken to address the concerns regarding topical medicines, weekly fire checks and recruitment. However, the concerns associated with the management of risk had not been sufficiently acted on. We also found other concerns that had not been identified by the provider. Improvements to their governance processes had not been made to ensure they identified quality and safety concerns and took appropriate action to address these.

The registered manager appeared to lack an understanding of risks and the management of these. We asked whether anyone living in the service had any risks associated with their care and support and they said, "Not really", however we found people living with diabetes, severe allergies and risks associated with falls. They then went on to tell us how one person was on a liquid diet but not because they were at risk of choking. A staff member told us this person would be at risk of choking due to their positioning which we observed. When asked if anyone was displaying behaviours which could challenge they then told of one person who had begun to display these behaviours and we found records suggesting that others also displayed these types of behaviours.

The registered persons had not taken appropriate action in response to safety concerns. For example, the risk of people falling on the stairs was a known high risk, however, actions taken to address this concern were not reflective of the level of risk. The provider had implemented the use of technology equipment to reduce this risk but this had failed to keep people safe which was demonstrated when a further person fell on the stairs. We asked the registered manager on the day of inspection if they thought the current measures in place to reduce the risk of people falling on the stairs were working. They replied, "As shown today, no". Systems used to monitor the safety of the service, including accident and incident records had been ineffective. Despite these reflecting concerns, the registered persons had not taken any further action to reduce the risk of people falling on the stairs. Records further demonstrated there was a lack of prioritisation of actions needed when identified risks placed people at harm. For example, records such as meeting minutes, audits and provider visits briefly identified the stairs as an area of concern but these did not provide any detail or guidance about the actions needed to address the concern. This meant that the provider had not learnt from previous incidents to improve the safety of the service and their governance systems were ineffective.

The registered manager told us they had tried hard to ensure the safe and effective running of the home. They went on to say this was sometimes difficult because different people offered different advice. When we discussed this further, the registered manager acknowledged they understood their responsibilities as a registered person. However, on occasion the registered manager lacked an awareness and understanding of the level of risk in the home. We looked at the current risk assessment for the stairs, this was dated 7 July 2018. It stated the stairs were a low risk. Since that date, a person had fallen on the stairs and sustained a serious injury but the risk assessment had not been reviewed or updated. We asked the registered manager what level of risk they thought the stairs were and they told us, "High risk". The registered manager was unable to explain why the risk assessment had not been updated. Other risk assessments that were in place lacked detail and did not always provide staff with enough guidance to follow to mitigate the risks. For example, we asked the registered manager for the risk assessment regarding a person's diabetes, initially the registered manager thought the risk assessment was sufficient and it was only after some explanation from an inspector that they acknowledged it needed improving. Other people used walking aids and had equipment in place to reduce their risk of falls but this was not recorded on their falls risk assessment. This demonstrated that there was a lack of understanding of the purpose of risk assessment and demonstrated they were not used as a live working document to ensure people's safety. The systems used to monitor and assess the safety of the service had not been effective in ensuring it was safe and did not place people at risk of harm.

The registered persons had not always implemented nationally recognised guidance to ensure the quality and safety of the service. Concerns around diabetes management and the management of head injury were identified and the registered manager confirmed that national guidance had not be followed. The registered manager told us they were not aware of a lot of guidance from NICE and thought they only provided guidance on medicines. The registered persons had not identified this, meaning their governance systems had been ineffective and had not driven improvements to ensure people's safety.

Other quality assurance systems were in place and audits had been completed by the registered manager which looked at a number of key areas such as care plans, medicines and health and safety. However, these were not always effective. Where issues were highlighted and recorded for action there was a lack of evidence to show if these actions had been addressed and completed. For example, on the medicines audit, areas for improvement included 'some balances incorrect' and 'two new staff to sign register'. There was no evidence recorded to say this had been reviewed or completed. Other audits demonstrated that planned actions had not been completed in accordance with the timescales set. For example, there were numerous actions on the fire audit which had not been completed at the time of our visit despite some of these actions being planned for completion in June 2018. This meant the audits used were not always effective in ensuring identified actions needed were addressed.

A system was in place to record and audit accidents and incidents that related to areas such as falls. These audits did not always prompt investigations with the full rigour needed to ensure actions were taken to sufficiently protect the safety of people. For example, it was recorded that one person had hit their head on a wall, the incident audit record did not demonstrate that an investigation had been carried out into the cause of the person hitting their head or what measures had been put in place to mitigate the risk of this reoccurring. Additionally, the accident and incident audit did not demonstrate the trend of people falling on the stairs. This meant the audit that related to accidents and incidents was not effective in ensuring action was taken to address incidents or in driving improvement.

The provider told us in their action plan dated 13 June 2018 that they would 'fully audit the (registered managers) audits for the next six months' to ensure the quality and safety of the service. However, when we viewed the providers monitoring tool we found this had not taken place. We saw a form which was titled

'Providers Monitoring Form', the provider completed this after their monthly visit. We saw that they had signed off categories such as care plans, health and safety and fire safety which indicated they had checked this. However, there were no copies of the actual audits and it was difficult to ascertain what their audit consisted of. We found that the providers monitoring of the service had not ensured action was taken to address identified issues.

Additionally, the quality assurance processes that were carried out failed to pick up the shortfalls regarding risk assessment, deployment of staff, environmental risks and the management of people's medicines that we identified during this inspection.

Providers are required to seek expert advice as needed and without delay to help them make improvements. The provider stated on their action plan to us in June 2018 that they would gain the support of an occupational therapist to address the concerns around people falling on the stairs. However, the registered manager told us at this inspection they had not obtained this input. The registered manager told us they had found this difficult as some occupational therapists informed them they did not provide this service. They then went on tell us that they had not obtained the support of an occupational therapist because "The families didn't want this". Additionally, the registered manager told us that an independent care consultancy company had previously been employed by the provider but this had recently been stopped because the provider did not think "It was worth it". The registered manager confirmed that they had not received advice from any other professional to make improvements in the service. This meant that the registered persons had not acted sufficiently to gain support to improve the safety in the service. Following the inspection, the registered manager told us they had sought professional advice regarding the concerns around risk assessments and the stairs.

A failure to ensure effective systems were operated to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Regulations.

We identified areas within records that were not up to date or reflective of the current situation. For example, recording of controlled drugs (CD) needed improvement. The records of this medicines stock were not completely accurate as the CD register had not been completed correctly. Additionally, a person who was no longer in the home had more medicines in stock than recorded in the CD register. We were able to reconcile these medicines with the record of medicines received to the service but the CD register should be accurately maintained. We also saw risk assessments and care plans that were not detailed or that contained the correct information. Inaccurate records can cause confusion for staff and place people at the risk of harm.

A failure to maintain an accurate, complete record in respect of each service user and the management of the service was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to act in an open and transparent way when people come to harm. We identified examples of where people had received serious injuries following falls, but there were no records to confirm that they or their relatives had been given information, support or an apology about the incident, as required by the regulation. Two members of staff told us they had not heard of 'Duty of candour'. We discussed the requirements of this regulation with the registered manager and they did not have an understanding of what it meant.

The failure to act in an open and transparent way when people came to harm was a breach of Regulation 20 of the Health and Social Care Act 2008.

At our last inspection we found a failure to notify CQC of significant events that happened in the service. At this inspection we found one notifiable incident that had not been reported to us. The registered manager told us they were not aware such incidents needed to be notified to CQC.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following the inspection, the registered manager had notified us of similar incidents of this nature.

Arrangements were in place to share information between the staff. Meetings were held at the start of each shift to handover information about people's current needs and key information about this was recorded on a handover sheet. Staff told us this was effective. However, one member of staff told us, "Communication could be clearer, sometimes there are crossed wires". This was in relation to instruction from the registered manager.

Staff told us they enjoyed working in the home and felt the culture was good. One member of staff told us, "It is a lovely home to work in". Another told us, "The culture is nice, we can't please everyone but we try to achieve what people want, people are respected and their choices and dignity promoted".

At the last inspection in May 2018 staff told us they were not always empowered to contribute to the enhancement of the service. At this inspection we found improvements had been made. One member of staff told us, "As a team we are encouraged to make suggestions, we have staff meetings every couple of months and we are able to air our views". Staff told us that the registered managers approach had improved. One member of staff told us, "She has always been supportive to me, she was not always available but if you say how important it is, she will make time now". Another member of staff told us, "The registered manager was really good to me when I had a personal issue".

Feedback was sought from people, relatives, healthcare professionals and staff through the use of surveys and meetings. We saw the feedback was predominantly positive. One relative told us they had asked the registered manager if their relative could have a larger room and this was done. However, it was not always evident that individual issues were explored or resolved for people: for example, we saw that one person had requested extra blankets as they were cold but there were no recorded actions that this had taken place. When we discussed this with the registered manager, they told us "The girls would have put some more on".

The registered persons worked in partnership with healthcare professionals such as GPs, dentists and opticians to ensure individual concerns were addressed for people. Records demonstrated that where people had frequently fallen a referral had been made to the falls prevention team. This meant people were supported to access professionals to improve their health and well-being.

Despite the shortfalls in the home, the registered manager demonstrated that they were keen to work with people, staff and other professionals to make the necessary improvements in the home and it was clear they cared for the people who lived at Hazeldene. Following the inspection, we were sent an action plan from the registered persons and clear action for improvement was detailed.

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 Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify the commission without delay of relevant incidents. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2014 Duty of Candour The failure to act in an open and transparent way when people came to harm

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The failure to ensure risks were assessed and effective plans implemented to mitigate these; to ensure staff had the skills, knowledge and competence to manage risks; and a failure to ensure safe management of medicines. Regulation 12 (1)(2)(a)(b)(d)(e)(g)

The enforcement action we took:

We imposed a condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance The failure to have effective systems and processes in place to drive continuous improvements, to assess, monitor and mitigate risks relating to the health and safety of people.

The enforcement action we took:

We imposed a condition on the provider's registration