Hawksyard Priory Nursing Home Limited

# Hawksyard Priory Nursing Home

## Inspection report

Armitage Lane
Armitage
Rugeley
Staffordshire
WS15 1PT

Tel: 01543490112
Website: www.hawksyardpriory.co.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

We inspected this service on 20 April 2017 and this was an unannounced inspection visit. Our last inspection visit took place in 9 May 2016 we found the provider needed to make further improvements with medicines as some medicines and nourishment supplements were not recorded correctly to demonstrate people had these. Where restrictions were placed upon people these had not always been identified to ensure any restriction was lawful. At this inspection we found improvements had been made in these areas. However, further improvements were required.

Hawksyard Priory provides nursing and personal care for up to 106 people some of whom may be living with dementia. At the time of our inspection visit there were 86 people living in the home.

There were two registered managers 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.

Staff were aware of the signs to look out for that might mean a person was at risk of harm but were not clear on when they should report concerns outside of the organisation when this was needed. Individual risks had been assessed and staff understood how to provide support although this information was not always recorded to ensure consistent care. Where people needed support to make decisions, capacity had not been assessed to ensure that it was clear why people could not make specific conditions.

Each area of the home had its own staff team and this had been organised around the number of people who used the service. There was not always support in all areas to keep people safe. There were opportunities for people to engage with activities although some people felt they were would like more opportunities to engage with others and spent a large amount of time unoccupied. Staff felt supported by the registered manager but some staff felt that more supervision and training would help them to be able to support people more effectively. Quality assurance systems were in place although these systems had not identified these concerns and improvements were needed in the service.

People felt that staff were kind and caring. Staff treated people with respect and ensured their privacy and dignity was upheld. People received prescribed medicines when they expected and needed them. The provider had a complaints procedure available for people who used the service and complaints were managed and investigated.

People received support to manage their health and saw specialists where needed. Recruitment checks had been carried out to ensure new staff were safe and suitable to work with people who used the service.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People were not always protected from harm because staff had not identified where reports should be made about potential abuse. The staffing provided did not always mean that people had the support they needed to keep safe. Risks to individuals had been identified but information about how to manage these was not always recorded to ensure consistent care. Medicines were managed so that people received them safely as prescribed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were able to make decisions about their care although where they lacked capacity, assessments were not decision specific and did not identify how the decision about capacity had been reached. Where restrictions were identified, applications to ensure this was lawful had been made. Staff were trained to deliver care and support to people but not all staff were knowledgeable about how to assess people's mental capacity and support people with dementia. People were supported to have enough to eat and drink and people's health care needs were monitored.

### Is the service caring?

**Good**

The service was caring.

Staff knew people well and understood their likes, dislikes and preferences and were considerate and promoted people's dignity. People and their family were involved in discussions about their care and support. People's relatives and friends were free to visit them at any time.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People were given opportunities to be involved in activities and entertainment and to maintain hobbies and interests, although some people felt they were not involved in activities that interested them and were isolated. People and their families knew how to raise concerns and managers acted on information received.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

The quality assurance systems were not always effective and improvements were still needed within the service to ensure people received the care and support they wanted. The registered managers were available for staff although some staff felt they needed more support to enable them to provide effective care. People were encouraged to share their opinion about the quality of the service.

# Hawksyard Priory 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 April 2017 and was unannounced. Our inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of providing care or support for people.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public.

On this occasion we did not ask the provider to send us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we offered the provider the opportunity to share information they felt relevant with us.

We spoke with twelve people who used the service, eight relatives, three nurses, seven care staff, a member of housekeeping staff and one of the registered managers. We reviewed information from the local authority quality monitoring visits. We did this to gain people's views about the care and to check that standards of care were being met.

We observed care and support in communal areas. Some people had communication difficulties, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We viewed eleven records about people's care and medicines. We also looked at records relating to the management of the service including quality checks.

Requires Improvement

# Is the service safe?

## Our findings

On our last inspection visit we identified that further improvements were need with how medicines were administered and how the provider ensured people received nourishment supplements. On this inspection we saw improvements in this area had been made.

People were happy with how they received their medicines and they took these at the right time. Some people were prescribed medicines 'as required' (PRN). These are medicines that are prescribed to treat short term or intermittent medical conditions or symptoms and are not taken regularly. Individual medicine plans were written so that staff had guidance to follow about when to administer the medicine and the amount to give. The registered manager agreed that for some people these could be developed to ensure they contained more information about when medicines should be given to ensure this was consistent. Medication administration records (MAR) were well maintained and recorded when people had taken or refused their medicine. The nursing staff were responsible for administering medicines and had regular checks to ensure they remained competent to do so. This ensured staff continued to manage people's medicines safely.

People were not always protected from harm as although procedures were in place to report concerns of potential abuse; these procedures were not always followed. We saw where people with complex needs had harmed other people, this was recorded in incident reports but had not been identified as potential safeguarding and reports had not been made to the local authority as required. One member of staff told us, "I hadn't realised this could be safeguarding. We only usually record it in the notes." This meant that staff had not recognised all the categories of abuse that might affect people and action to ensure people were safeguarded had not taken place.

This evidence demonstrated there was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014.

Each floor had a separate team of staff that included nursing and care staff. A large number of people received support in their bedroom due to their complex needs, which meant at times there were limited staff available in communal areas. We saw people's requests for assistance were generally responded to promptly, however on one floor we needed to alert staff, as we found one person on the floor and there was no means to call for assistance near-by. In some lounge areas we saw people were left alone for significant lengths of time and did not have facilities to summon support if this was required. Some people needed individual support because of the risks of them falling. An extra member of staff was commissioned to support them during the day but when this support ended, we saw that there were incidents where they had been found on the floor and the report stated they may have fallen. No other staff support had been provided to keep them safe at these other times. The registered manager informed us that staffing was organised based on how many people used the service and they did not consider people's dependency levels.

This evidence demonstrated there was a breach of Regulation 18 of the Health and Social Care Act

(Regulated Activities) 2014.

Staff understood the risks associated with people's care and these were assessed when people started to use the service and reviewed to ensure they remained up to date. One member of staff told us, "If people are becoming agitated, we would try and talk with them and move to a different area so they don't upset other people. We all have different ways of working based on our relationship with people and some days different things work." Another member of staff told us, "We have a very relaxed approach here and people are able to move around freely. This seems to help people become less agitated." We saw when people became anxious, the staff were able to sit with them in a private area and spoke with them about what they were feeling, or gave them an opportunity to express themselves. The care records included information about risks and whether people may become anxious, however specific individual information about the support people needed was not recorded. This meant people may be at risk of receiving inappropriate or inconsistent support.

Assessments of other risks that related to people's care had been undertaken. For example, where people had been identified as being at risk of skin damage, equipment was provided such as pressure relieving cushions and mattresses to reduce the risk of skin damage. Staff understood how to support people to move to reduce any risk and when people were supported to change position, this was recorded to ensure this was completed at the agreed times.

People could be assured that safe recruitment practices were followed. The necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity, proof of eligibility to work where required and appropriate references had been obtained prior to employment and were retained in staff files.

Requires Improvement

# Is the service effective?

## Our findings

On our previous inspection we found the provider had not identified where some people who lacked capacity, may have restrictions placed upon them and there was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014. On this inspection we found improvements had been made. However, further improvements were needed with how people's capacity was assessed.

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. Where needed, capacity assessments had been completed, these were not decision specific and there was only one assessment for all aspects of care. This included whether to have bed rails and whether to resuscitate in the event of their death. Decisions had been made in people's best interests and involved family and friends who were important to them. The registered manager agreed the assessments needed to focus on each individual decision and record how a decision about people's capacity had been reached.

Some people who used the service who lacked capacity, had restrictions placed upon them to help to keep them safe. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where restrictions had been placed upon people, for example, if they were unable to go outside the home without staff support for their safety; applications had been made to ensure these restrictions were lawful. Where these had been approved, the staff knew how to keep people safe and how to ensure restrictions were the least restrictive. One member of staff told us, "DoLS don't mean that people aren't able to go out or make decisions about what they want, it's about protecting them to ensure they are safe."

People had a choice of what to eat and drink and a menu was prepared informing people of the choices. People had mixed views about the choices and quality of the food. One person told us, "I like the food, the chef here is good and I'm happy with what is cooked." Another person told us, "I don't like everything and if you don't like the choices, you can have something else but it's something like an omelette or jacket potatoes and I want a proper meal." Another person told us, "I just ring down to the chef if there's a problem or I want something different." Another person told us, "I prefer to get my family to bring my own food in or get something delivered." We saw where people needed a specialist or blended diet; this was provided and attractively presented. People could choose to eat in their bedroom or in the dining room and where needed, were provided with individual support. People were encouraged to be independent throughout the meal and staff were available if people wanted support and extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others.

Staff received training that was relevant to their role to enable them to support people who used the service. New staff completed an induction programme which included shadowing more experienced staff. All staff completed the Care Certificate; this sets out learning outcomes, competences and standards of care that are

expected. Staff also received further specialist training to support people with complex needs. However, we found that not all staff knew how to support people who may be living with dementia when delivering personal care, recognising how to assess capacity and had not recognised different forms of potential abuse. Recent training was discussed with staff during any supervision, although some staff felt that this was not completed frequently enough to enable their performance to be reviewed. Supervision is a process, usually a meeting, by which guidance and support is provided to the staff; this meant that further support may be needed.

People had access to health professionals and services and people felt that their health needs were met. Records confirmed that people received support from health professionals and referrals were made when needed, including investigations for serious health conditions. People's weight was monitored and some people were provided with a specialist diet to support them to manage health conditions, such as swallowing difficulties. When there had been a need identified, referrals had been made to appropriate health professionals, including speech and language therapists (SALT). One member of staff told us, "If we see people are losing weight or having difficulty eating, we can make a referral to the SALT team and they are very supportive so people get the help they need." The GP visited the service when people were unwell and one relative told us, "The staff are very responsive when people aren't well, they will call the doctor and let us know. They are also very good at keeping us informed of everything. If [Person who used the service] isn't well, we will always get a call to inform us." People told us they continued to receive routine appointments with an optician, dentist and chiropodist. One person told us, "It's important for me to see what is happening so I don't fall, so I get to see the opticians regularly so I know if I need new glasses."

Good

# Is the service caring?

## Our findings

People spoke positively about the staff and told us they were caring and kind. One relative told us, "It's absolutely fabulous here. I can't fault them. I know [Person who used the service] is really well cared for and the staff are lovely." Another relative told us, "It's comforting to know that [Person who used the service] is well looked after. We don't have to worry any more about how they are and if they are safe and you can tell how much the staff care for people."

People had developed good relationships with permanent staff who knew them well. The staff had a good understanding of people's needs and preferences in relation to the way their care and support was provided. For example, some people had limited verbal communication skills but staff understood when they required assistance from how they used non-verbal communication and gestures. One relative told us, "[Person who used the service] isn't able to talk like they used to, but the staff always seem to know what they are saying. They'd let you know if they weren't happy, I don't see that at all."

The staff provided encouragement and support to people, based on their individual needs. We heard people and staff speaking about family members and topics which interested them. People were helped to maintain relationships that were important to them. We saw friends and family members visit throughout the day and they told us they were welcomed at the home. One relative told us, "The staff make us feel really welcome here and are just as interested in us as they are in [Person who used the service]. This makes it better for everyone as they ask about family and what's been going on. I think it helps the staff too as they can talk to [Person who used the service] about it and keep them involved."

People were involved in making decisions about their care and were supported to maintain their independence. This included how and where they spent their time, where they preferred their meals to be served and the times they chose to get up in the morning and go to bed at night. Where people needed support to help to make certain decisions they received support from and advocate. An advocate is a person who works as an independent advisor in another's best interest. Advocacy services support people in making decisions, for example, about their finances which could help people maintain their independence.

People's dignity and privacy was respected by staff. Staff greeted people by their preferred names and personal care was provided in private areas of the home. When people became upset they were supported to have private time away from others and were able to express themselves without upsetting other people. One member of staff told us, "This is a large home and we have lots of space and rooms. If people need some personal space then this is made available. Not everyone wants to be around other people all the time."

Requires Improvement

# Is the service responsive?

## Our findings

People had mixed views about how they were supported to engage with activities that interested them. Many people received support and care in their bedroom and although some individual activities were organised with people, such as reading to people and hand massage, we saw the most people spent their time in their room unoccupied. One person told us, "I get quite bored." Another person said, "The staff say 'hello' but I've just got my television and music on all day, that's all I have to do."

We carried out an observation in one of the lounge areas and for large periods of time there was no interaction from staff and people were unoccupied. Some people received individual support due to the risks of falls. The staff stayed with people to ensure they were safe but did not engage with people in a meaningful positive way, or provide opportunities to engage with an activity that interested them.

Activity co-ordinators organised group activities on the ground floor of the service throughout the week. On the day of our inspection a game involving balloons had been organised to encourage their co-ordination. One member of staff told us, "We are always looking for different things to do with people. We will try different activities each week and if people enjoy it then we can do this activity again." Another member of staff told us, "We are lucky as we have a car here that can accommodate people who use a wheelchair, so we can go to different places. Relatives can use this too so people can go out and join in family events or go out for a meal.

People were supported to follow their faith, either outside of the home by attending a service at their preferred place of worship or attending a religious service conducted in the home. One person told us, "It's important to me to be able to practice my beliefs. It's lovely having such a beautiful church next door too."

People were confident in how to make complaints if needed. We saw where people had raised concerns; these had been recorded and acted upon. One person told us, "I'd tell them if I wasn't happy." A relative told us, "I don't expect things to be perfect and understand mistakes can happen. When things have been wrong, I've let them know and they've put it right and that's what I want to see." The provider's complaints procedure was on display on the notice board in the reception area and we saw where complaints had been investigated, a record was kept of the outcome and people were informed of the investigation and any action that was taken.

People were encouraged to visit the home to see if they would like to live there. One relative told us, "I just came to look around; I didn't make an appointment and just turned up as I wanted to see things as they really were. The staff were happy to show me around and I could ask questions about the home before we made a decision." Pre-admission assessments had been undertaken to assess whether people's care and support needs could be met at the home and this information was used to develop a support plan. One person told us, "The staff have asked me what I want here and I'm quite happy that it's right."

Requires Improvement

# Is the service well-led?

## Our findings

Quality assurance systems were in place to identify where improvements needed to be made. However, these were not effective as further areas of improvement were required and the provider has been performing below the standards required. Although improvements had been made in the areas we had previously identified as concerns, further areas need improving. The quality assurance systems had not identified that potential safeguarding incidents had occurred and alerts had not always been made to the local authority as required. The care plans did not include personal information about how to support people who may have complex needs. The systems used to review these plans had not recognised these did not record people's specific needs and assessments of capacity did not include information about how people were able to make individual decisions. The quality assurance systems had not identified that where people had individual staff support, this was not used effectively to ensure people's welfare and they were not always supported to engage with activities that interested them.

The above evidence shows that effective systems were not in place to ensure the quality of care was regularly assessed, monitored and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not meeting their registration requirements, as they had not informed us about specific incidents that had occurred. For example, when people had a serious injury or when safeguarding incidents had occurred. When this was highlighted with the registered manager, these notifications were sent to us. Since our inspection we have received further notification of significant events as required.

There were two registered managers in the home who worked together to manage the service. The staff felt they received supported on a daily basis and to develop their skills and knowledge although some staff felt that they did not receive regular supervision in order to review how they worked. Supervision helps to identify their skills, where they needed support and provide an evaluation of their work. One member of staff told us, "It's been a while since I had a supervision meeting. I know I can speak to the nurses and staff but it's nice if this is planned. Another member of staff told us, "I do have supervision but I can also speak to the manager at any time if I have any concerns." As part of the quality assurance system staff were observed how they supported people, helped them to move and how they washed their hands as part of the infection control audit. One member of staff told us, "It's good that we have our own moving and handling trainers here as they can watch what we do with people and make sure we are competent and safe."

The staff were informed of any changes occurring within the home through staff meetings, which meant they received up to date information and were kept informed of developments. The provider sought feedback from the staff and people who used the service through questionnaires. People we spoke with and their relatives confirmed they had been consulted about the quality of service provision. People and their relatives were invited to meetings and were informed of any changes and developments within the service.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be

informed of our judgments. We found the provider had displayed their rating in the entrance hall to the service.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Systems and processes had not been established and operated effectively to investigate, immediately upon becoming aware of, any allegation of such abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes were not operated effectively to assess, monitor and improve the quality of the service provided in carrying out the regulated activity. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Sufficient numbers of suitably qualified and competent skilled person were not being deployed to meet the support needs of people who used the service. |