Bupa Care Homes (GL) Limited

Hazelmere House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hazelmere House Care Home Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Hazelmere House Care Home Nursing Home provides accommodation for up to 56 people who have nursing needs. At the time of our inspection there were 38 people living at the home, two of whom were in hospital. The home provides a wide range of long and short term nursing and residential care for older people. All bedrooms in the home are en-suite and communal facilities include a large conservatory and bar area. There is wheelchair access and a secure keypad entrance. Car parking is available to the front and side of the building.

This service was last inspected in June 2016 where we rated the service as requiring improvement. We identified breaches of regulations 11 (Need for consent), and 17 (good governance). After our inspection June 2016, the provider submitted an action plan to the Commission outlining the action they would take to improve the service.

The care home had a registered manager. 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.

There had been a change in registered manager since our last inspection in 2016. The new manager successfully registered with the Care Quality Commission in September 2017.

At this inspection we found that the new registered manager was working diligently and was making significant improvements in the management of the home and staff. On taking up their new position they had carried out their own assessment of the home's compliance with the requirements of the Health and Social Care Act 2008 and associated Regulations and had identified that significant improvement was required to ensure the safety and wellbeing of the people who lived at the home.

On this inspection we identified further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of this report.

The atmosphere in the home was welcoming and sociable. People told us that they were well cared for and spoke highly on the manager and staff.
People told us that they felt safe living in the home and staff were committed to providing good standards of care.

Measures designed to reduce risk were not always put into practice so some people remained at risk of harm or their needs not being met.

Safeguarding systems, processes and practices protected people form abuse, neglect, harassment and breaches of their dignity and respect.
There was an adequate number of suitably trained and experienced staff on duty to meet the needs of the people who lived at the home.
Staff recruitment procedures and process were thorough, with all appropriate checks being made to make sure new employees were suitable to work with vulnerable people.

Staff were well trained and well supported. They told us that they appreciated the support, direction and leadership provided by the management team and their morale was good.

We could see that people were involved in decisions about their care. They told us that staff listened to them and acted on what they said. However, staff needed further training on gaining consent to care and did not always complete assessment in accordance with the Mental Capacity Act 2005 (MCA), Code of practice to ensure people receive the right support to assist them with their decision making.

People enjoyed a varied and nutritious diet, which catered for their individual needs and preferences. They were fully engaged in assessing the quality and presentation of meals served, via residents and relatives meeting and were able to give direct feedback given to the manager and staff.

Social activities were organised in the home which were tailored to peoples' individual needs. They told us that they enjoyed them and the activities coordinator who organised them was excellent at their job.

Staff were aware of the need to support people approaching the end of their life but care planning arrangements were not always person-centred to ensure their wishes and needs were understood, met and respected.
The home had an effective complaints procedure. People's concerns and complaints were taken seriously and responded to and used to improve the quality of care.

The home had an established quality assurance system in place but some checks and audits undertaken by the management team were not always effective because they failed to identify the areas of concern we identified during our inspection.

People, their relatives' friends and staff praised the manager for their leadership, guidance and the way they had involved them in the day to day running of the home.

The registered manager was aware of incidents in the home that required the Care Quality Commission to be notified of. Since the day they started work in the home they had been open and candid with us and had submitted statutory notifications as required.

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.

Significant improvements had been made in the overall management of the home but measures designed to reduce risk were not always put into practice so people remained at risk of harm.

Safeguarding systems processes and practices protected people form abuse, neglect, harassment and breaches of their dignity and respect.

There was an adequate number of suitably trained and experienced staff on duty to meet the needs of the people who lived at the home.

Is the service effective?

Good

The service was effective.

Managers and staff acted in accordance with the Mental Capacity Act and ensured that people received support with their decision making.

Nursing and care staff presented as well trained, caring and compassionate. They had a good understanding of people's needs, their likes, dislikes and personal preferences.

People enjoyed a varied and nutritious diet.

Healthcare professionals were involved in people's care.

Is the service caring?

Good

The service was caring.

Staff were caring and compassionate.

People were treated with kindness, respect and were given emotional support when needed.

People were encouraged to express their views; they were listened to and actively involved in making decisions about their care and support.

People's privacy, dignity and independence were respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive

Staff were aware of the need to support people approaching the end of their life but care planning arrangements were not always person-centred to ensure their wishes and needs were respected.

People's concerns and complaints were taken seriously and responded to and used to improve the quality of care.

The atmosphere in the home was relaxed and sociable. People enjoyed a range of activities and hobbies which they described as excellent.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in place who was making positive changes throughout the home, however there remained some areas for improvement.

Quality assurances processes were in place but not always rigorously implemented.

People, their relatives' friends and staff praised the manager for their leadership, guidance and the way they had involved them in the day to day running of the home.

Hazelmere House 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 took place on 28 November 2017, and was unannounced. Two additional announced inspection visits were undertaken on the 6 and 21 December 2017.

The inspection team consisted of two adult social care inspectors, a specialist advisor on the care of people with dementia 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.

Before the inspection, we checked information that we held about the service and the service provider. We looked at any notifications received and reviewed any other information held about the service prior to our visit.

The inspection was prompted in part by a late notification of an incident following which a person using the service sustained a serious injury. This incident occurred before the current manager took up post. The incident was at the time of the inspection subject to a criminal 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 from falls. This inspection examined those risks. Since the inspection the service has been told by the police they will not be preceding with a criminal prosecution but the matter remains open to and under investigation by the CQC.

We invited the local authority to provide us with any information they held about Hazelmere House. They told us the home had previously been subject to an action plan due to concerns around staff training, care

planning, monitoring and review. They told us that they had visited the home on the 21 August 2017 and found that the new manager had made improvements in all areas, but concerns remained about the quality of recording, care planning and review of care.

During the inspection, we used a number of different methods to help us understand the experiences of people living in the home. We spoke with a total of 20 people living at the home, four visiting relatives and nine staff members including the registered manager, regional director, the resident experience manager, clinical services manager, two nurses and three care staff.

Throughout the inspection, we observed how staff supported people with their care during the day. We looked around the building including, with the permission of the people who used the service, some bedrooms. We looked at a total of five care plans. We looked at other documents including policies and procedures; staffing rotas; risk assessments; complaints; staff files covering recruitment and training; food and fluid records, maintenance records; health and safety checks; minutes of meetings and medication records.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe. All the people who lived at the home told us that they felt safe. Their comments included: "Oh yes I feel very safe, they check the doors and windows every night", "The staff are wonderful, I admire them, when I ring the call bell they come", "I feel safe here because there are always people around to help if needed. I was having falls at home so I'm much better here", "I've got two buzzers but I rarely use them, but when I do they get to me pretty quick" and "Yes I feel safe, everything is wonderful".

All relatives spoken with made positive comments about the care provided and were confident their loved ones were safe. One of the relatives spoken with said: "My (relative) has been here for two years and the place is very good and they have a lovely room. I think they are safe because staff take precautions including protective rails to side of their bed and they use special equipment to assist them with their mobility".

At our last inspection in June 2016, we found that the home had systems in place to safeguard people from abuse. Medicines were managed and administered appropriately and any risks to health and welfare were identified and minimised to ensure people were safe. There were sufficient numbers of suitable staff to support people and ensure peoples' needs were met.

On this inspection we found that individual risk assessments were completed, for example, to assess peoples' risk of falls, nutritional risk and developing pressure ulcers. The assessments were updated regularly and there was a record of the actions to be taken to reduce the risk of harm to people. However, not all the care plans reflected people's individual needs or the risks they were presented with in their daily lives. For example, one person had been admitted to the home approaching the end of their life, but their care plan did not reflect their needs. This person was assessed at high risk of developing pressure ulcers. They were provided with a suitable pressure relieving mattress and staff were repositioning them but there was no care plan on tissue viability to keep them safe. Records showed that in the days preceding our inspection they had developed a pressure ulcer to their heel. Staff had responded referring them to the specialist tissue viability nurse and drew up an appropriate care plan to treat the wound but had not drawn up a care plan on tissue viability. We checked this person's pressure relieving mattress and found that it was set incorrectly for a person much heavier than they were. This meant that the pressure relieving mattress was not providing effective pressure relief. We looked at pressure reliving mattresses provided for a further five people and found that two of them were also set incorrectly. In one case the person's pressure relieving mattress was set for a person who weighed in excess of 100 kg when they only weighed 49 Kg. This meant that these people were placed at unnecessary risk of developing pressure ulcers.The nurse call bell system is a two stage system, one button indicates the person needs assistance and the red button is for emergencies. It is crucial therefore that people are able to use the call bell system effectively. We found that this was the case for most of the people we spoke with. However, one person who was being nursed in bed did not have their call bell to hand. We looked at this person's care plan on maintaining safety and found that it indicated that they should have their call bell with them at all times. When we asked nursing staff about this they told us that this person was unable to use their call bell due to cognitive impairment. This was not reflected in their care plan and their inability to use the call bell had not been risk assessed or

mitigated.

The issues outlined above constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

The registered manager had a safeguarding file which clearly documented the procedure to be followed in the event of any abuse or allegation of abuse. We could see that the procedure did not have the telephone numbers of the local social services department. The manager explained that the local authority Safeguarding policy with telephone numbers was on display on the notice board and I saw this to be the case. However, the manager rectified this and included the information within the safeguarding file during the inspection. This file also contained records of all the safeguarding incidents and we could see that these had been appropriately reported to the local authority as well as the Care Quality Commission (CQC) as required. Any actions taken as a result were clearly recorded along with the outcome of any investigations. We checked our records and could see that the registered manager was submitting notifications of any safeguarding or other incidents at the home, to the CQC.

The manager showed us how analysis of incidents, accidents and errors had resulted in the development of action plans which included further supervision, support and staff training, and or disciplinary action against staff, where it was deemed appropriate. We could see that the registered manager promoted learning from past experience in order to support staff to develop their skills and keep people safe.

Staff members confirmed that they had received training in protecting vulnerable adults and that this was updated on a regular basis. The staff members we spoke with told us that they understood the process to follow if a safeguarding incident occurred and they were aware of their responsibilities for caring for vulnerable adults. We saw that the provider had a whistleblowing policy in place and staff were familiar with the term "whistleblowing". Staff told us they would report any concerns regarding poor practice to senior staff. They were aware of the need to escalate concerns internally and report externally where they had concerns. This indicated that they were aware of their roles and responsibilities regarding the protection of vulnerable adults and the need to accurately record and report potential incidents of concern.

The arrangements for how medicines were managed were safe. The home utilised a monitored dosage system (MDS) with medicines pre-packed by the dispensing pharmacy in bubble packs according to the prescription for each person. This helped to minimise the potential for human error in the administration of medicines.

Medication fridges and the medicine rooms were being checked regularly, so any medication was being stored correctly at the right temperature. Medicines were checked on receipt into the home, given as prescribed, stored and disposed of correctly.

We saw Medicine Administration Record (MAR) sheets relating to the MDS system and saw that records tallied with the medicines administered from the bubble packs with the exception of two minor errors made in counting remaining stocks of medicines. However, we could see that these were only recording errors because the actual stock of medicines tallied with the record of medicines received and administered.

Controlled drugs were stored securely and the records showed that these were administered and accounted for correctly. We found that a recording error had also been made in the monitored drugs book. This again was a minor error in that staff had inadvertently entered the incorrect date when particular medicines had been administered. This was easily detected and would have been picked up at the next medication audit because the precise time the medicines were given were recorded. We fed these recording errors back to

the Care Services Manager who took action to address them with the staff involved.

Medicines were administered by staff who had received additional training in medication administration and they underwent regular checks to ensure that they remained competent. The registered manager had audits in place to monitor medicine procedures.

During our last inspection of the home in June 2016 some people had raised concerns about the time it took staff to answer calls bells and on occasion we had found that people had waited for over 30 minutes before receiving the care and support they required. Managers were monitoring call bell answering times and were supervising staff to ensure people were not being put at risk of their needs not being met. On this inspection we found that care staff were responding effectively when call bells were sounded. People told us that there were times when they were required to wait for anything up to five minutes and one person said that they had waited for ten minutes on one occasion. We could see that managers were monitoring call bell answering times diligently and they had secured significant improvements in response times. They produced reports which showed that any call bell not responded to within five minutes was identified and addressed with the team of staff on the floor at the time.

We looked at staff rotas for day and night staff, ancillary staff and cooks and could see that there were enough staff on duty to provide safe and effective care. All of the people we spoke with were satisfied with staffing levels. Nurses were seen to work hands on alongside care staff providing effective care and sensitive support. This provided for a positive atmosphere in the home with the majority of people glad to inform us that they received safe and effective care.

Recruitment and selection of staff was carried out safely with appropriate checks made before new staff started working in the home. This reduced the risk of employing unsuitable people.

Our observations during the inspection were of a clean, fresh smelling environment which was safe without restricting people's ability to move around freely. Staff had access to and used personal protective clothing when delivering care as well as when serving food.

The provider had received a four star rating in food hygiene from the local Environmental Health Department. The manager told us that she had received the report and was working with kitchen staff to ensure that a five star rating was archived on the next visit from the Environmental Health Officer. The manager subsequently informed us that the Environmental Health Officer had visited again and awarded the home a five star rating. A five star rating is the highest rating for food hygiene which can be achieved.

We checked some of the equipment in the home, including bath hoists and saw that they had been subject to recent safety checks.

We found that the people living in the home had an individual Personal Emergency Evacuation Plan (PEEP) in place. PEEPs are recommended by the fire authority and would be used if the home had to be evacuated in an emergency such as a fire. They provide details of any special circumstances affecting the person, for example if they were a wheelchair user.

Following notification of an incident where a person suffered injuries following a fall we looked at how risk was managed in respect of falls. Where people were assessed as being at risk of falls they were provided with a nurse call pendant which they wore on their person. This enabled them to summon assistance in an emergency if they were unable to reach the nurse call bell in their rooms or bathrooms. Falls risk assessments were kept under review and were updated and revised in response to any identified risks. The

registered manager analysed all accidents and incidents to ensure people received the right support to prevent them from further injury.

Good

Is the service effective?

Our findings

All the people living at the home who we spoke to and their family members made positive comments about the home and the standard of care received. Comments included: "I have been here four years the girls are wonderful, the care is excellent and the food is good", "I could not cope at home because I can't stand so they move me with a hoist and I feel more confident here and I am well looked after" and "I cannot find a single fault with anything, and I've been here eight years and I think it is a very nice place and the staff work very hard". Comments from family members included: "They (Nurses and care staff) help (relative) with medication and food and they are friendly and considerate with them, in fact they are like part of the family because, I see them every day".

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 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).

At our last inspection in August 2015, we found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005.

On this inspection we found that significant improvements in compliance with the MCA had been achieved but more needed to be done to ensure that all mental capacity assessments recorded what assistance had been given to help people make decisions. The registered manager acknowledged this and told us that the home's quality assurance procedures had identified that staff needed further training and development regarding the Mental capacity Act and DoLs.

The provider had policies and procedures to provide guidance for staff on how to safeguard the care and welfare of the people using the service. This included guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the manager had applied to the supervising authority for DoLS where appropriate.

Records showed that 11 of the people who lived at the home were subject to a DoLS or an application had been made to the supervising authority. We were able to view the paperwork in relation to both standard and urgent DoLS applications and could see that they were being completed correctly.

Mental capacity assessments were in place where appropriate and people were receiving support to help them with their decision making. However, we found two instances where mental capacity assessment had not been completed in accordance with the MCA code of practice. Staff had completed the two stage test

confirming that the person had a mental impairment but only ticked the boxes as to whether the person could understand, retain, weigh or communicate their decision. The MCA code of practice requires that those completing mental capacity assessments explain why the person was unable to understand, retain, weigh or communicate their decision and state what steps they have taken to help the person understand the questions put to them. In both instances staff recorded how the decision was made in the person's best interest, with involvement of their relatives so there was no detriment to the person. This did not comprise a breach of the regulations but staff must record their assessment in full to ensure people always receive the right type of support to assist their decision making.

The quality of the food and its presentation was a topic which all people were happy to discuss. Their comments varied but most people told us they were content with the quality and variety of food provided. Comments included: "The food is good", "I think the food is excellent, plain English just as I like it and I prefer to eat my meals in my room and be in bed about 4.30 because eight hours is enough being in the chair", and "The quality of the food is good I like stuff like chicken and potatoes with veg and we get tea and biscuits throughout the day".

The menu provided a variety of home cooked foods. The home followed a four week flexible menu which was called the principle menu and was set by the corporate provider. The menu posted in the dining room offered a number of choices for lunch and evening. People were asked what they would like at every meal time. Special diets such as gluten free and diabetic meals were provided if needed and people told us that an alternative was always available if one did not fancy what was on the menu.

We could see from records that people were being assessed for their nutritional needs with nutritional assessments on their records and regular recording of their weight. There was evidence of referrals to the speech therapy team for swallowing assessments and the dietician with people receiving fortified drinks and specialist diets, where appropriate. We saw that people had put on or lost weight after following dietician recommendations. Whilst these recommendations were followed, care plans did not always reflect the care being implemented. For example we noted that one person who received nutritional support via a percutaneous endoscopic gastrostomy (PEG) had lost noticeable weight over a four-week period. However, when this was discussed with one of the nursing team, they told us that this was a planned weight loss advised by the dietician, but there was no mention of this in the person's care plan. The manager explained she was not aware of any planned weight loss, and on further investigation, clarified with the Inspector that no weight loss plan was in place as the resident was still receiving food orally as well as by PEG. The Nurse incorrectly informed the inspectors. However, this did not explain why the variation in the person's weight was not addressed in their care plan. (A "PEG" is a medical procedure by which a tube is passed into a patient's stomach through the abdominal wall. Food is passed through the PEG tube at prescribed regular intervals, so the person receives adequate nutrition.)

People were supported to access healthcare services. For example one person's care records demonstrated that they presented with symptom of a specific health condition and were seen by their doctor who responded promptly and arranged the appropriate treatment urgently. There was also evidence of referrals within people's records, to doctors, the optician, dietician, speech therapist and physiotherapist. Subsequent visits from health care professionals were recorded so staff members would know when these visits had taken place and why.

Care records showed that people benefited from an assessment of their needs before their admission to the home. Nursing and care staff presented as caring and compassionate. They had a good understanding of peoples' needs, their likes, dislikes and personal preferences. Throughout our visit we saw that staff took

time to ensure to engage with the person before providing care and support. They were courteous and polite and patient affording people time to understand and engage. All people spoken with spoke highly of the staff and the care they received. They told us that they were treated with respect and were made to feel valued and involved.

Care and nursing staff told us that they were well supported and benefited from regular supervision with their respective line managers. We looked at staff supervision records and saw they were comprehensively documented and focused on learning, development and staff welfare. The registered manager kept a summary document of supervisions which recorded which staff had received supervisions and appraisals and those which were due. We found that the summary document was accurate as dates recorded tallied with supervision records in the relevant staff members' files. We could see that all staff benefited from an annual appraisal. Records of appraisals were comprehensive and well documented. We saw that staff were sent an appraisal preparation document so they could articulate what was important to them in their role and what they would like to discuss at the meeting. Staff told us that appraisals and supervisions were well managed and useful. They praised the new manager advising us that they were transformational in their management style and that they gave staff confidence in their role and encouraged them to take responsibility for their own development, ensuring they performed to the highest level possible.

Nursing and care staff told us that they benefited from a comprehensive range of training opportunities. One staff member said: "I have undergone lots of training including safeguarding, tissue viability, moving and handling, fire marshall training and added that the management were bordering on being overzealous where training is concerned".

We could see that new starters benefited from a comprehensive induction. The home's induction training pack included the Care certificate framework. The Care Certificate provides clear evidence to employers and people who receive care and support that the health or social care support worker in front of them has been assessed against a specific set of standards and has demonstrated they have the skills, knowledge and behaviours to ensure that they provide compassionate and high quality care and support.

Training records were found to be accurate and up to date. They showed that staff had received training on a broad range of relevant topics including: Basic Food Hygiene, Behaviour that we find challenging, Fire Training for Care Home Employees, Complaints Handling in Bupa Care Services, Control of substances hazardous to health (COSHH), Dementia and Cognitive Issues, Infection Control, Medication Awareness, Mental Capacity Act and DoLS, assisting people with their mobility, Nutrition & Hydration, Pressure Ulcers , Safeguarding, Nutrition & Hydration, and others specific to each staff members various roles and responsibilities. Staff told us that managers checked their knowledge on important topics at regular intervals to ensure their skills were up to date. We checked one staff member's file and found that they had recent knowledge checks on: Safeguarding, Information handling, staying safe, COSHH, Malnutrition Universal Screening Tool, Falls prevention and Tissue viability. We noted however that one staff member had completed training on the Mental Capacity Act in 2012 and had not had a refresher since or had their competency assessed. The manager gave assurances that further training on the MCA and DoLS was planned to take place in the near future.

The premises were scrupulously clean, well decorated, well-furnished and well equipped with a range of aids to promote independence and assist people with their mobility. Where people were assessed as being at risk of falls they were provided with a nurse call pendant which they wore on their person. This enabled them to summon assistance in an emergency if they were unable to reach the nurse call bell in their rooms or bathrooms. The manager informed us that the home is due a comprehensive refurbishment in the near future and that further consideration would be given to how the home's décor might assist people with

orientation around the building.

Good

Is the service caring?

Our findings

All the people spoken with during our inspection made positive comments about the staff and the standard of care provided. They praised the care staff and told us that they were always treated with dignity and respect. We asked them if they felt involved in decisions made about their care and whether they felt valued and listened to. Comments included: "Oh yes they address me by my preferred name, we have resident and relatives meetings but at any time if you say anything or ask for anything it is attended to", "I have been here before and they know me. I have had a stroke and they know exactly how to look after me and assist me with washing and dressing", "I can have a bath when I want one, the staff are very good" and "I am not unhappy with anything, I have choices as to what I can eat, and I enjoy living here".

We observed effective and positive interactions taking place between people and staff throughout the day. One person, who had decided to remain in the dining room to listen to music, was checked upon regularly by staff who ascertained that they remained happy to be on their own. Staff were observed to knock on doors before entering a person's room. People were dressed appropriately and staff encouraged people to maintain their independence, for example by supporting them to have their meals independently if they wished or have access to quiet areas in order to listen to music.

The staff members we spoke with showed that they had a good understanding of the people they were supporting and they had a good understanding of how to promote dignity and respect.

We saw that the provider was aware of equality and diversity issues and responded to these. For instance assistive technology was used where possible to promote independence including people with hearing difficulties being provided with specialist technology to help them hear the television.
We found that the registered manager and staff were knowledgeable about human rights and the importance of promoting equality and valuing diversity. One of the people who lived at the home did not speak English as their first language. Their relatives told us that they had lived at the home for over a year and were very happy. They told us that their relative had settled in very well and they were always made to feel welcome. They said "The staff know them well and they know what they need and they ask him things and he nods if he understands and they take it from there, like if he wants the toilet or another blanket. Some of the staff learnt a few (their native language) phrases so they can communicate better with him". Other relatives told us how they had been made to feel welcome and one said: "it is like being in a big family".

We saw that personal information about people was stored securely which meant that they could be sure that information about them was kept confidentially.

The provider had a range of information available for people living in the home in the reception area as well as a welcome booklet that was kept in each person's room. One person showed us the menu which had been delivered to them in their room to help them make an informed choice. There were leaflets inviting feedback and photographs of recent activities that had taken place in the home, as well as the latest activities programme. The latest CQC inspection report was also available for people to view as were notes

taken from recent residents and relatives meetings.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in June 2016, we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not maintain accurate, complete and contemporaneous records of care provided.

Information from the local authority indicated that visits they had carried out in August 2017 found that some progress had been made in regards to maintaining accurate and contemporaneous records of care interventions but further development was required. They told us that they had found gaps in repositioning charts and fluid charts that were incomplete and inaccurate. Mental capacity assessments were found to lack important information and care plans and risk assessments were judged not to be sufficiently person centred or updated.

The registered manager and the care services manager told us that they were making a concerted effort to ensure that records of people's care were accurate and sufficient to ensure their safety and wellbeing.

On this inspection we found that staff were aware of the importance of accurate and up to date record keeping but identified gaps in recording that could put people at risk. For example some people had been identified as being at risk of malnutrition and/or at risk of becoming dehydrated. Care records, hand-over sheets and charts relating to people's food and fluid intake over a twenty-four-hour period did not always accurately record what people had been offered to eat or drink. The records for two people showed that they had not been offered sufficient fluids throughout the day and that they had not been offered anything else to drink throughout the following night .Both of these people looked to be well hydrated and we accepted the manager's explanation that people were being offered sufficient fluids but staff were not keeping adequate records.

We also identified gaps in the positioning charts of a person who had been assessed at high risk of developing pressure sores. The person's skin was intact and again we accepted the manager's explanation that the person would have been repositioned in accordance with the care plan but again staff failed to make a contemporaneous record.

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

The manager told us that she had been working closely with staff through training and direct supervision and where necessary had taken disciplinary action to improve the standard of recording in the home and acknowledge that further improvements were required to ensure people received safe and effective care. The local authority praised the new manager for her determination to address this issues and had confidence that, with the measures taken, sufficient improvement would be made in the near future.

Everyone in the home at the time of our inspection had received a pre-admission assessment to ascertain whether their needs could be met. We looked at the pre-admission paperwork on the care plans that we

viewed and could see that assessments had been completed.

We looked at the care plans for five people and found that care was not always planned in accordance with the principles of person centred care. Person centred care is an holistic approach to care that takes into account the whole person, not simply focusing upon their condition or symptoms but also their preferences, well-being and wider social and cultural background.
Some of the care records seen were task focused and there was limited information about people's social histories or backgrounds for staff to understand each person well. When this was discussed with the registered manager, they told us that they had identified that some care plans did not follow the principles of person centred care and were in the process of addressing this through supervision and further training of the staff team.

The manager and staff presented as compassionate and caring. They told us that they were committed to supporting people at the end of their lives to live and die well with dignity and respect. They told us that they worked in partnership with the individual, their families and other organisations to deliver the best quality of care possible. However, we found inadequate care planning for one person who was considered to be at or nearing the end of their life. This person had been admitted to the home for palliative care. They were living with dementia and other conditions which put them at high risk of developing severe pain and other health care complications such as anxiety. Their doctor had prescribed anticipatory end of life medicines designed to enable prompt symptom relief. However, there was no end of life care plan, developed with the person and their loved ones. Staff had used the "Abbey Pain Assessment to ascertain whether this person was experiencing pain but this had not been updated in over one month and not since the anticipatory medication was prescribed. When we spoke with this person and their relative, they told us that they were well cared for and comfortable. However, they did have concerns about dignity and privacy issues and would have appreciated opportunity to address these with nursing and care staff through the care planning process. The care planning documentation which staff had used to plan their care was designed for a person planning to stay in the home on a short stay or respite basis. The Clinical Services Manager (CSM) told us that this should not have been used for a person admitted to the home for palliative care. It included an entry which indicated they had "not expressed any likes or dislikes" regarding personal care. There was no care plan which addressed this person's personal care needs, no record of their personal preferences in this regard or evidence that such issues had been discussed with their loved ones. The Manager was then informed of this by the inspector who stated that the CSM was going to change this care plan to a fully detailed plan of care.

The above comprises a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that appropriate 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) records were in place on three of the care files we reviewed. We saw that either, the person, or where appropriate, their relative or health professional had been involved in the decision making process. We found that the records were dated and had been reviewed and were signed by a General Practitioner.

A 'Do Not Attempt Cardio Pulmonary Resuscitation' form (DNACPR) is used if cardiac or respiratory arrest is an expected part of the dying process and where cardio pulmonary resuscitation (CPR) would not be successful. Making and recording an advance decision not to attempt CPR may help to ensure that the person dies in a dignified and peaceful manner.

People told us that they were listened to and their complaints were taken seriously. One person said: "Oh yes they listen, and take us seriously, I made a complaint and they sorted it out straight away no fuss". One

of the relatives spoken with told us that they had a meeting with the manager three weeks ago to discuss certain aspects of care. They said "the manager listened to me" and told us they were reassured by the action taken and records kept which showed their relative's needs were being met.

The home had a complaints policy and processes were in place to record any complaints or compliments received and to ensure that these would be addressed within the timescales given in the policy. Copies of leaflets were available in the reception area and the policy was also set out in the welcome documentation. We looked at the complaints records and could see that a total of 11 complaints had been received since the beginning of 2017. We looked at two of these in detail and could see that these had been investigated fully and dealt with appropriately.

The provider employed an activities co-ordinator, who was described by many people living at the home as excellent. Their job was to help plan and organise social or other events for people. Comments included: "The activities coordinator is brilliant; they take me down in my wheelchair when anything is on. I particularly like the choir. As I say (activities coordinator) is outstandingly good at what they do. Today it's manicures and Holy Communion" and "There are a lot of activities and they had a party for me when I was 100". Relatives also made positive comments including: "They try to involve (relative) as much as they can, (relative) likes going to watch the choir and when they bring the birds in and they take him down in his chair so they are very good with him".

The registered manager told us that she had been working closely with staff through training and direct supervision and where necessary had taken disciplinary action to improve the standard of recording in the home and acknowledge that further improvements were required to ensure people received safe and effective care. The local authority praised the new manager for her determination to address this issues and had confidence that, with the measures taken, sufficient improvement would be made in the near future.

Requires Improvement

Is the service well-led?

Our findings

When we carried out our last inspection of Hazelmere House Care Home in June 2016 we found that it was not always effective, responsive or well led. We identified that there were recurring themes where improvements needed to be made in care planning, care monitoring and review, record keeping, need for consent and quality assurance procedures. This inspection has identified breaches in the regulations on safe care and treatment, and good governance.

The new registered manager told us that on taking up their position in the home they had carried out their own assessment of the home's compliance with the requirements of the Health and Social Care Act 2008 and associated Regulations and had identified that significant improvement was required to ensure the safety and wellbeing of the people who lived at the home.

All the people spoken with during this inspection including the people who lived at the home, their relatives, staff and representatives of the local authority spoke highly of the new manager. People who lived at the home and their relatives told us that the new manager listened to them, took them seriously and took effective action to improve the quality of care provided.

Nursing and care staff who presented with buoyant morale told us that the new manager was supportive, informative and involved them in developing solutions to problems and improving the quality of care provided. One of the care staff spoken with said: "I feel much more comfortable and confident in my role since the new manager has arrived". They gave an example as to how the new manager had listened to staff concerns and worked to improve moving and handling techniques and training, which resulted in a safer environment for both the people who lived at the home and staff. They gave another an example of effective leadership when the new manager played an active part in staff training on safeguarding vulnerable adults. They told us that the new manager had helped staff to identify where they lacked confidence and worked with them to develop their skills and knowledge. They said they felt much more confident in completing a referral themselves. They also said they liked the new manager's style of management which was said to be: "more democratic and consultative".

A representative of the local authority told us that the new manager was working diligently and effectively to improve the standards of care at the home but they were aware that there was much to be accomplished to ensure the safety and wellbeing of the people.

We could see that Hazelmere House Care Home had an established quality assurance system in place and we could see that audits were being completed on a regular basis by the registered manager, the hotel services manager and other senior staff. There were also external audits carried out by the provider's quality assurance team and the regional director.

We found that some of the checks and audits undertaken by the management team were not always effective because they failed to identify the areas of concern we identified during our visit. For example, we found that concerns highlighted by us on the 28 November 2017 had not been addressed satisfactorily when

we visited again on the 21 December 2017.

On the 28 November we identified that three of the people who lived at the home were at increased risk of pressure sores because staff had not set their pressure relieving mattress on the correct setting. The Clinical services manager had taken action to address these concerns on the 28 November and instigated a safety check which required staff to check on a daily basis whether each person's pressure relieving mattress was set correctly.. When we visited on the 21 December we found one person's pressure relieving mattress was again set incorrectly. We looked at the safety checklist for this person and could see that their pressure mattress had been consistently set incorrectly since the 28 November 2017. No senior member of staff or clinical manager had checked to see whether staff were setting the mattress on the correct setting and the checklist was ineffective.

We also found a number of inconsistences in people's care records about their needs and care and inadequate recording of the care provided in one case. This had not been picked up by the provider's care plan audits. These examples demonstrated that some of the systems in place to monitor and address quality and safety issues were ineffective because they failed to mitigate potential risks to people's health, safety and welfare.

The above comprised a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. The provider had not always assessed, monitored and improved the quality and safety of the service provided in the carrying on of the regulated activity.

We saw there were quarterly full staff meetings, the most recent on the 28 November 2017.The minutes of this meeting showed that there was an extensive agenda with items discussed including: training, phones, care plans, recruitment, staffing. The minutes were very well documented and clear with a good attendance of staff. Other meetings included, Housekeeping Staff meeting 16 November 2017, Kitchen staff meeting 15 November 2017, Nurse and senior care staff meeting 10 November 2017. The minutes of these meetings recorded a number of examples where changes had been made as a result of staff suggestions.

A staff survey was completed quarterly called "People pulse survey". We looked at the results of the survey from April 2017and saw there were high levels of staff satisfaction at the home, any actions identified for further improvement had been progressed for example, nurses group supervisions had been introduced.

Resident involvement was evidenced by meetings minutes and a policy relating to resident involvement, which was reviewed in June 2017. The most recent residents meeting was held 23 November 2017 with eight people, five relatives and four staff present. The minutes of the meeting were comprehensive and illustrated that the registered manager had responded to the points raised. The minutes were colour coded with the issue typed in black, the action typed in blue and the resolution typed in red to make them easier to read.

The registered manager was aware of incidents in the home that required the Care Quality Commission to be notified of. Since the day they started work in the home they had been open and candid with us and had submitted statutory notifications as required.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The report from the previous inspection for Hazelmere House Care Home was displayed in the foyer for people to see and publicized on the

provider's website.

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 12 HSCA RA Regulations 2014 Safe care and treatment Measures designed to reduce risk were not always put into practice so people remained at risk of harm.

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 The provider did not maintain accurate, complete and contemporaneous records of care provided. The provider had not always assessed, monitored and improved the quality and safety of the service provided in the carrying on of the regulated activity.