Hazelroyd Limited

Hazelroyd Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Hazelroyd Nursing Home is a nursing home providing personal and nursing care to 23 people aged 65 and over at the time of the inspection. The service can support up to 30 people.

People's experience of using this service and what we found
People were not safe. There were not enough staff to give people the care and support they needed or to keep the home clean. Standards of building maintenance and cleanliness were poor and infection control procedures were not always followed.

Risks were not assessed or managed appropriately. There were no processes in place to learn lessons when things went wrong.

People were protected from abuse, but consideration had not been given to the isolation many people were experiencing due to having to stay in their rooms because of the broken lift.

Medicines were managed safely.

Systems were in place to support people to have choice and control of their lives, but this was minimised for some people because the lift did not work. The provider had not adequately assessed or minimised the impact of this on people's freedom to get to the lounge, dining room and outside areas. There was also impact on visitors who needed to use the lift to visit their relatives.

Staff did not receive the training they needed to equip them with the skills and competencies to do their job. Staff were recruited safely.

People had access to healthcare professionals within the home, but some healthcare appointments had been missed due to the lift not working.

People's nutritional needs were met.

People and relatives gave mixed feedback about the care people experienced. People's privacy and dignity was not always maintained.

Care was not always planned with a person-centred approach. Some people were restricted in accessing activities due to not being able to leave their rooms.

The service was not well-led. The registered manager had left the service and the interim manager was absent from the service for several weeks. The provider's quality assurance systems were not effective in identify and addressing issues.

Following this inspection, we contacted the infection control team and building control team to make them aware of our concerns.

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

Rating at last inspection
The last rating for this service was Good (published December 2018).

Why we inspected
The inspection was brought forward because of concerns shared with us by the local authority and the infection control team.

We have found evidence that the provider needs to make significant improvements. Please see all sections of this full report.

Enforcement
We have identified 5 breaches in relation to safe care and treatment, staffing, person centred care, premises and equipment and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will continue to work with the local authority and clinical commissioning group to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Hazelroyd Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors and an assistant inspector on the first day and two inspectors on the second day.

Service and service type
Hazelroyd Nursing 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.

The service did not have a manager registered with the Care Quality Commission. In the absence of a registered manager the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This Inspection was unannounced

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service and two relatives about their experience of the care provided. We spoke with ten members of staff including the service lead, nurses, care workers, cleaning staff and catering staff. We spoke with the provider following the inspection.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with the provider who gave us assurances they were taking action to address issues identified during the inspection.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Several areas of the building were affected by damp, this included a food storage area, the laundry room and some people's bedrooms. We saw black mould around the window and on the wall in the bedroom of a person who was nursed in bed. This person had moved rooms when we returned for day two of the inspection. Some tiled walls in the basement were bowed. We asked the business manager to get the opinion of a structural engineer which was completed between the days of inspection. They identified the main problem as being damp. We made a referral to the local authority building control team.

● A letter of 'Fire safety matters' sent to the provider in February 2019 by the fire authority raised concerns about staff not being able to ascertain the location of a fire due to issues with the fire panel and recommended 'upgrading the fire alarm to a fully addressable system'. It also recommended further training for staff. Neither of these recommendations had been fully actioned with 25 staff not having recent fire training.

● A flagstone on the accessible patio had lifted and presented a trip hazard. This was directly above the staff room which had a large hole in the ceiling.

● The door to a communal toilet had a hook and catch on the outside. This presented the risk of somebody being locked in the room.

● Water temperatures in the home were very variable. The hot water in one person's washbasin was 50 degrees centigrade. This is hot enough to scald. There were no up to date checks of water temperatures and no action had been taken to address this when we returned for the second day of inspection. Staff told us there was not always hot water available. They said this happened after people had baths. Water temperature checks for January, February and May 2019 recorded 'No hot water' in a number of bedrooms.

● Not all personal risk assessments in people's care files included detail of the risk could be reduced.

● The passenger lift at the service had not been working for several months which meant some people could not access communal areas and were at risk of isolation due to having to stay in their rooms. There were no risk assessments in place in relation to this.

● People being cared for in their rooms did not always have access to their call bells. This included a person who was blind and therefore had no means to alert staff. One person told us they were "lost without the call bell."

● The system for safety equipment such as pressure mats was not compatible with the nurse call system. This meant alarms did not sound in a timely way to alert staff that people may be at risk. One pressure mat had an installation date of October 2017 with the instruction to replace within one year of that date.

● A health and safety audit completed by the provider in June 2019 identified a number of areas where safety standards were not met. There was no evidence of these findings being transferred to an action plan.

Not assessing and managing risk to ensure the safety of people was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● A recent inspection by the local authority infection prevention and control advisor had raised a number of issues. There was little evidence of these issues having been addressed.
● Lounge chairs were visibly dirty and odorous. We had to ask for these to be cleaned.
● Some mattresses were odorous but clean bedding had been put over them.
● Toilets were not always clean.
● No bed pan washer was available. Staff told us they cleaned bed pans by emptying them down the toilet and then cleaning them. When questioned about this some staff said they rinsed bed pans in the sink.
● Cleaning staff told us they struggled to keep on top cleaning the service.

Not ensuring safe systems to prevent the spread of infections was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough staff to meet people's needs safely and in a timely way. For example, on the first day of the inspection, two people had not received personal care before lunchtime. One of these people told us they had not been supported to wash or receive continence care since during the night. They said they "Felt a nuisance as staff are so busy".
● Staff told us they struggled to meet people's needs, particularly during the morning and at meal times, due to people's complex needs.
● The service lead told us 13 of the 15 people being nursed in bed required support with their meals. They said some people needed a long time to eat and therefore other people had to wait for long periods of time for their meal.
● A visiting relative told us there were not enough staff.
● Procedures for recruiting new staff were safe.
● Following the inspection, the provider told us they had reviewed and increased staffing at particular times of the day.

Failure to ensure sufficient numbers of staff were deployed to meet people's needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Safe systems were in place for administration of medicines, but room temperatures were not recorded in all areas of medicine storage. A large stock of prescribed supplements were stored in a cleaning cupboard which also housed an immersion heater. This meant the room was much too warm to store the supplements. The supplements were disposed of by a nurse during our inspection.
● Protocols for medicines prescribed on an 'As required' (PRN) basis were in place but record had not been made about the effectiveness of the medicine.
● Creams and lotions were applied as prescribed.
● Thickeners for drinks were used safely.

Systems and processes to safeguard people from the risk of abuse
● Staff understood safeguarding and knew what to do if they thought somebody was at risk.

Learning lessons when things go wrong

● There was no analysis of accidents and incidents which meant any trends for which action could be taken to mitigate the risk had not been identified.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff were not up to date with training. This included training in fire safety, moving and handling, infection control and nutrition and hydration.
- Some staff said they had received supervision with their manager whilst others said they had not. Staff said the service lead was supportive.

Failure to ensure staff received the training they need to support them to deliver care safely was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law. Ensuring consent to care and treatment in line with law and guidance

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Assessments of people's mental capacity were completed, and effective systems were in place to make sure DoLS applications were made as needed. Records showed process had been followed when decisions needed to be made in the best interests of people who lacked capacity.
- The service lead told us they were in the process of acting to comply with conditions on one person's DoLS authorisation.
- Reviews of care plans in relation to DoLS did not always accurately reflect when the DOLS had expired.

Supporting people to eat and drink enough to maintain a balanced diet

- People differed in their opinion of the food they received. Some said it was good, but one person said "Food is awful, used to be really good"
- Staff struggled to give people the support they needed at mealtimes. This was due to the number of

people who needed support in their rooms.
● Catering staff provided meals which met people's individual needs.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● One person had missed two important hospital appointments due to the lift being out of order which meant they could not leave the home. The service lead told us they had arranged for a private ambulance service to support the person to a rearranged appointment, however we were concerned this had taken several weeks to organise.
● Records showed staff arranged for healthcare professionals to visit people as the need arose.

Adapting service, design, decoration to meet people's needs
● The provider's plans for refurbishment and redecoration of the service had been affected by the breakdown of the lift. Although some redecoration had taken place, further work was needed to provide a pleasant environment and make sure surfaces could be cleaned effectively.
● Four people were unable to access baths or showers due to the lack of such facilities on the unit they resided on. Due to the lift being out of order they could not access facilities on other floors. A further six people were unable to use bathing facilities due to baths not being able to accommodate the equipment people needed to bathe safely. For example, none of the bathrooms had been adapted to meet the needs of people who needed to use a hoist with bathing sling.
● A toilet on the ground floor had a hook and catch on the outside of the door. This meant the room could not be easily accessed and also presented the risk of a person being locked in the room.
● The provider gave us assurances following the inspection that a suitable lift had been identified and would be fitted as soon as possible.

Failure to provide safe and suitable equipment to meet people's needs was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- One person told us they were very disappointed with the room they had to move into due to the issue with the lift. We saw the person had moved from a very large room with its own facilities to a very small room which could not accommodate the person's furniture. The person told us they felt 'hopeless' and wanted to move out.
- The activities co-ordinator had supported a person to attend events which met with their needs in relation to diversity.
- One person said, "The staff are lovely, kind. Treat me well". Relatives differed in their opinion of the care provided. One told us staff were caring but another said, "They don't care, not really".
- Staff appeared caring and were apologetic to people who were having to wait for their care needs to be met.

Supporting people to express their views and be involved in making decisions about their care

- Care records did not routinely include evidence of people being involved in making decisions about their care. The service lead told us it was their intention to work with staff to make sure people were included in the care planning process to make sure their opinions and decisions were recorded and respected.
- Although a 'Resident of the day' programme was in place, we found this was not being followed. For example, we heard a staff member asking a colleague who the resident of the day was as they were finishing their shift.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity needs were not always considered or met. We observed staff holding a handover meeting, in which personal details of people were discussed, in front of people who lived at the home.
- A ground floor lounge had been made into a bedroom for one person. On the first day of the inspection, we saw the person's bedroom furniture had not been brought to their new room and their personal items and clothing were on display. The door to the room was held open. We expressed our concerns to the service lead. On the second day of the inspection we found the room to be in the same state but saw wheelchairs and a laundry trolley were being stored in the room. This demonstrated a lack of respect for the person's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care records contained some information about people's preferences but lacked evidence of a wholly person approach. 'This is me' documents were included in care files, but some were blank, and others did not include detail of what was important to the person. For example, one person's religious needs had not been mentioned in their 'This is me' when other records indicated this was important to them.
- One person's records evidenced they displayed some behaviours that might challenge. Staff had recorded this as 'in a bad mood' or 'aggressive'. Where the record asked for a resolution of this behaviour staff had recorded they 'walked away'. This meant the person was not supported to resolve their feelings which resulted in their behaviour.
- Care was not always planned with a person-centred approach. For example, a bath list was in place and a care worker told us it was the nurse's decision when people were supported to have a bath.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- One person was living with a sensory deprivation, but we saw no evidence of how this person was supported to meet their needs in relation to this. The person spent their time alone in their room and we found they were unable to access drinks or their call bell.

Failure to provide care and support to meet people's individual needs was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

- A member of care staff said the broken lift had an impact on the social aspect of the service because some people were isolated in their rooms. They said staff tried to spend time with people but there was a lack of social engagement.
- One person told us they liked to go to the communal areas but couldn't due to the lift not working. They said they missed speaking with another person living at the home and wanted to know how they were doing. They said they missed the company.
- One person's relative was experiencing significant difficulty in visiting their relation because of the broken lift.

● An activities organiser worked at the service five mornings each week. They were very enthusiastic and engaged people in a variety of activities. The number of people able to join in was very restricted because of the broken lift. On the first day of the inspection the activities organiser had decorated the conservatory with American memorabilia to celebrate Independence Day. They had a popcorn machine and had organised for the lunchtime meal to have an American theme.

Improving care quality in response to complaints or concerns

●One person's family had written a note on a whiteboard in their relative's room. The note was in relation to concerns about the care provided. We asked the service lead if staff had made them aware of these concerns and they said not. This meant staff were not recognising complaints and reporting them appropriately.

End of life care and support

● Care plans included some information about people's wishes as they approached the end of their lives although some lacked specific detail. We saw the review of one person's care plan dated December 2018 said 'Arrangements yet to be discussed' but there was no evidence of this discussion having taken place.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

- Some systems for auditing the safety and quality of the service were in place but these were not robust and had failed to identify many of the issues we found during the inspection.
- The provider had failed to respond appropriately to issues which could affect the safety of people living and working in the service. For example, fire safety, environmental safety and infection control.
- The lift had not been working since March 2019. The provider had failed to recognise, or put systems in place to mitigate, the impact this had on people's daily lives and the additional pressure on staff.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; and how the provider understands and acts on duty of candour responsibility.

- The previous registered manager left the service in April 2019. The provider had employed an interim manager shortly before the inspection, but they were absent from the home for a period of five weeks. The service lead was managing the service, but they told us they were struggling with the responsibility due to not having any appropriate training or experience which meant they were unsure of regulatory responsibilities. The service lead was aware of issues within the service and was working hard to address them but felt unsupported.
- A visiting relative told us they had no idea who the manager was and did not know what was happening in the home. Staff told us they did not think the home was well run although they thought the service lead was supportive. They said they felt demoralised and did not have confidence in the provider. One said, "I could cry, things have got quite bad".

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of person-centred approach and many people were experiencing deterioration in the care and support they received. This was largely due to many people not being able to leave their rooms because of the lift and the additional pressure this was having on staff.
- People did not know what was happening at the home and one told us they wished to leave.

Working in partnership with others

- The provider had been working with the local authority but had failed to act appropriately on advice from other professional bodies.

We found no evidence that people had been harmed however, systems were either not in place or robust

enough to demonstrate safety and quality of service were effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care Care and support was not delivered with a person centred approach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People did not have access to equipment necessary to support them to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Not enough staff were available to meet people's needs effectively. Staff had not received the training they needed to support them in their roles.