

The Park Gate Care Home LLP

Hamble Heights

Inspection report

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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 well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Hamble Heights is a nursing home providing personal and nursing care to up to 60 people. The service provides support to older people some of whom may be living with dementia. At the time of our inspection there were 46 people using the service. Hamble Heights provides care for people over 4 floors, each floor providing specialist care to people living with different needs, for example, one floor delivers specialist dementia care and another residential care.

People's experience of using this service and what we found

People using the service were not always kept safe. We could not be assured risks associated with people's needs were always assessed appropriately or managed. A lack of robust record keeping meant we could not be assured people were getting enough daily fluids and being repositioned in line with their care plan. We could not be assured risks associated with people's needs were always assessed appropriately or managed. Care plans sometimes lacked information to keep people safe.

Environmental risks were not always managed effectively; Staff did not have regular fire evacuations to keep people safe. Peoples risk assessments were sometimes missing key information to keep them safe and to support staff.

Medicines administration records (MAR) confirmed people had received their medicines as prescribed. However, we found some concerns with medicines that wasn't always safe. The service has since put in some measures to improve medicines. Health professionals felt people were not always kept safe as improvements were required to meet people's clinical needs, especially around pressure area care.

Governance systems were not always effective in promoting a person-centred culture. A new manager was in place and was working to ensure new systems were in place and effective and was getting to know people at the service. There were systems in place to monitor the quality and safety of the service provided, however these were not always effective in identifying areas for improvement or where safety had been compromised.

Relevant recruitment checks were not always completed. For one staff member there were gaps in their employment history which meant the service could not check the staff members employment history to make sure they were of good character and had the necessary skills. Staff received support and one to one sessions or supervision to discuss areas of development. They completed training but some further clinical training was required. Systems were in place to protect people from abuse. Sufficient staff were deployed to meet people's needs.

People were supported with their nutritional needs. People received varied meals including a choice of fresh food and drinks. Staff knew people well and treated people with kindness and compassion

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 29 January 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last 3 consecutive inspections. We will describe what we will do about the repeat requires improvement in the follow up section below.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of some regulations.

Why we inspected

The inspection was prompted in part due to concerns received about poor pressure care, lack of fluids and staffing. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations

We have identified breaches in relation to safe care and treatment 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below

Requires Improvement ●

Hamble Heights

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

Two inspectors carried out the inspection with the support of a registered nurse 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.

Service and service type

Hamble Heights is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Hamble Heights is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 4 months and had submitted an application to register. We are currently assessing this application.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 7 people and 3 relatives who used the service about their experience of the care provided. We spoke with 12 members of staff including the manager, deputy manager, clinical lead, operations manager, maintenance manager, head of quality, clinical manager, registered nurses, care practitioner and the chef.

We reviewed a range of records. These included 6 people's care records and multiple medication records. We looked at 4 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.

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received feedback from 15 relatives. We also received feedback from 2 health and care professionals.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Medicine administration records (MARs) confirmed people had received their medicines as prescribed. However, some records had missing photographs of people for identification. We spoke to staff and they are ensuring this is all up to date.
- Topical medicines administration records were in place. However, we found gaps in some records so could not be assured these were always applied as directed.
- Some people required their drinks to be thickened with a prescribed thickener to reduce the risk of aspiration. These were prescribed individually and kept securely. However, records viewed contained conflicting information about the level being administered. For example, for one person the MAR stated that they were to have level 2 thickener, but it was noted on the GP round that they were to have level 3. This was in total contrast to the instructions relayed from the speech and language therapist who assessed the person whilst they were at a recent hospital visit and indicated they could have normal fluids.
- For another person their nutrition care plan stated they should have level 2 consistency but the 'quick link' at the front of their care plan stated it was level 1. We spoke with the registered nurse who told us they had forgotten to change it.
- One person required oxygen. We saw a clear hazard sign on the door. However, information was missing on cleaning, for example the nasal cannula. We asked a registered nurse when this had last been changed to support best practice and they were unable to tell us. The provider has now assured us records are now in place to support this and that it is regularly cleaned.
- Some people in the home required their medicines to be hidden in their food. These are called covert medicines. While most of these records showed this had been in their best interests and signed by the GP, for some people it was not always clear if there had been pharmacist involvement. Pharmaceutical advice is necessary because some medicines should not be crushed as this will alter their efficacy. For one person, their prescribed medicine must not be crushed. However, there was no indication of how to administer them covertly.

Medicines were not always managed safely. This was a continued breach of Regulation 12 of the Health and

- People we spoke with were happy with their medication support. One person told us, "The tablet people are absolutely marvellous. You get them at exactly the right time. They're very, very good." Another person said, "It's excellent". A relative told us, "The nurses and carers have been wonderful with managing my mother's medication. Some of her symptoms had been very difficult to manage when she was in her own home and it was difficult to get appointments with the local doctor's surgery. Since her admission to Hamble Heights she is no longer in pain as the nurses have been in regular contact with a doctor to ensure she is given the right medication to treat her symptoms. Her medication is given at the same time each day and I am kept fully informed when changes have been made to prescribed drugs."
- There were effective processes for ordering stock and checking stock into the home to ensure that medicines provided for people were correct.
- People's allergy information was recorded in the care plans and medicines administration records.
- There were up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current regulations and guidance.

Assessing risk, safety monitoring and management

- Issues relating to fire safety were not always addressed in a timely manner. A night time drill with staff had taken place a year ago and an action was to retrain all staff, and this had not happened. We brought this to the attention of the service, and this has since been actioned.
- During the inspection we noted mattress settings for 2 people were wrong and this was previously also picked up by a healthcare professional. The service immediately took action and put in safeguards to prevent reoccurrence.
- Individual risk assessments identified potential risks and provided information for staff to help them avoid or reduce the risk of harm to people. However, we found some of these were generic and not focussed on specific health conditions. For example, for some people we could not see risk assessments for Parkinson's, risks associated with having a pacemaker, the use of hoists and dementia.
- Some people were living with diabetes and had care plans to support this. However, for one person who was a diabetic there was no information to support staff on how to manage this. Records also showed there had been a medicines error for this person and their insulin was not available on one day. This could have caused them harm.
- Records were not always up to date and contained conflicting information. For example, for some people's records said see call bell risk assessments, however none were seen. We also saw records that stated people were mobile and during inspection we saw that they were unable to weight bear. A health professional told us the service didn't manage risks well, they said, "For example a severely frail patient nursed in bed, we were informed that she was mobile with a Zimmer frame. This lady has significant contractures of lower limbs and is immobile. On an airflow mattress on wrong setting."

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risk assessments had been completed for the environment and safety checks were conducted on electrical equipment. A fire risk assessment was in place and weekly checks of the fire alarm carried out. Personal emergency evacuation plans (PEEPs) were in place to guide staff in how to keep people safe during an evacuation.

Staffing and recruitment

- We received mixed responses about staffing. Some people felt there were enough staff and they came quickly when they requested help, others felt they could do with more staff. One person said, "There's not

enough. They could do with a little more." Another person said, "They come immediately, day and night." A relative told us, "There are enough staff. They're very attentive to [person's name]." Another relative said, "I only see staff on mum's floor and there definitely seems to be an adequate number of staff. I very rarely hear call bells ringing and if they are, they are not left for long periods." Some relatives felt there were not enough staff.

- We observed that staff were not rushed and responded promptly and compassionately to people's requests for support. Staff rotas were planned in advance and reflected the target staffing ratio which we observed during the inspection. A professional told us, "At times there appears to be a lack of adequate staffing levels to maintain a good level of monitoring of residents."
- Recruitment processes were followed that meant applicants were checked for suitability before being employed by the service. Staff records included an application form, 2 written references and a check with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- However, we found one file had gaps in their employment history. This meant we could not be assured employment gaps had been fully explored to ensure staff were safe to work at the service.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe living at the home. One person told us, "I feel quite safe. I absolutely love it here." Another person said, "I don't feel worried about anything. I feel safe." A relative told us, "Absolutely. There's always someone around. The staff are caring, and they come around to meet his needs." Another relative said, "I believe my mother to be safe and she's very happy with the care she receives and the pain and anxiety she suffered before her admission has gone as a result of feeling safe and secure at Hamble Heights." Some relatives felt their loved ones were not always kept safe.
- Staff had the knowledge and confidence to identify safeguarding concerns and act on them. Staff were required to complete safeguarding training as part of their induction. Safeguarding policies and procedures were in place to protect people from abuse and avoidable harm.

Preventing and controlling infection

People felt the home was clean. One person told us, "Every day it's cleaned and sometimes twice a day." Other comments included, "It's spotless". A relative told us, "It's very clean. They keep it lovely." While most of the home was clean and no malodours were noted. There were 2 kitchen areas that were in need of refurbishment. The service told us plans were in place to update these very soon and we could see one kitchen area had already been updated.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- The provider was enabling visiting at Hamble Heights according to current government guidance

Learning lessons when things go wrong

- The service had systems in place to monitor incidents and accidents to ensure that there had been an adequate response and to determine any patterns or trends.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained 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

At our last inspection the provider had failed to ensure that staff had access to effective supervision to ensure they had the right skills and competencies to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- People felt staff had the skills to carry out their role. One person told us, "They know what they're doing." A relative told us, "The use of agency staff is common-place, as I'm sure is the case in most care homes following Brexit and COVID. However, they often don't appear to have knowledge of the resident. An example of this was my mum being bought a drink with a straw in last week. She is in the later stages of dementia and has for a long period of time needed to be spoon fed all food and drink." Another relative said, "The carers are all aware of their duties and seem to be fully trained as I'd expect. My mother's state of mind reflects that the carers are well trained."
- Staff were supported by supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. One staff member told us, "We receive regular supervisions and if we have any concerns outside of this period it's not a problem to ask, as the management team are all very approachable and happy to assist or answer any questions, a door always open attitude which is great."
- The provider had a system to record the training staff had completed and to identify when training needed to be repeated. This included essential training, such as, medicines, manual handling, infection control, health and safety, safeguarding adults, fire safety, food safety and basic life support. Extra training included training on dementia, Parkinson's, epilepsy, dysphagia, and diabetes. Most training was completed online. Registered nurses had received extra training for example, catheter care.
- Arrangements were in place for staff who were new to care to complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People were happy with their care. When people moved to the home, they and their families, where appropriate, were involved in assessing, planning and agreeing the care and support they received.

However, we found some plans did not have enough information to support staff. For example, for one person could get agitated and try to pack up their room. There was no guidance in place to support staff on how to manage this safely.

- One person could, at times get frustrated and become emotional in situations and there had been incidents with staff. However, no information on how to support this person and for staff to remain safe while providing care was in place.
- There was no evidence of comprehensive reviews of care. Reviews we saw seemed to have the same information from a long time ago with no dates when incidents occurred. There were also no records showing people's involvement in their care plan reviews.

The failure to include relevant health and safety concerns in peoples care plans is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, district nurses and other health professionals. One person told us, "They're red hot in calling the doctor. But I've always suffered from ingrowing toenails and when I was at home, I had a chiropodist and they sorted it out, but now they're in growing again and my left foot is agony. I have to wear slippers when they take me out in the wheelchair."
- Health professionals we spoke with were concerned about people's health care. A health professional told us, "I feel there are some very good skilled, caring nurses who are very skilled and knowledgeable and attempt to maintain good standards of care however it can appear to be insubstantial without the support structures around them to maintain this. I also feel that there are some registered and non-registered workers that do not have the appropriate training/understanding to provide effective care. For example, lacking knowledge of equipment use such as airflow mattresses, catheter care, basic personal hygiene needs, maintaining skin integrity, fluid intake, communication skills, common conditions and how they progress i.e. dementia." Another health professional told us, "Knowledge of dressings not apparent and wound care. No evidence of care plans being followed after previous visit. Still not being repositioned to offload pressure appropriately."
- Records showed significant gaps in repositioning records. For example, one person was required to be repositioned every 4 hours on their side. Records showed that they could have been left for over 10 hours at times before being repositioned. For another person the handover sheet states that they were to be sat in a chair daily. But repositioning records referred to them lying in bed. When we visited them at inspection they were laid in bed.
- During the inspection we did not see records to show that staff had received training on how to manage people's wound care and to support people with a feeding tube through the skin and stomach wall know as a percutaneous endoscopic gastrostomy (PEG). Since the inspection PEG training has been arranged.

The failure to ensure people received appropriate and timely health care supports a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- Most people and their relatives were happy with the food. One person told us, "The food is absolutely marvellous. There's a limited choice of 2 main meals, but you can ask for the vegetables you like. I ask for creamed potatoes and that's what I get." Another person said, "It's really amazing. It's of a good standard. It's simple food, beautifully served." A relative told us, "She likes the meals and if she doesn't like what they've cooked, they'll make her whatever she wants, within reason." A relative told us, "The food is amazing,

always plenty of choice and residents can choose to eat in the dining area with others or if they prefer to eat in their room the meal is provided on a tray. My mother says it's like going to a fancy restaurant every day and she looks forward to her meals."

- Two people thought food could be improved. One person said, "The vegetables are too hard. They're rock hard. I've told them, there's lots of elderly people here and they haven't got many teeth. But the mashed potatoes are lovely. The desserts are homemade and they're beautiful. But 9 times out of 10 if I eat in [my room] the food's cold when it comes. It's not fair on people in bed." Another person said, "It varies. It's usually not bad, but on some occasions, especially in the evenings, it's awful."
- During the inspection we looked in people's rooms to see whether drinks were available to them and within reach. A relative told us, "Frequently no jug of water and glass is left." Most of the people we saw had drinks available to them and people we spoke with felt they had drinks available to them. However, records showed people were not always being given the right amount of fluids with some days very little recorded. We also viewed 1 person's records who had a catheter and could be at risk without sufficient fluids. Records showed poor intake of fluids. Therefore, it was not easy for staff to identify whether people had received enough to drink each day.
- We spoke to senior staff who assured us this was a recording issue and people were getting plenty of fluids. We saw no evidence of any one not being hydrated. Please see the well-led section for more information on poor records.
- During the inspection we observed the lunch time experience for people. Lunch was a social activity with people chatting and a friendly atmosphere. People were offered a choice of drinks.
 - People made choices and requested things without hesitation, and these were provided quickly. One person requested vegetarian sausages, and these were brought. The staff member suggested she had some of the red wine sauce on them in case they were too dry. People were asked if they wanted their food to be cut up for them.
 - Staff were attentive and thoughtful. Some people praised the food and thanked the staff at the end of the meal. 'Thank you, that was delicious.' One person's walking frame had been moved out of the room because it was in the way of other diners, when they stood at the end of the meal it was noticed quickly and the frame was brought to them.

Adapting service, design, decoration to meet people's needs

- People told us they were happy living at the home. One relative told us, "We don't believe this service delivers high quality care, having said that, there are a few long term carers/staff who really do their best in difficult circumstances. However, the standard of the rooms has deteriorated with leaks not addressed and blown bulbs not being replaced in lights." They also told us, "Mum loves watching the TV. She never listened to the radio at home. Despite having told staff this, the TV is never on when we visit. On several accessions recently the aerial cable and the batteries from the remote are missing."
- The environment had been decorated and accessorised to provide a positive and suitable environment for people who lived there.
- The home was suitable to meet the physical care needs of people with wide corridors and doorways, and bedrooms large enough for the use of any specialist equipment required.
- Each person had their own ensuite room and these were personalised with their belongings.

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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We observed staff seeking consent from people before providing care and support. One person told us, "They tap on the door and ask if they can come in."
- Staff had been trained in the MCA and DoLS and supported people to make day-to-day choices and decisions.
- Some DoLS authorisations had been made and others were awaiting assessment by the local authority. The service had a system to ensure that DoLS were reapplied for when required and that any conditions were complied with.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to provide consistent and effective leadership, there was poor record keeping and poor governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At the time of inspection there was no registered manager in place. One relative told us, "We have seen significant changes in the home since 2017 - unfortunately not in a good way. There has been a constant stream of managers - most only staying between 6 - 12 months. However, constantly changing managers is not beneficial. Communication with families is minimal and the opportunity to actually speak to a manager is non-existent."
- A health professional told us, "I have significant concerns around the level of care provision in Hamble Heights. In the 3 years that we have been visiting Hamble Heights there has been a significant turnover of staff, particularly senior/management staff and I feel this has contributed to the poor standards we have seen. My concern is that these are not recent inadequacies and concerns that have been raised, and despite significant support from other teams also, that change does not appear to have happened and the same concerns are still being raised."
- A new manager had submitted their application to become the registered manager. Feedback about the new manager was positive and relatives and staff felt they were approachable and supportive. One relative told us, "There were problems before, we weren't happy, but things are a lot better since the present manager came. All the issues were resolved. It's got a lot better. The staffing levels are better and so is the cleanliness. Before [relative] wasn't happy, the home was understaffed, and he had to wait too long. We have a good relationship with the management." Another relative said, "My mother was in quite a state when she was admitted to Hamble Heights in much pain and requiring help out of the car and a wheelchair. Help arrived in the form of [managers name] who was accompanied by 3 carers. She was welcomed so warmly and after a hug from [managers name] it was clear how reassured my mother felt."
- Correspondence had been sent to people and their relatives but not everyone knew who the manager was. One person told us, "I don't know who that is. But I like all the staff." Another person said, "They've got a new one. She came around and I asked, 'Who is that woman?' and they said, 'Oh, she's the manager.'" One

relative told us, "At no point since COVID have we had any contact from any manager. We receive an update when they change managers, but they never appear present in the home."

- Staff we spoke with were happy with the manager. One staff member told us, "There have been many changes, especially of management. Each time we get one settled they send her to sort another care home. With the recent changes I feel much more settled. Staffing levels are now good, it was very challenging, but I feel more settled. I feel valued, there is an open-door attitude. I feel it is better than it has ever been. The carers are good. My only concern is the moving of carers between areas, it is not good for dementia residents especially."
- As mentioned throughout the report record keeping was poor and not robust. Records seen often contained conflicting information and showed large gaps of non-recording of important information, for example fluid charts. We looked in detail at 9 peoples fluid charts who were at high risk, each person should have had a daily intake fluid intake of 1600mls. For one person, for 5 days in November the most fluid they had taken in those days was 600mls and for 2 days 200mls was recorded. Other records were also poor and showed low fluid intake. Records showed people were not being offered fluids for very long periods.
- We brought our concerns to the attention of senior management, they told us, they had reviewed the records. They felt this was a recording error and in relation to one person were confident they were getting the correct food and fluids as they had gained weight since moving into the home. They told us, "We are committed to ensuring the health, safety and well-being of the people who live at Hamble Heights and have already commenced addressing record-keeping concerns."
- Care records had been transferred from paper to electronic records since the last inspection. However, we found not all staff were updating records and not all staff were recording in the same place. This meant it was hard to find information such as what action had been taken when someone had a fall or incident.
- The provider and manager used a series of audits and processes to monitor the quality of care. These included audits of medicines, environment, mealtimes, infection control, accidents and incidents. However, these had failed to ensure compliance with Regulations, and where actions were recorded as needed these weren't acted on to keep people safe and improve the quality of care. For example, poor record keeping and gaps in records had been noted in a September provider visit and we still found concerns during our inspection.
- The provider informed us there was a quality assurance process in each service. This consisted of 16 separate governance folders. Within these were scheduled clinical and non-clinical, operational audits. This also enabled the Operational, Clinical Support and Head of Quality to visit the services and review these files to seek assurances.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate enough improvements had been sustained to ensure the service was effectively managed. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- The service has made changes since the inspection to address the concerns, including staff being reminded daily about the importance of good record keeping. All staff, including agency staff, at the start of each shift were asked if they were confident in using the IT system. As well as other actions to support staff, senior management will be reviewing record keeping weekly and following up and supporting staff.
- Since the inspection the provider has upgraded the system and arranged for more staff training on the electronic care planning system and for guides to support staff to ensure records are maintained consistently.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider sought feedback from people or their families using a quality assurance survey. This was sent out annually seeking their views. The last survey for people was in January 2022 which was mostly positive. Newsletters were also produced in the home and sent to relatives to keep them updated.
- People told us they had residents' meetings but not that often. One person told us, "I believe they had one over a year ago, but they're not a regular thing." Another person told us, "They ask our opinions. They asked me what I thought of the hairdresser." Another person said, "The management are proactive, and they take on board our ideas." People had recently been consulted around new furnishings around the home.
- Staff were supported by team meetings and daily handovers. Staff meetings were an open forum amongst staff and were usually held to discuss concerns about people who used the service and to share best practice. We emailed staff for feedback on how they felt working for the service but did not receive many responses.
- Senior staff were involved in clinical meetings and daily meetings across the home to ensure any outstanding actions were followed up.
- The service worked in partnership with the local doctor's surgeries and community health teams. One health professional told us, "They have always appeared to be open to work in partnership with us however, at times have not always been responsive to recommendations and advice given. With regards to ward rounds, they have attempted to maintain a degree of routine with these, unfortunately the standard of information still remains lacking and concerning. That being said recently I feel more positive that they are endeavouring to improve the situation."
- They also told us, "Having raised the concerns again more recently I can see that Encore have drafted in staff to support and make changes. Having had discussions with Encore clinical lead and operations manager, it appears that they are determined to make changes to improve care provision at Hamble Heights however, this needs to be long term and consistent and not short lived."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were happy with the staff at the service. One person told us, "The nurses are lovely to be with. There's a lovely nursing service. They enjoy being with us and we enjoy being with them. They care for you and hug you. The staff is lovely. You can talk about your family or anything really. Everything is so easy." Another person said, "The staff are brilliant." A relative told us, "The professional established staff are excellent and valued by my wife and I. We think the world of them; they're like members of our family." Another relative said, "The main thing they do really well is their interaction with the residents - mum gets upset at times when I am there and if the staff see it, they very quickly know how to get her smiling again."
- We received mixed feedback about whether people would recommend the service. One person told us, "I've recommended it to my family." Another person said, "I was [in hospital] and I was so pleased to hear I was coming back here. It's so much nicer and kinder than where I was." One relative told us, "I can honestly say that the care my mother has received has been excellent and my mother's health and wellbeing vastly improved. The carers are attentive to her needs and she is very well cared for. She regards the carers as her friends. We, as a family, are very happy, we chose Hamble Heights for our mother." Another relative told us, "If I was now looking for somewhere for my parents to live, I would not choose Hamble Heights." Some other relatives felt the same.
- During the inspection we saw many lovely interactions with people and staff and it was clear staff knew people well and wanted the best for them. One staff member told us, "This is by far the best nursing home I have worked for. The staff are excellent, very caring and seem to be handpicked to work there, all very caring and I feel the residents are very well cared for." Another staff member said, "I personally have no concerns with Hamble Heights and would just say it's a great place to work, all staff are very friendly and appear to appreciate one another."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was an open and transparent culture in the home. The previous inspection report and rating was displayed prominently in the reception area.
- The provider notified CQC of all significant events and was aware of their responsibilities in line with the requirements of the provider's registration.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Failure to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any such risks and ensure the safe and proper management of medicines.

The enforcement action we took:

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Failure for the lack of consistent and effective leadership, poor record keeping and poor governance. The provider had not ensured the effectiveness of the governance arrangements to operate effective systems and processes to assess and monitor the quality of the service and to identify and mitigate risks.

The enforcement action we took:

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.