SHC Clemsfold Group Limited

Horncastle House

Inspection report

Plawhatch Lane
Sharpthorne
East Grinstead
West Sussex
RH19 4JH

Tel: 01342810219
Website: www.sussexhealthcare.co.uk

Date of inspection visit:
07 August 2018
08 August 2018

Date of publication:
13 September 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 7 and 8 August 2018 and was unannounced.

Horncastle House 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. Horncastle House accommodates up to 43 people in one adapted building. There were 26 people using the service during our inspection. Horncastle House provides nursing care to older people; some of whom are living with dementia.

Since our last inspection, services operated by the provider had continued to be subject to a period of increased monitoring and support by commissioners. As a result of concerns raised about other locations operated by the provider, the provider is currently subject to a police investigation. There have been no specific criminal allegations made about Horncastle House at the time of our inspection. However, we used the information of concern raised by partner agencies about this provider to plan what areas we would inspect and to judge the safety and quality of the service. Since May 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find. Our findings from inspections of other locations operated by the provider also informed the planning of the inspection of Horncastle House.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The former registered manager had left in September 2017 and their deputy had taken over the management of the service. They had applied to the CQC to become registered but had then left the service in April 2018. A peripatetic manager had been in place for 11 weeks prior to our inspection. A new manager was due to start work at Horncastle House the week following our inspection.

Horncastle House was last inspected in March 2018. At that inspection it was rated as 'Inadequate' overall and 'Requires Improvement' for Caring and Responsive domains. At this inspection, there had been improvements in some areas, but we continued to find that risks to people's safety and well-being had not been adequately monitored or reduced. As a result, we found continued breaches of Regulations across all areas we inspected.

The service was not consistently safe and there were not enough staff deployed to meet people's needs. Not all identified risks to people had been appropriately minimised. New risk assessments were in place for choking and behaviours that may challenge but staff practice in these areas did not keep people safe or monitor them for changes and trends.

There was evidence of a lack of learning from incidents in that actions arising from safeguarding investigations had not been embedded so that people were kept consistently safe going forward.

The service was not effective. There had been improvements to staff training in some subjects such as epilepsy and first aid but other training was not as effective as it could be. Agency staff continued to make up many staff on shift on some occasions and were not always knowledgeable about people's needs.

Feedback about meals provided was poor and people did not always have support to eat and drink when they needed it. Weights charts had been miscalculated by staff, which made it appear that some people had lost very large amounts of weight, when they had not. These miscalculations had not been picked up by managers. People were referred for dietetic input when they had lost weight however.

Staff knew how to care for skin wounds but records about this were not always available and repositioning of people to relieve pressure had not always happened in line with care plan directions. Not all individual medical conditions had been incorporated into care plans so that staff could ensure people's treatment was appropriate.

The service was not fully meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) 2005 because applications for DoLS had not been made for people who would need to be prevented from leaving the service alone for their own safety.

The service was not consistently caring because people's needs were not always properly considered. Dignity and respect shown to people had improved but required more action to make sure everyone was protected. Not everyone who spoke with us felt they had been involved in care planning.

The service was not always responsive. Care plans were sometimes confusing or contradictory creating the opportunity for staff to provide care or treatment inappropriately. End of life care planning required further improvement to ensure all people's needs and wishes were respected. Complaints had been logged but information about investigations and outcomes was not available.

The service was not well led because people remained at risk when insufficient improvements were made following our last inspection. Auditing and oversight checks did not pick up on issues highlighted by inspectors. Feedback had not always been used to drive improvement.

Staff reported a poor culture but were beginning to feel more supported.

Several improvements were found during this inspection. Recruitment checks and systems had been modified to ensure suitable applicants were employed. Information about Do Not Attempt Resuscitation (DNAR) orders was now available to all staff and was included in handover documents for ease of reference. Personal Emergency Evacuation Plans (PEEPs) had been updated to include current information about people's mobility and capacity.

Medicines, aside from creams, continued to be safely managed and audits of them had ensured standards were maintained. Fire safety checks and routine maintenance checks had been regularly carried out. There were some adaptations to the service to make it suitable for older people or those living with dementia.

Positive feedback was received about staff, and our observations showed mostly gentle and patient interactions. Independence was promoted whenever possible and people said they enjoyed activities and entertainment provided.

The provider made statutory notifications to the CQC. The service notified the Commission of incidents and events that they were legally required to.
It is a requirement that the provider displays their CQC rating at the service and on every website maintained by or on behalf of them. Although the rating from the last inspection was conspicuously displayed at the service, the provider's website showed the rating for Horncastle Care Centre and not Horncastle House.

We found breaches of nine of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response to our findings and will publish our action when this has been completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

There were not enough staff deployed to meet people's needs.

Known risks to people had not been minimised. This included risks associated with choking, falls, challenging behaviour and the environment.

Safeguarding investigations had not always resulted in all the changes necessary to keep people safe in future. This showed a lack of learning from incidents.

Medicines were safely managed but prescribed cream application records were not always completed at the time of application.

Recruitment processes had been improved and all necessary checks were being documented.

Information about Do Not Attempt Resuscitation (DNAR) orders was now shared during staff handovers

Fire safety checks had been routinely carried out and Personal Emergency Evacuation Plans(PEEPs) had been recently updated.

Is the service effective?

Inadequate

The service was not effective.

Although staff training had improved in some areas it remained ineffective in others. There remained a high reliance on agency staff.

People were not always supported to eat and drink. Most people did not enjoy the food served.

Wound care had not been appropriately documented although staff were knowledgeable about it. Medical conditions had not been properly assessed.

The service was not fully meeting the requirements of the

Deprivation of Liberty Safeguards and Mental Capacity Act 2005.

Some adaptations had been made to the premises to make it suitable for older people/those living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's needs were not always considered appropriately.

Dignity and respect shown to people had improved but requires further input.

People and relatives did not always feel involved in care decisions.

Positive feedback was received about staff and kind and gentle interactions were observed.

People's independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained conflicting information and there were no care plans at all for some conditions.

End of life care planning required further improvement to ensure all people's needs and wishes were respected.

Investigations and responses to complaints had not been documented in most cases.

People said they enjoyed activities and entertainment provided.

Is the service well-led?

Inadequate

The service was not well led.

There had not been sufficient improvement since our last inspection; leaving people exposed to risk.

Auditing and oversight had not always been effective.

Feedback was not consistently acted upon to change the service for the better.

There had been no registered manager in post since September 2017.

Staff reported a poor culture but were beginning to feel more supported.

The provider made statutory notifications to the CQC.

Horncastle House

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 8 August 2018 and was unannounced. The inspection was carried out by two inspectors and a specialist nurse advisor on both days. An expert by experience was on site for one day. The expert by experience had a personal understanding of having a loved one living in a care home.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with people who lived at Horncastle House and observed their care, including the lunchtime meal, medicine administration and some activities. We spoke with 12 people in detail and with three people's relatives. We inspected the environment, including communal areas, bathrooms and some people's bedrooms. We spoke with three registered nurses, four care staff, the peripatetic manager, the service review and transformation lead, another peripatetic manager supporting the service and the provider's chief operating officer.

We 'pathway tracked' 13 of the people living at the service. This means we looked at people's care documentation in depth, obtained their views on how they found living at the service where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care and whether care is delivered in line with people's needs.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

We displayed posters in the communal areas of the service inviting feedback from people and relatives. Following this inspection visit, we received additional feedback.

Inadequate

Is the service safe?

Our findings

At our last inspection, people and their relatives told us they felt there were not enough staff and that responses to call bells were sometimes delayed as a result. At this inspection we continued to receive similar feedback. One person said, "Sometimes I need to go to the toilet first thing so I ring my bell but they're so short staffed that they just can't get to you quickly". Another person added "My call bell doesn't work so I just call out for a nurse and it depends if someone's near here and hears me call out- I really do need a bell". We made managers immediately aware that the call bell did not work when we visited this person in their room. It was discovered that the call bell had been disconnected from the wall. Managers told us that maintenance staff said they knew the circumstances in which this happened. However, neither managers nor care staff were aware of this when we asked, and the lack of effective communication about it had placed this person at risk of not being able to raise the alarm if they needed help. A relative told us they had arrived to find their loved one's call bell sounding for at least "15-20 minutes" without staff attending them.

Staff also told us there were not enough of them to consistently meet people's needs for care and support. One staff said "The safety of the resident and their wellbeing is my main priority, but sometimes we don't have time. We have really been short staffed here. We just have two nurses. As you can see I am doing my best, but I am just so busy. I try and talk to the residents as much as I can". Another staff commented "Two permanent nurses and no permanent manager means we are always run off our feet, but we try our best". A further staff member added; "Sometimes I am so tired, I could cry".

People using the service had a range of health and care needs including medical conditions, need for support to mobilise, to wash and dress, assistance with eating and drinking and with continence, with repositioning in bed and end of life care. Our observations confirmed that people's needs were not always met in a timely way. At lunchtime on both days of the inspection some people's meals were left on the table in front of them even though they needed full support to eat. There were not enough staff to support everyone who needed assistance at the same time, so food went cold before it was offered and some people were left looking at meals they were unable to eat without help. Some staff moved between more than one more person to give support, but this did not create a relaxed atmosphere or provide an uninterrupted experience for them. People who remained in their bedrooms received their meals almost an hour after others had eaten and there was a lack of staff on the first floor during the downstairs mealtime. One person was heard to remark "Bit behind today, nearly quarter past 12 already, must be short staffed".

Call bells often rang for more than five minutes before being answered by staff. One person's took nine minutes to receive a response and they were observed to be distressed when staff attended. Call bell audits had been carried out up until May 2018 but no records were available of any more recent checks to ensure that people were receiving timely responses. The management actions documented in May's audit; following a call bell which took seven minutes to answer, suggested that staff should go to the person and explain that they would come back to them if they were engaged with other duties at that time. This was not mindful of the needs of the person who had used their call bell. The managers told us that recorded checks were made on each person overnight, at least every hour and 'night observations 'sheets confirmed this.

The managers told us that there were two registered nurses and five care staff on duty in the mornings and afternoons, and one registered nurse and three care staff overnight. They said that a dependency tool had been used to assess the number of staff needed in relation to people's needs, but that a different tool was being sourced because it was recognised that the first did not take into account all the necessary information about the service. Staff rotas showed that the assessed staffing levels had been met most of the time, but there were at least three occasions in the last couple of months when one staff had not turned up for work and could not be replaced at short notice. However, regardless of the dependency assessments; people, staff and relatives reported a lack of sufficient staffing and our own observations agreed with this.

The failure to deploy staff in such a way as to meet people's needs is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team said that a recruitment campaign for permanent staff was underway and that some new staff were ready to take up post once their pre-employment checks had been completed satisfactorily.

At our last inspection, risks to people living at Horncastle House had not been identified, assessed or minimised in a number of different situations. At this inspection people remained at risk because actions designed to reduce the possibility of harm had not been carried out by staff.

For example; at our last inspection there had been no assessments in place about the risk to some people of choking. At this inspection, choking risk assessments had been put in place and contained details about how staff should keep people safe. However, observations showed staff were not following instructions in care plans and risk assessments. One person was deemed to be at risk of choking on food and drinks and staff were supposed to supervise them to prevent this. At lunchtime on the first day of our inspection this person sat alone at a table positioned behind a wide pillar which minimised staffs' line of sight. The person was not supervised by staff as they ate and drank and was given chewy chicken goujons for lunch. The management team said that the person had capacity to refuse to eat the soft diet recommended for them or to be supervised, and did not like staff to watch them eat. However, a specific mental capacity assessment carried out by speech and language therapists in relation to eating and drinking risks, found that this person lacked capacity to make these decisions.

Another person was observed being given an unthickened drink by care staff when they had been assessed as at risk of choking due to swallowing difficulties and thickening granules had been prescribed for their drinks. Their care plan about eating and drinking said they should be sat upright to eat and drink, but was observed drinking while slumped to one side in their chair. Staff told us that a further person was "Losing their swallow reflex and it's risky if they are given drinks in the normal way". This person's care plan had not been updated to show the decline in their swallowing and advise staff how to safely support them to drink. Neither was any reference made in staff handovers about the need for extra care around fluids for this person. A relative raised concerns with us about their loved one. "[Person's name] had a bad choking spell a couple of months ago and when I arrived to visit [Person's face] was a red, purple colour at lunch. I walked up to [Person's name] and I couldn't believe it when I got there, [Person] had no drink, just an empty glass with a napkin in". They also described finding the person flat on their back with a meal next to their bed on another occasion. The inappropriate management of dysphagia (difficulty swallowing) had been highlighted on multiple occasions at several of the provider's other locations by CQC and partner agencies. Allegations about the provider's safe management of dysphagia were the subject of several historical and current safeguarding investigations. This learning, and that from our last inspection, had not been applied at Horncastle House to mitigate risk to people.

We had significant concerns about choking risks to people and asked the management team to carry out an

immediate review of people who may choke to ensure the risks had been properly assessed and were reduced in practice. We received assurances during the inspection about this, and written confirmation that this had been carried out.

At our last inspection, falls were not being managed in a way which kept people safe. At this inspection we continued to have concerns about the completeness of actions designed to prevent further incidents. One person had experienced a number of recent falls and a risk assessment about this had been updated on 1 August 2018. Special alarmed equipment had been put in place to make staff aware when the person stood and tried to walk. The assessment stated that staff should assist them to mobilise for short distances. A staff member was observed gripping this person by their trouser waistband to walk them to the toilet. This was not a safe manoeuvre. The staff member said they had received recent moving and handling training but had seen other staff support the person in this way. The risk assessment about supporting this person was not detailed enough to describe exactly how staff should be assisting them; creating the risk that they may fall again or be inappropriately supported.

Another person had a recent fall from their wheelchair but their care plan and risk assessment did not guide staff to ensure the lap strap was tight enough or in the correct position. During our inspection this person was observed leaning over the side of their wheelchair with the strap very loosely secured. The falls risk assessment had not been updated since the fall from the wheelchair, so the risk of recurrence remained.

At our last inspection there were no care plans or risk assessments in place to detail any triggers to behaviours that may challenge; or information about how staff should manage them. At this inspection, care plans and risk assessments about behaviours had been put into place but continued to lack detail about any known triggers in some cases. Records of separate incidents of challenging behaviour had been made but did not record what had happened to lead to them. The management of behaviours was not always effective in practice. One person's record of behavioural incidents described what had happened, stated that the person was reassured and offered drinks but then noted that the outcome was that the person continued to be agitated, with no further intervention recorded. There had been no analysis of behavioural incidents to identify themes and develop management strategies; although managers told us that some people had been prescribed medicines to help with agitation.

People had been referred to dieticians when they had lost weight but records of people's weights had been miscalculated on tables held in people's care files. Gains were sometimes recorded as losses and vice versa. The tables reviewed sometimes showed people had lost 19 or 20kgs. This was not correct and our calculations showed weight losses were far lower. However, the incorrect adding up on these tables had not been picked up until inspectors highlighted it during the inspection.

At our last inspection, environmental risks had not been effectively minimised with doors to the sluice and a pantry (with high voltage equipment in it) being left open. At this inspection, sluice doors were consistently locked. The picture sign to the pantry had been removed and the door was kept locked but there was picture signage on the kitchen door which was open on several occasions during the inspection. A professional kitchen contains a number of risks to people, including from knives, hot ovens and other equipment. We brought this to the immediate attention of the managers who removed the picture sign and instructed that the door should be kept shut there. Although not many people using the service were independently mobile there was a risk that they could enter the kitchen and injure themselves.

Staff were observed putting hot lunch plates in front of people and telling them to be careful, but people then told us that the plates were so heated that they could not even touch the sides of them. One person said, "This plate is incredibly hot". Most people were living with dementia or memory loss and it was not safe

or considerate to deliver meals on such hot plates. The peripatetic manager spoke to kitchen staff who said plates would be delivered warm and not hot in future. All staff were made aware that plates should not be given to people if they are too hot.

One staff member tucked a tissue into a person's top when a cup of tea was left with them instead of suggesting a food protector was used. The staff then left the room, the tissue fell off and the person spilled their tea all down their clothes. Staff were very busy and this impacted on the support people sometimes received. Another person said they had been too hot in the recent heatwave but had to share a fan because there were not enough to go around. Temperatures had been extreme from June to August with some days exceeding 30 degrees Celsius. It is important for older people to maintain a reasonable body temperature and more could have been done to ensure people were comfortable. The peripatetic manager told us they had ordered more fans following the inspection

The failure to assess, monitor and mitigate risks to people is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, people had not been consistently protected from potential abuse or neglect by the operation of robust safeguarding systems. At this inspection, we read information about investigations undertaken by the local safeguarding authority, but found that actions taken within the service in response to these was not as thorough as it could have been; leaving people at further risk. For example; on 10 May 2018 the local safeguarding authority raised concerns in writing about a number of issues; including choking risks to a person. Although the management team assured us these problems had been resolved, and had taken actions in response to some of the concerns raised, we found this person remained at risk of choking during our inspection.

Following another safeguarding investigation, the local authority had written to the service on 2 August 2018 to highlight that their investigation found care plans and risk assessments did not match; creating the risk that staff would not know how to support the person appropriately. These documents had not been updated at the time of our inspection. Some care plans stated that the person could weight bear, while others said they could not. One record stated they should be supported by two staff with a hoist to move, while another recorded that 'one staff to help with activities of daily living'. These anomalies in care plans; which had been discussed with the service by the local authority, had not been resolved in a timely way to protect the person from further harm.

The failure to operate robust safeguarding systems is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew how to raise any safeguarding concerns and the local authority had been informed of any incidents which might require their involvement. Some actions had been taken to protect people, such as providing new bed rail bumpers for a person who had injured themselves in bed and making referrals to speech and language therapy about swallowing problems. A staff member told us "I know my residents, and I would have no problem whistleblowing if I saw something wrong. I care. I wish I had more time to spend with them".

At our last inspection some people's prescribed creams were not securely stored or consistently applied in line with the prescriber's directions. At this inspection all creams were locked away when not in use and records of applications had been regularly completed in most cases. However, one person had a cream prescribed for use three times daily and charts showed it had only been applied twice a day in the previous month. Staff and managers could not explain why this had happened. On both days of our inspection

creams charts for applications due in the mornings had not been completed by lunchtime. Staff said that people had received their creams but they were "Too busy" to fill out the charts until later in the afternoon. This practice gave rise to the risk that staff may not remember which creams had been applied if the charts were not completed at the time of the application. Since our last inspection, charts were kept in people's rooms for ease of access and completion by staff, but this was not always happening at the point of application.

The failure to maintain accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines continued to be managed safely. Staff were knowledgeable and confident when administering medicines. Medicine administration records included a photo of the person and information that was relevant to them, including any known allergies. Tablets and liquid medicines were stored and labelled correctly. There were instructions for staff about giving medicines people could take as and when they were needed; which ensured people had access to pain relief or laxatives, with suitably spaced doses.

The temperature of medicines storage areas was taken daily and there was evidence that following a rise in temperature, an air conditioning unit had been installed. This was in operation on the days of our inspection and the medicines room was cool despite the weather being extremely hot outside. Staff were observed to be caring and patient when giving people medicines. One person told us "They're [staff] very good with my pills, I'll say that for them". A staff member told us "We take medication very seriously, it is a big responsibility and I am very careful. We have support".

At our last inspection thickening granules, which can pose a hazard if swallowed dry, were found in a person's bedroom. At this inspection tubs of thickener were kept locked away.

At our last inspection, risks associated with people's epilepsy had not been appropriately managed. At this inspection, detailed care plans were in place for each person with the condition and staff had received recent training about how to respond to seizures and administer emergency medicines. One person had two care plans in their folder about epilepsy, with different information about the type of rescue medicine they should be given if necessary. Managers said they would remove the incorrect care plan immediately. Staff were knowledgeable about how to deal with seizures and could competently describe their actions.

At our last inspection, where people had Do Not Attempt Resuscitation (DNAR) orders in place, this had not been communicated during staff handovers and some staff were unable to say which people would require resuscitation if they stopped breathing. At this inspection, people's DNAR status was clearly recorded on handover sheets in red print and staff were able to tell us which people did and did not have DNAR orders in place.

At our last inspection Personal Emergency Evacuation Plans (PEEPS) did not hold up to date information about people's mobility and/or capacity. At this inspection, all PEEPS had been recently reviewed and contained an accurate reflection of people's care needs.

At our last inspection, recruitment processes were not sufficiently robust to ensure suitable staff were employed to work with people. At this inspection a new system had been introduced to ensure that all necessary information and documentation was received before applicants were employed. A detailed checklist enabled administration staff and managers to see at a glance which processes had been completed and those which required further input. Disclosure and barring service (DBS) checks were recorded, references sought and followed up and application forms fully completed to explain any gaps in

employment. There had been no new staff employed since our last inspection in March 2018, but the checklists had been completed in retrospect within recruitment files to ensure all the appropriate information was held.

At our last inspection, we highlighted the need for improvement in relation to odours in the service. At this inspection, we found the service to be mostly fresh and clean throughout; with minimal unpleasant odours. Carpets were being freshened and domestic staff told us they did their best to make sure the service was hygienic for people living there. Staff used protective gloves and aprons when delivering personal care and were observed washing their hands frequently. Infection control audits had been carried out to test that systems for keeping the service clean and hygienic had been followed.

Fire safety checks continued to be carried out and documented regularly. This included full fire drills which happened at different times of the day and evening. Notes had been made about how well the drill had been responded to and how quickly staff and people reacted. Water, gas and electrical safety checks were conducted routinely as were maintenance of the passenger lift and other equipment such as hoists used in people's daily support.

Inadequate

Is the service effective?

Our findings

At our last inspection, findings showed that the service was not always effective in meeting people's needs. Staff had not received some necessary training to support them in carrying out their roles and keeping people safe. At this inspection, there had been increased training in some areas, but gaps remained in others.

Records showed that permanent staff completed basic mandatory training. Some training however had not been updated and other courses had not been completed by staff. For example; only one staff had been trained in end of life care, even though this was raised at our last inspection. There were people receiving end of life care during this inspection but staff had not had specific sessions about how to manage this. Staff described some people as being for 'TLC' (tender loving care) and others as receiving end of life care. When we asked staff to explain the difference they were unable to do so. This inconsistent terminology could lead to misunderstandings about people's care needs, and suitable training would likely improve this.

Training was not always effective in practice. Our observations showed that some staff supported people to move safely and others did not. All staff had received moving and handling training but one staff told us "I always transfer with two people and I have been trained, but we have new hoists and I depend on someone to show me as we just had a PowerPoint to train us.'' Four staff had not received supervision in line with the provider's policy. The peripatetic manager said that arrangements were in place for this to happen and for formal supervision to be provided to nursing staff; who had received informal sessions previously.

During the inspection we received feedback from some staff and a relative which suggested that not all staff felt they were treated equally or inclusively. The peripatetic manager said they were aware of a single incident when a meeting agenda had been defaced; which they had pursued by trying to find out who had been responsible. However, there continued to be a lack of equality and diversity training for staff in the service; which may have been helpful as a first step to ensuring everyone working in the service was up to date with current learning about this topic. A number of people living in the service showed behaviours that challenged at times, but not all staff had received training in this area.

At our last inspection, agency staff frequently made up the majority of those on shift; and the situation had not improved at this inspection. On the first day of our inspection, for example, four out of five care staff on day duty were from an agency and on the second day of our inspection, both nurses on day duty were agency (but a permanent nurse was called in by managers to assist inspectors). The nurse on duty overnight was also employed via an agency. The management team told us that agency staff were now being sourced from the same agency on repeat bookings to try to ensure continuity in people's care. However, people and relatives continued to have concerns about the reliance on and competency of agency staff. One relative said "I worry myself sick at night as the place is running on agency staff". They went on to say that agency staff did not always understand their loved one's needs or specific risks to them. Another person said "My only concern is that a lot of staff are agency staff and not quite the same as having permanent staff. If permanent they would know people that little bit better". Knowledge and understanding of people's needs varied between the agency staff; with some staff being able to tell us about aspects of people's care and

others being less able to do so. Although agency profiles for care and nursing agency staff showed the training and experience of the staff member, training records were not available for agency chef's or kitchen assistants. This meant the provider could not be sure that staff preparing, cooking and serving food to people were appropriately trained to do so.

The failure to ensure staff are supported with appropriate training and are competent to work with people is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, no staff in the service had received training about epilepsy and not all staff had been trained in first aid. At this inspection that situation had been resolved. Staff had received epilepsy training; with nursing staff also being trained in the administration of rescue medicines. Staff had also received training in first aid and were able to competently answer questions about what they had learnt.

People did not always receive enough support to eat and drink. Some people were brought to the dining room and seated there even though there were not enough staff to support everyone to eat at the same time. This left some people watching while others ate or being served with a meal they were unable to eat alone. Staff moved between people they were supporting which interrupted each person's meal. The dining room was overcrowded and excessively hot. People who remained in bed waited almost an hour after those in the dining room for their lunch. On both days of our inspection food charts had not been completed to show what people had for breakfast or lunch until the afternoons. Managers told us that staff completed the paperwork, "In one go" later in the days, but this practice gave rise to the possibility that staff would not remember exactly what and how much people had eaten. The retrospective recording of food was raised as an issue at our last inspection but had not been resolved.

At our last inspection, concerns were highlighted about people's fluid intake. We continued to find that some people did not have access to sufficient drinks. On the first day at 1:50pm, several people's fluid charts had no drinks showing on them since 6:00am that morning. These were mainly people who were cared for in bed. We brought this to the immediate attention of managers, especially because it was over 30 degrees outside. On the second day of our inspection we found the same situation, despite our feedback the previous day. One person's fluid chart had been blank from 6:00am until 1:00pm the day before, but when we reviewed it on the second day, entries had been made in retrospect from 8:00am. The amounts of fluid shown were precise, for example:175mls of tea between 08:00am and 09:00am 30mls of water at 9:00am-10:00am but staff were unable to say how they would remember exact amounts after the event. Managers told us they would rely on fluid chart entries to know whether people were receiving enough to drink but there had been no management review of charts to ensure staff were completing them to check that people had sufficient to drink. Two weeks after our inspection the peripatetic manager contacted us to say that further records about people's fluid intake had been discovered in the kitchen. They said these were maintained by kitchen staff and explained the gaps we had seen in between people's drinks. However, neither staff nor managers knew about these other charts during the inspection. Some of the people we identified as having long gaps between drinks had been assessed as needing staff support to take them, so it was not clear why nursing and care staff would not have been aware of the charts kept by the kitchen. Fluid charts did not record target amounts for each person, although this information was documented in care plans. They also only noted the amounts offered to people, rather than those actually drunk. Those people who sat in communal areas were offered drinks from a trolley at specific times during the day. Drinks were also provided with lunch served in the dining room.

On the second day of our inspection some people who were cared for in bed did not have drinks within their reach and records showed they had not been offered fluid for several hours. Fluid charts were stored in

people's bedrooms so they were immediately accessible by staff supporting people to drink. We made the managers aware and requested that all people were offered drinks at least hourly every day, that a record of what was drunk should be made at the time it was given, that staff should be reminded of the need to ensure people were adequately hydrated and that fluid charts should be checked by managers daily. A plan was put into place straight away and following the inspection we received written confirmation of actions being taken in relation to hydration management.

The failure to meet people's nutritional and hydration needs is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we received mixed feedback from people and relatives about their experiences of the meals on offer. At this inspection there had been no improvement, with most of the people we spoke with saying that they did not enjoy the food. One person told us "Sometimes the lunches are not quite what I would like, salmon was alright today but potatoes were a bit dry". Another person said, "The other day we had pork but it was so tough you couldn't put your knife in it'. A relative told us that their loved one did not like the food and we observed that not many people finished their lunchtime meal. One person was reasonably positive however, and remarked, "Very nice and get a good choice because I don't eat fish. I sometimes moan but had jacket potato today". Other people did not feel they received much choice with one person saying, "No choice; it's just put in front of us" and another adding "In the evening we have a bowl of soup and a sandwich. We don't have variety in the evening".

We observed lunch and although there were two options, most people were served the same meal. Only one dessert choice was shown on the menu but kitchen staff came out and offered people ice cream or mousse instead. There were picture menu boards on display but the items shown bore no resemblance to the meals being served. There were typed menus on tables but people were not shown plated meals to support them to choose what they would prefer. Most people were living with dementia or a degree of impaired memory which might make it difficult for them to make or remember their choices.

The failure to meet people's needs and preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, wound care had not been appropriately managed in some cases. At this inspection, staff were unable to provide wound care records or progress notes for one person's sore skin. A body chart noted the soreness between June and early July 2018; with the last record reading 'Redness still noted'. Staff were unable to say what had happened after this, but did say the redness had healed.

Some people were at risk of developing pressure wounds and had special air-inflated mattresses on their beds. The pump for these mattresses should be set according to people's current weight so they receive the therapeutic effect of them. One person's air pump was set at 80kgs when they weighed 59.3kgs in July 2018. Another person had a recent skin wound and their air pump setting was meant to have been reviewed on 7 July 2018 according to a sticker on the pump. Staff confirmed this had not happened and could not be sure if the mattress was inflated to the correct level. This person's care plan about their skin recorded that they should be supported to reposition in bed every two to three hours during the day. This was to take the pressure off any one area of the body at any time and help to prevent pressure wounds developing. On the first day of our inspection at 11:30am the 'turn chart' for this person showed they were last repositioned onto their left side between 5:00am and 6:00am that morning. This meant there had been a gap of at least five and a half hours between turning and the person was still on their left side when we visited them. We brought this to the immediate attention of managers who said that this person was able to reposition themselves. However, this was not reflected in care plans, which clearly instructed staff to regularly support

them to turn 'to help with the healing of the sore'.

At our last inspection we had concerns about care plans for people with specific health conditions because they were not sufficiently detailed to ensure people received the right support. Although some care plans had been put in place since our last inspection and contained adequate information, other conditions were not properly assessed so that staff had the most appropriate guidance. For example; there was no clear detail about footcare for a person with diabetes, no care plan at all about a specific infection another person had, and lack of step by step instructions for staff to follow in the case of other medical conditions. This was especially important given the high agency staff usage in the service.

The failure to mitigate risks in relation to people's health care is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about wound care and could describe the actions they would take in response to pressure wounds. Where people had experienced skin tears or pressure wounds these were healing at the time of our inspection. Staff told us, "We always look at skin during personal care. We understand how important this is."

Some people were prescribed meal supplements or fortified foods to help them maintain a healthy weight. These had been documented as regularly provided to people. Where people experienced swallowing difficulties, speech and language therapists were involved in their assessment and care recommendations. People were able to see a GP if they became unwell. Staff worked together to deliver care. Staff told us they held handovers at the start of shifts and used a communication book to update staff on important information. Three communication books were being used at the same time and did not always show important information about people. However, there was an example where all staff were informed that a person was using a sensor mat in communal areas. Nursing and care staff worked well with kitchen staff to update them following information from the dietitian or SaLT, however this guidance was not always followed by staff in practice.

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 make 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and supervision inside and outside of the service.

At our last inspection, the service was not working in accordance with the principles of the MCA. At this inspection, people's needs and choices were not always met in line with current legislation and best practice. The peripatetic manager said that they were aware that not all MCA assessments were decision-specific and that a special project was to be put in place to review these as soon as possible. In addition, neither the peripatetic manager or staff were able to say which people had DoLS authorisations or applications in place. The management team confirmed that some people living at Horncastle House would need to be prevented from leaving for their personal safety, but that not all these people had DoLS applications or authorisations in place. This was potentially breaching people's rights. Where side rails were in use to prevent people from leaving their bed for their safety, there were no MCA assessments or best interest decision records in place to ensure people's right to choose was preserved.

The failure to operate within the terms of MCA is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training about MCA and DoLS and some MCA assessments were now specific to the decision being considered. The peripatetic manager was trained to train others about both MCA and DoLS and spoke about their plans to introduce more training and guidance for staff. Staff mostly sought verbal consent from people when delivering their care and, where best interest decision meetings had happened, these appropriately involved people, relatives and external professionals.

There had been a number of adaptations to the service to support people living with dementia or memory loss to orientate themselves. Picture signs were in use to help people navigate between their bedrooms and communal areas. Bedroom doors had people's name or a photo on them, and some were designed to look like an external front door, with letterbox and door knocker. Some people had clear boxes mounted by their bedroom door, containing items which had personal meaning to them and which aided memory and recognition of their own space.

Requires Improvement

Is the service caring?

Our findings

Staff consistently spoke kindly with people but their actions were not always considerate of how they may affect people. For example, a person was observed asking kitchen staff for a fresh jug of water for their bedroom because, "It's completely dry" but the response they received was that "We'll do it when we get time". It is extremely important that older people are well-hydrated, especially during hot weather and this request should have been dealt with promptly. We heard from relatives during and after the inspection to say that staff had to be prompted to ensure a person was wearing their hearing aid and that batteries were working. This was important in supporting the person to communicate and engage with others. Another relative said that a person's personal care was often not completed properly in line with their care plan; meaning they could not present themselves in the way they wished.

Information was held in people's care files about their communication needs in line with the Accessible Information Standard, however this information was not always up to date. Providers of health and social care services have new responsibilities to support people who have sensory impairments and/or learning disabilities. Menus on lunch tables were printed in a small font when some people living at Horncastle House had reduced vision or sight impairment. Care plans about communication did not promote alternative ways of engaging people; for example, by using pictures, braille or large font.

The failure to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, people's dignity was sometimes compromised when laminated signs about their needs were displayed in their bedrooms. At this inspection some of the signage had been removed but we continued to find signs still in use for some people. These were designed to prompt staff, but proper thought had not been given to how this might feel for the people concerned. A person was observed being supported to walk, by staff pulling up and holding onto the back of their trousers. This was not dignified for them in a room full of people and visitors. This is an area requiring further improvement.

People and relatives said that they did not always feel involved in decisions about their care. One relative said that they wished to see care plans and had asked, but this did not happen. Two people said they would like to be included in discussions and decisions about food; particularly breakfast. One said that currently, "You just have what they bring, porridge or something, we don't usually see a menu" and another remarked "We're not all very happy with it [Food offering]". This is an area requiring improvement.

At our last inspection, kitchen staff were heard swearing within earshot of people. At this inspection we had no further concerns about this. At our last inspection, records of complaints made by people and their relatives had been accessible to anyone visiting the service. At this inspection the complaints folder was kept securely in the office. One person said they were "Definitely treated with respect" and that staff were "Very, very kind". Signs were used on people's bedroom doors to show when personal care was being given and to prevent others entering at those times.

Feedback we received about staff was positive. People said that they appreciated how busy staff were and that "They're all very pleasant here". Another person said, "Staff care well for residents, carers are very kind and considerate". One relative said they had, "No complaints" about the care their loved one received, while another was very concerned about aspects of their loved one's support. One person responded to our questions by saying "I have to be here, put it that way".

Staff were observed gently and patiently interacting with people. One staff member cheerfully described a person's meal to them and engaged in lively 'small talk'. Staff used appropriate touch to reassure people and used people's names when speaking with them, giving a personal feel to conversations. Staff told us they were passionate about looking after people in their care. One staff member said: "I treat these residents like my family. I know them all'.

People were encouraged to be independent where possible. Staff followed one person with a wheelchair when they walked around so that they could continue to be independently mobile but had the reassurance of knowing support was close at hand if needed. Activities staff played a game with some people in which they were encouraged to throw a soft ball back to the staff member. This developed coordination and gave people the chance to show what they were able to do. People seemed to enjoy the game and the opportunity. Staff spoke confidently about people's levels of independence, and care plans documented which care tasks people could achieve for themselves and which they needed support with.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, the service was not consistently responsive to people's needs because care files did not contain important and specific information about people's health and care needs, or it was contradictory. At this inspection there had been some improvements but we continued to be concerned about the lack of detail in some care plans or the differences between one record and another; which could place people at risk.

Since our last inspection, individual care plans had been put in place for some of the specific conditions we had identified, such as epilepsy. These plans gave good guidance about the condition and how risks from it could be minimised. While some other conditions had care plans in place about their management, others did not. For example; there were no care plans about the management of a particular infection which staff had told us required 'Barrier nursing'. This is when special precautions are taken to ensure an infection is not spread to staff or other people. There was no information in this person's care file to demonstrate how the risk of infection was being managed. The peripatetic manager contacted us after the inspection to say the GP said that this person did not need to be isolated from others because the infection was confined to one place on their body; which was covered by a dressing. The GP added that staff should use protective aprons and gloves when supporting this person. However, none of this detail was recorded in care plans when we inspected; and staff were unclear about what risks the infection may pose.

Other care plans about conditions or equipment provided basic guidance but did not give sufficient detail about, for example; how to carry out specific, intimate nursing tasks without causing harm to the person, signs that medical attention should be sought or close monitoring should happen and details of hygienic practice to be observed in a person's daily care. Care plans about dementia were general and did not include personalised information about how the condition affected each individual person.

A large number of contradictions were found between documents held in people's care files. These made it difficult to see exactly what people's current needs were. One person's care plan about mobility said they were 'Able to feed self independently', while a safe environment care plan stated they needed supervision while eating and drinking. A further care plan about healthy skin said that the person should be encouraged to drink, and drinks should be placed in reach. There were no drinks in this person's reach during the inspection and staff had differing views about whether the person needed supervision while they drank. There was a risk that this person would not receive appropriate care because of confusing information.

Another person's care file contained recent, emailed information from speech and language therapists, (SaLT) to say the person needed to be supervised and monitored closely after a choking episode. This had not been specifically incorporated into the care plan. Another person's nutrition care plan noted they were at risk of choking but gave no directions about supervision of food and drinks or leaving them in reach. Older care plans had not been removed from care files when updated ones were put in place so it was possible to refer to the out of date information in error. Hospital passports, used to share important information about people when they needed to be transferred to hospital were not all up to date to reflect people's current care needs.

People were not consistently supported with physio exercises designed to improve their strength and mobility. One person had been recommended daily exercises following a series of falls. Their care plan did record that the person was not keen on doing the exercises and the majority of entries on an exercise log showed they had refused to participate. However, the log sheet also showed that support to exercise had not been offered on every day. There were no records to show physio opportunities were offered on 19 days since 23 June 2018. Another person's care plan said they should have daily exercises, and accompanying hospital documentation said this should happen for 12 weeks following an injury in February 2018. During April and May 2018 there were 15 days on which no record was made to show the exercise plan had been completed. There was also confusion about the period in which exercises should be continued. Nursing staff told us it was only for six weeks, when hospital instructions were for 12 weeks and in any event exercises had been carried out after the 12-week-period ended. The care plan had not been specific about the period to be covered.

The failure to assess and design care or treatment to ensure people's needs were met is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, there were no specific end of life care plans in place for people. At this inspection this had improved overall and some people had detailed plans in place, which included medicines that were ready in case people experienced pain or discomfort. However not all people had these plans, even though staff told us that those people were reaching the end of their lives. Staff used differing terminology to refer to people's last weeks and days.

We recommend that best practice guidance around end of life care is sought and that appropriate end of life care plans are developed and implemented for all people using the service.

Summary sheets had been introduced into people's care files so that the most important aspects of their needs were clearly documented and easily accessible. At our last inspection care staff had not been involved in handover meetings; which meant they were not always well-informed about updates to people's care or condition. At this inspection care staff were now included in these daily meetings and said that they found them helpful. Although handover sheets included information about people's on-going care needs and conditions, important details were not always documented about changes, so that all staff were aware. This is an area for further improvement.

Following our last inspection, 'ten at ten' meetings had been introduced so that managers and staff could have a daily ten- minute catch up about what was happening in the service and any changes. This was another way of improving communication in the service and staff said they found them, "A useful tool for us".

At our last inspection complaints had not been handled in line with the provider's complaint policy. At this inspection, complaints had been entered into a log but actions taken in response to them were only documented in one case. There were no records of investigations carried out or responses made to complainants in the other cases. This was not in line with the provider's own complaints policy.

The failure to operate an effective complaints system is a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they knew how to make a complaint and were mostly confident it would be dealt with appropriately. One person said, "I know how to make a complaint as I've been told – the staff are responsive most of the time" and another remarked "We know [Peripatetic manager's name] is in charge and if you go

to her she'll sort it out". One relative however said they had cause to make several complaints and, "Some things have improved but it's definitely not consistent".

People who were able to speak with us said they enjoyed activities on offer. One person said, "I like it when they have the quizzes and I like doing the crossword". Another person added, "I have enough to keep me busy and I do try to join in". During the inspection a ball-throwing game was underway, which people seemed to really enjoy. A giant crossword was also used to engage people and jigsaws and other puzzles were available. There was a budgie and a fish tank for people to look at if they chose to.

Activities staff worked full-time in the service and prepared a schedule of entertainment for each week. The schedule used words and pictures to show the activity on offer. Activities were more energetic and group-based in the mornings and individual in the afternoon. Outside entertainers visited once a week. One of the activities staff told us they enjoyed being with the people and having fun with them. We observed some fun interactions between the activities staff and people; where people appeared relaxed and happy. Staff said that people who were cared for in bed or who did not join in with communal activities were visited in the afternoons. They were offered hand massages, a chat or the opportunity to listen to music. One person particularly enjoyed art and activities staff said they spent time painting with them. Records had been maintained about the activities people liked and took part in. A religious service was conducted once a month for anyone who wished to attend.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2018, we judged that the service was not well-led. At this inspection, our judgement remained the same. Although there had been some improvements in the four months between inspections, these had not been sufficient to reduce a number of significant risks to people; leading to a high number of continued breaches of Regulation. For example, some people continued to be at risk of choking, of becoming dehydrated, of receiving inappropriate care and/or treatment due to inadequate or contradictory care planning, and of not having their needs met due to staff deployment and training issues. All of these areas had been specifically raised at our last inspection but had not been properly resolved.

Although some work had been undertaken to improve risk assessments for choking for example, staff practice did not ensure that known and documented risks were reduced. Management checks were not being carried out to ensure people were receiving enough to drink until we raised concerns; and staff continued to complete records about intake hours after the event, creating opportunities for error or inaccuracy. The management team said care plans were still, "A work in progress", but all the time they remained inaccurate or confusing, people were at risk of receiving inappropriate support. One person's care file had been audited by a quality and support manager in May 2018. This piece of work highlighted many actions that were required to update and improve care planning for that person. However, at the time of this inspection some of those actions had not been completed. For example, the language used to describe a wound site had not been amended and there was no end of life, dementia or sexuality care plans in place for them two months after the audit.

Weight charts for people had been grossly miscalculated by staff but this was not picked up until inspectors highlighted several charts during the inspection. There had been no management oversight of the chart entries and staff had not escalated concerns when their records showed people had lost extremely large amounts of weight. There had been a weights audit in the service in June 2018, which reviewed losses in April and May 2018. However, some of the weights cited in the audit differed from information in the charts we reviewed, which also differed from those documented by visiting dieticians. It was difficult therefore to assess how effective the audit had been.

Call bell audits had not been completed since May 2018 and we continued to receive feedback and observe that people did not always receive a timely response when they used them. New manager's 'daily walk around' checks had been introduced since the last inspection with the aim of picking up on any shortfalls and remedying them promptly. However, this system did not go far enough to provide meaningful assurances in some areas. For example, spot checks on people's fluid intake centred on where thickener was stored and that charts recorded its use. They did not include ensuring that people had received adequate fluid that day and that staff were completing charts contemporaneously; or observations to see that those people who needed thickened drinks received them. The lack of effective management processes for reviewing fluid, food, repositioning, weight and creams charts had allowed risks to people to go unchecked.

Although there had been increased input into the service from a team of quality and peripatetic managers,

their oversight had either failed to identify where risks remained and recommend action to address them, or where risks had been recognised, improvements and changes had not taken place in a timely way. An action plan produced for CQC documented the completion of some tasks which were found to still require resolution. For example, end of life care plans were noted as in place for all people as at 17 April 2018, but a provider quality audit found one person did not have one in May 2018; and still did not have it during our inspection. Target fluid amounts written onto fluid charts and adherence to the provider's complaints policy were also signed off as completed when we continued to find problems in both areas. Other items listed on the action plan had been addressed reactively following our last report, but without assessing the wider implications of our findings. For example, choking risk assessments were introduced but no checking processes for staff practice were initiated. Care plans about the specific medical conditions we had highlighted were produced and contained good guidance for staff, but no work had been done to proactively identify other conditions about which individual care plans were necessary.

The provider's chief operating officer said they believed that improvement had been made since our last inspection, but acknowledged that further changes were needed. They said the problems we continued to find were caused by the lack of a stable staff and management team. Although recruitment of permanent staff was ongoing, there remained a high reliance on agency staff. At the time of our inspection there was no registered manager in place and the last registered manager had left in September 2017. A new manager was due to commence work the week after our inspection and would need to apply to register with the CQC. It is a requirement of the provider's registration that there is a registered manager in place and the absence of one for over 10 months had contributed adversely to the governance of the service. Regardless of the lack of a registered manager however, the provider had responsibility to oversee the service and ensure its safety and efficiency.

The failure to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

A detailed medicines audit had been carried out on a weekly basis. The positive impact of this work was demonstrated because medicines, aside from creams, were managed consistently and safely in the service. Health and safety audits reviewed the environment, storage and cleanliness and were effective in highlighting and addressing any issues which came to light. Accident and incident audits were carried out monthly and gave an overview of events in the service. However, the times of falls and incidents were not used in the auditing to identify any trends and potentially inform staffing deployment decisions.

Feedback was invited from people and their relatives at regular meetings. Minutes of resident meetings showed that those who attended were generally happy with their care. One person said, "I'm delighted". However, during a relatives' meeting at the end of June 2018 two relatives raised the frequent use of agency staff and gaps in people's food and fluid charts. The response given was that these areas were being monitored, but at the time of our inspection this had not been satisfactorily resolved.

The failure to act on feedback is a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

A survey about people's experiences of Horncastle House had been recently issued to a small number of people and relatives. Only two responses had been received at the time of our inspection and these gave positive responses. Staff meetings were held regularly to garner staff views about the service. No staff survey had been issued since our last inspection but the management team discussed developing a local questionnaire. This was in response to concerns raised with us by staff and a relative about some staff

feeling they were treated differently or less favourably. Staff were friendly, open and cooperative throughout the inspection but some spoke of an, "Unpleasant culture" developing. The management team said they would consider ways of monitoring and addressing this situation.

The peripatetic manager had been working in the service for 11 weeks at the time of our inspection. Not all the people we spoke with knew who the current manager was but one person said, "The manager is [Peripatetic manager's name] and she listens to you which I like." A relative however told us that they had received assurances that changes would be made but that these had not happened. Staff told us they were exhausted by the changes in management and their morale was low. However, most staff we spoke with said they were beginning to feel more supported and cared for by the peripatetic manager and the provider. Despite the reports of low morale, staff remained professional, focused and worked hard during the inspection.

The peripatetic manager told us about improvements made since the last inspection. These included the organisation and indexing of care files, which we acknowledged made reviews of them easier. The introduction of ten at ten meetings and daily manager walkarounds had been designed to improve communication and identify some shortfalls. A bespoke recruitment campaign had been initiated; taking into account the remote rural location of Horncastle House, and with the goal of reducing the level of agency staff used on a regular basis. Actions in these areas had taken place and we also heard about plans for improvements going forward. These included: night visits by a manager, evening relatives' meetings and work by a clinically-trained quality support manager was felt to be improving nursing staff confidence. Plans were afoot to give some staff specific responsibility for particular aspects of care. The peripatetic manager accepted that care plans required significant continued work but said they wished to ensure plans were all cohesive and relevant; which would take longer. The peripatetic manager told us they were proud to see the changes that had been made at Horncastle House but that, "A lot more needs to be done".

The service worked in partnership with professionals such as GPs, dieticians, SaLT, opticians, podiatrists and specialist nurses in skin care, where further advice was needed about people's individual health and medical needs. The peripatetic manager said that managers from the provider's locations met together to discuss developments in the social care arena and areas of good practise to be shared.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given and on every website operated by or on behalf of them. This is so that people, visitors and those seeking information about the service can be informed of our judgments. Although we found the provider had conspicuously displayed their rating at the service, their website gave the rating assigned to Horncastle Care Centre and not Horncastle House; which could cause confusion to those seeking information about the service.

This is a breach of Regulation 20A of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The peripatetic manager was aware that they had to inform CQC of significant events in a timely way and notifications had been received appropriately since our last inspection.