Hastings Court Ltd

Hastings Court

Inspection report

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Date of inspection visit:
27 April 2017
28 April 2017
02 May 2017
07 May 2017

Date of publication:
29 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Hastings Court on the 27 April, 28 April, 02 and 7 May 2017. Hastings Court provides accommodation and nursing care for up to 80 people, who have nursing needs, including poor mobility, diabetes, as well as those living in various stages of dementia. There were 58 people living in the home during our inspection.

The home was purpose built to provide a safe environment for people living there. Bathrooms were specially designed and doors were wide enough so people who were in wheelchairs could move freely around the building. Accommodation was provided over three floors and split into four units. Peony unit provided nursing care, Poppy and Sunflower units provided care and support for people who lived with dementia and Bluebell unit provided 10 blocked beds for those who had left hospital and needed care and support before either going home or on to a long term placement.

Hastings Court is owned by Hastings Court Ltd and the organisation has one other care home in Essex.

This comprehensive inspection was brought forward by six months due to a large number of concerns raised by families, friends and staff.

Due to a high number of concerns raised about the safety of people, care delivery, deployment of staff and staffing levels we brought forward the scheduled inspection to the April 2017, so we could ensure that people were receiving safe care from sufficient numbers of suitably qualified staff.

At this inspection, people's safety was being compromised in a number of areas. Care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as breathing irregularities, diabetes and skin conditions did not have sufficient guidance in place for staff to deliver safe treatment. We also found that not all care plans reflected people's health needs such as care of people post-surgery, catheters and breathing issues. The deployment of staff impacted on the care delivery and staff were under pressure to deliver care in a timely fashion. Shortcuts in care delivery were identified in that person care was not delivered in the way people needed. We also found the provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves, as required under the MCA Code of Practice.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes and dislikes. Information in respect of people's lifestyle choices was not readily available for staff. The lack of meaningful activities at this time impacted negatively on people's well-being.

Quality assurance systems were in place but had not identified the shortfalls in care delivery and record

keeping. Incidents and accidents were recorded but there was no overview available that identified actions taken and plans to prevent a re-occurrence. We could not be assured that accidents and incidents were consistently investigated with a robust action plan to prevent a re-occurrence.

People's medicines were stored safely and in line with legal regulations. However people did not always receive their medicines as prescribed. There were missing signatures for medicines. These had not been followed up to ensure that people received their prescribed medicines. We also found poor recording of topical creams, dietary supplements and 'as required' medication.

People and visitors we spoke with were complimentary about the caring nature of some of the staff, but said that the changes to staff, use of agency staff and staff leaving had impacted on how the home was run. Some people were supported with little verbal interaction, and some spent time isolated in their rooms. Peoples' dignity and independence was not always promoted.

Feedback had been sought from people, relatives and staff in 2017 but had not been undertaken since changes to the running of the home were implemented and the new management team had been introduced. 'Residents' and staff meetings had been held on a regular basis which provided a forum for people to raise concerns and discuss ideas.

Staff told us they thought that communication systems needed to be improved and they required more support to deliver good care. Their comments included "It's been a bad time for us, but we are committed to improve."

People had a choice as to where they ate and they and their relatives were positive about the food provided. People told us they felt listened to in regard to their comments and suggestions about food and mealtimes.

People and their relatives were positive about the physical environment and aspects of the care they received such as their rooms and the support they received to dress the way they chose. The provider had established an organisational system whereby the registered manager was provided with practical support and guidance from area and regional managers along with head office support in regard to areas such as HR.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Hastings Court and bank nurses all had registration with the nursing midwifery council (NMC), which was up to date.

We found a number of breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Hastings Court was not consistently safe. Risk assessments, whilst in place were not up to date. The management of people's individual safety and skin integrity was poor and placed people at risk.

People's needs were not always taken into account when determining staffing deployment.

The management and administration of medicines was not always safe.

Staff had received training in how to safeguard people from abuse and staff recruitment practices were safe.

Is the service effective?

Requires Improvement

Hastings Court was not always effective.

The provider had not ensured and evidenced staff had undertaken best interest assessments in line with the best practice framework associated with the MCA.

Staff had not all received essential training to carry out their roles effectively. Safe care delivery was not consistent throughout the service.Not all staff received on-going professional development through regular supervisions and appraisals.

People were provided with a well balanced and nutritional diet which supported them to maintain their health.

Staff ensured people had access to healthcare professionals when they
needed it

Is the service caring?

Requires Improvement

Hastings Court was not consistently caring.

The provider had not ensured that people were not consistently

shown dignity and respect by staff.

People who remained in their bedroom received very little attention.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any interaction. However we also saw that some staff were very kind and thoughtful and when possible gave reassurance to the people they supported.

Peoples care records were held securely.

Is the service responsive?

Requires Improvement

Hastings Court was not consistently responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

Staff told us that people were able to make everyday choices, but we did not see this happening during our visit. Care plans were not all up to date and reflective of their individual needs. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

Whilst a complaints policy was in place we were not assured that complaints were handled appropriately. Not all visitors felt their complaint or concern had been resolved appropriately.

Is the service well-led?

Inadequate

Hastings court was not well led. People were put at risk because systems for monitoring quality were not effective.

Management had not ensured that the delivery of care was person focused or ensured that people were not left for long periods of time with no interaction or mental stimulation.

The home had a vision and values statement, however staff were not clear on the home's direction.

People spoke positively of the care staff, but commented that staffing levels and the use of agency staff had impacted on the running of the home and the care delivery. Staff and visitors had an awareness of the management team but felt communication could be improved

Hastings Court

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 checked 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.

We visited the home on the 27 April, 02 and 7 May 2017. This was an unannounced inspection. The inspection team consisted of two inspectors.

During the inspection, we spoke with 15 people who lived at the home, six relatives, ten care staff, two registered nurses, appointed manager, deputy manager and the area manager. On the 7 May 2017, we spoke by requested appointments to four visitors and three staff.

Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning on Elderflower unit and Poppy unit. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been raised 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 also contacted the local authority to obtain their views about the care provided in the home. Before the inspection, the provider had also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, five staff files along with information in regards to the upkeep of the premises. We also looked at seven care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Hastings Court. This is when we looked at their care documentation in depth and obtained their views on how they found living at Hastings Court. It is an

important part of our inspection, as it allowed us to capture information about a selected group of people receiving care.

Requires Improvement

Is the service safe?

Our findings

Not everyone told us they always felt safe. One person told us, "I do feel safe usually, I rely on the staff at the moment and I do have to wait for assistance sometimes." Another person said, "I have had concerns over the past few months, but it is slowly getting better again, it's been difficult with staffing I believe." Their relative told us, "Issues with staffing that has meant waiting for staff, despite ringing for help, but I am assured that it is being addressed." Feedback from staff and other visitors were also mixed. Visitors told us "I have had concerns that there is not enough staff at times and they have used a lot of agency," and "It's changed here, and not for the best, however a new manager has started and things are changing slowly." People who lived with dementia were not all able to tell us their experiences but we observed that people were comfortable with staff.

Peoples' risk assessments were not all accurate and some lacked sufficient guidance to keep people safe. Individual risk assessments were in place, which covered areas such as mobility, continence care, falls, nutrition, pressure damage and overall dependency. They looked at the identified risk and included a plan of action. However, some risk assessments did not include sufficient guidance for care staff to provide safe care and others were not being followed. For example, one person who came to live at Hastings Court had multiple specific needs that had not been recorded or assessed to prevent health complications. Two people who lived with type 2 diabetes did not have a care plan to guide staff in ensuring that their diabetes was managed safely. People's normal blood sugar levels were not recorded when they first came to live at the service and therefore there was no baseline see to ensure their diabetes was controlled if they were unwell. One person was losing weight and received fortified high calorie food which may make their sugar levels unstable. One staff member said "We are adding full fat milk, cream, cakes and sweets, anything that will add weight." Staff however had not considered the impact this may have on their diabetes and there was no random monitoring of blood sugars to monitor and mitigate risk. The lack of risk assessments and guidance for specific health needs placed the people at risk from unsafe care.

Risk assessments directed staff to monitor people's fluid intake when it had been identified the person was at risk from dehydration. Some records were incomplete and not added up to provide the total amount of fluids taken. Therefore the records would not be an effective way of monitoring how much they had eaten or drunk. There was also no guide amount for staff to aim for individual people, such as against the person's body weight. We identified three people on Poppy unit whose records indicated a fluid intake of less than 350 mls in 24 hours on three consecutive days. Staff had not recorded if a refusal had been followed up or whether it had been identified to the registered nurse (RN). One RN was not aware that two specific people had not been drinking well. This placed people at risk of dehydration and as a result possible skin damage.

Good skin care involves good management of continence and regular change of position. There was guidance for people in bed to receive position changes. However on the first day of the inspection peoples' positions were not changed. Gaps in the daily records for position changes confirmed that people were not being moved regularly. For example, one person remained in bed on their back for up to six hours until they received personal care after lunch. We identified throughout the inspection, four people had not been assisted to the toilet or offered a change of position in over six hours from 9 am until 2 pm. This increased

the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care. These people were therefore at risk from pressure damage because staff had not followed the guidance and managed people's skin integrity safely with regular checking and movement of position. We were told that it was lack of staff leadership that had impacted on the care delivery.

People who lived with behaviours that challenged had support plans in place which included distraction directives and one to one time. These however lacked any further directives that told staff of actions to take when there was physical aggression. Staff also said one to one time was not always possible due to staffing levels and the deployment of staff. One person's behaviours had escalated in March 2017 and included verbal and physical outbursts towards staff, visitors and other people. This had not been raised as a safeguarding for advice and support. Other people told us that they felt unsafe and frightened by the behaviours. This also had a negative impact on the person as they were becoming isolated and therefore more frustrated. There had been some confusion as to whether consultation with the specialist consultant had been undertaken. Some staff said there had been a visit and other staff said there had not. No urgent referral had been sent to the mental health team for advice and support whist waiting for a re-assessment. Therefore the risk to people, visitors and staff had not been mitigated in a timely manner.

The recording and the giving of medicines to people were not always safe. Current practices had not ensured people received their prescribed medicines on time. During our inspection morning medicines prescribed to be given at 8am took up to four hours to be dispensed. The midday medicines were then still dispensed at midday. The medicine giver had not signed the MAR with the actual time the medicine was administered and therefore it could not be evidenced as being given safely and as prescribed. Medicines given for pain relief were not always reflected in care plans as when to be given. For one person on pain relieving patches the pain care plan stated the person did not have pain. Staff when asked were not sure of the origin of the person's pain. There were no individual PRN protocols in place for medicines as to when it may be required, side effects to be aware of and of possible reactions to other medicines. There were also no pain charts or records completed with details of why they had been given or if the medicine was effective.

All the above issues had not ensured that people were protected from unsafe care and were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Hastings Court Nursing Home was divided into four units over four floors and the staff were allocated into separate staff teams to provide 24 hour care. On the first day the staffing numbers were not as detailed on the rota. The staff skill mix and deployment within the service impacted on safe care delivery. To cover staff shortages on Peony unit, staff had been moved from other units which meant other units were short staffed and the skill mix was not accurate. This impacted negatively on care delivery. For example, people did not receive the level of personal care to meet their needs. Personal care is washing, continence care, changing of clothing and oral care. On the 27 April 2017 at 12:30 pm, five people on Peony unit were still waiting for staff to assist with personal care. Staff told us that they had not yet been able to respond to peoples' individual needs.

Staff were moved from Sunflower unit and that meant that Sunflower unit was not sufficiently staffed. Staff told us that a replacement had not been found until 10 am. Throughout our inspection we observed multiple delays in calls bells being responded to in a timely manner. For example there were two instances when a staff member answered the bell and then did not return for up to 20 minutes. Staff told us that due to the lack of staff they had not been able to give people the showers, assisted washes and continence care that they were required to have. One staff member said, "We have done our best but it hasn't been good today." We asked staff if they felt the staffing levels at present were sufficient to provide safe care. Staff told

us, "last minute sickness, staff leaving without notice, it's all caused worry on the floor," "Lots of staff sickness and staff leaving." Visitors told us, "It's been an on-going problem I believe." One visitor whose relative was there on respite care was particularly concerned as they had waiting for assistance to transfer to the bathroom and had been waiting for over an hour. Both the person and relative were concerned that these delays to support would affect their recovery and independence.

During the inspection, we were informed by staff and visitors that there had been staff shortages over the weekend which were not covered. One visitor informed us that they had been told by staff on duty that five staff had not turned up for work and not been replaced. This surprised the senior management team as they said it was an accumulation of staff absence over the weekend and not on one shift. We have asked the management team to investigate these concerns. Feedback from visitors confirmed that they had concerns about staffing levels and had lost confidence with the service. The staffing rota confirmed shortages over the weekend but we were told that that these were covered. We looked at the work allocation sheets which covered those dates and found that there were inconsistencies in the amount of staff deployed to each unit. We have received further complaints from family and staff following the inspection visits. These concerns have been passed to the management team. Following the inspection we received information that the ratio of staff of staff met the dependency of the people who lived there. Whilst there were questions in respect of suitable ratios, there was no evidence received that the numbers of staff had impacted on care delivery that weekend. For example no increase in incidents and accidents, delayed response to call bells or formal complaints.

During and following the inspection we received feedback from visiting health professionals and families that on many occasions the main telephone was not answered when they rang to speak to the clinical team. One health professional felt that it had delayed treatment and advice for people who lived at Hastings Court. Families said, "It is worrying not to get through especially if my relative is poorly." Staff said staff deployment did not always give them the opportunity to ensure people were received safe care. This is an area that requires improvement.

There were some elements of safe care. There were systems to manage the storage, ordering and disposal of medicines safely. The clinical rooms were tidy and staff ensured that the room and fridge temperatures were checked daily.

The environment was well maintained and clean. There were appropriate numbers of domestic staff that completed cleaning schedules in order to ensure that the home was clean. Staff were able to tell us how they ensured that infection control risk was managed whilst working: this included the use of gloves and aprons, ensuring that equipment was clean, and not using hoist slings for more than one person. They spoke of the systems in place to manage stomach upsets and infectious skin disorders such as scabies. These were underpinned by organisational policies.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Equipment such as hoists and wheelchairs were stored securely but were accessible when needed. Regular checks on lifting equipment and the fire detection system were undertaken to make sure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and where required, each person had an individual personal evacuation plan. The provider employed a dedicated facilities manager who was responsible for overseeing the safety of the environment and premises.

Safeguarding policies and procedures were up to date and appropriate for this type of home in that they corresponded with the Local Authority and national guidance. There were notices on staff notice boards to guide staff in whom to contact if they were concerned about anything and detailed the whistle blowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest.' Staff told us what they would do if they suspected that abuse was occurring at the home. Staff confirmed they had received safeguarding training. They were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by the provider of Hastings Court and bank nurses all had registration with the Nursing Midwifery Council (NMC) which were up to date.

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Requires Improvement

Is the service effective?

Our findings

People told us that they saw their GP when they needed and told us that the staff were "Good about making sure I see the optician and dentist." We were also told, "I'm looked after," "The carers are very good but it can be a bit muddily." However, we found staff and management at Hastings Court did not consistently provide care that was effective.

Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. However there were people who lived on Poppy and Sunflower that would not always be able to give consent to personal care. This was not reflected in the initial mental capacity assessment or reflected in the care documentation. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. We identified that certain decisions about where people spent their time had not been asked, considered or referred for a best interests meeting. During our inspection we noted that on Poppy unit 12 people remained in their rooms and on continuous bed rest. We asked why and were told that was what was 'normal' for them. One staff member said, "Sometimes we get them up." There was no evidence documented of the rationale for that decision and who made that decision for them. A visitor said, "I don't see many people up in the lounge, but it might be better for them." Staff were unable to tell us about how certain decisions were made such as remaining in bed, sitting in a recliner chair and receiving covert medicines (covert medicines are medicines hidden in food and drink). One person was able to tell us clearly how they wished to spend their time but the documentation stated that they did not have the mental capacity to make that choice. Staff said, "Well, they might have changed their mind." There was no consideration given for those whose mental capacity may fluctuate daily. We met one person who was in bed and they told us, "I have to stay in bed I think, for my legs." However, when we spoke with staff they were not aware of a problem with the person's legs and did not know why they were on bed rest. There was no supporting documentation that explained the reasons why the person was on bed rest and whether any other option had been considered. This told us mental capacity assessments whilst undertaken, were not decision specific and were not recorded in line with legal requirements.

In March 2014, changes were made to the Deprivation Liberty Safeguards and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. We were told that DoLS referrals had been submitted for some but it was acknowledged that not all had been referred as yet. People were restricted from free movement by bed rails, tables placed in front of their chairs, positioned in recliner chairs and people remaining on bed rest without a clear rationale in place. This meant there was a lack of decision specific mental capacity assessments for people living at Hastings Court on how their freedom may be restricted or what least restrictive practice could be implemented. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had completed various training to make sure they had the skills and knowledge to

provide the support individuals needed. Some staff told us they were behind in some areas and this was already known to the organisation. The training programme showed that the percentage of essential training completed by care and nursing staff was at 70% and training was on going. Whilst some staff had received training it was not effective in all cases. We observed poor practices in supporting people to move, assisting people with their food and in delivering person centred care. There was also a lack of understanding shown by staff in supporting people who lived with dementia. This was observed by the lack of interaction when supporting people and not always managing behaviours that may challenge, effectively and consistently.

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which would be supported if necessary by additional training. Staff said, "Supervision is a bit hit and miss but it has now been organised." Staff told us they had felt unsupported due to staff changes and lack of leadership. This was reflected in the unsafe practices we observed. Appraisals for staff had not been undertaken and staff had not been supported to undertake further training to develop their skills, such as the health and social care diploma. The provider needs to ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was an area that requires improvement.

The organisation had recently introduced a new induction programme which they hoped would support new staff and build a strong team. Following the inspection we received positive feedback from staff who had recently completed the induction.

People had regular access to healthcare professionals and GP's visited the home on a weekly basis. They felt staff were good at escalating any concerns and following their advice. Each person had a multi-disciplinary care record which included information when dieticians, speech and language therapist (SALT) and other healthcare professionals had visited and provided guidance and support. Input was also sourced from the falls prevention team, Parkinson's nurse and tissue viability nurse. There was mixed feedback from visiting health professionals. We were told "They take guidance well and will call if they need advice." Whilst another said "I think communication is a problem, staff change and I'm not sure that advice always get through." People however felt confident their healthcare needs were effectively managed and monitored. One person told us, "If I'm ever unwell, they always get the nurse for me."

People's risk of malnourishment was assessed and reviewed on a monthly basis. Older people and people living with dementia are at heightened risk of malnourishment due to multi-factors such as poor mobility, physiological changes and swallowing difficulties. The provider utilised the Malnutrition Universal Screening Tool (MUST) to identify anyone who may be significant risk of malnourishment or experiencing weight loss. Where people had lost weight or were of a low weight, guidance was in place which included for fortified snacks and drinks to be offered in-between meal times. Food charts were in place for care staff to record people's nutritional intake if there was an identified need. This enabled staff to monitor people's food intake and identify where people may need additional encouragement. One staff member told us, "We always know who is not eating and tell the registered nurse or team leader, we should all be documenting peoples food and drinks" Staff were able to discuss how they encouraged and supported people to eat. For example one staff member said, "X eats better if they eat at the table."

A menu was displayed throughout the home. People were offered a variety of choice and were able to choose from options for each meal time. We spent time observing the lunchtime meal whilst sitting and interacting with people. Each unit had their own dining room with individual tables set up. Tables were decoratively laid with napkins, glasses and condiments, so people could chose a drink and flavour their food as they so wished. The staff served the meals from hot trolleys and each person was able to choose how

much they wanted. For people living with dementia, they were empowered to make decisions on what they preferred to eat. Staff members showed them the options which enabled them to make a choice. People spoke highly of the food. One person told us, "The food is always very good; there is a choice and it's well-cooked."

Requires Improvement

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. Staff did not always focus on people's comfort, and therefore there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact who were given very little time and attention throughout the day. People spoke positively of some care staff, but a visitor expressed some concern about lack of communication between staff and the people who lived at Hastings Court. Comments included, "I visit every day and sometimes I feel it's manic and not everyone is given attention," and "I see staff too busy, too busy and they are too busy to help people when they call out, I worry that people might not get the care they need." We were also told "Some very nice staff, kind," and "The care staff are really good."

People were not always treated with dignity and respect. People's preferences for personal care were recorded for each person but not always followed due to staff being rushed or staff shortages. Documentation on when people received oral hygiene, bath or a shower recorded that often people would not receive a bath or a shower as they preferred. One person said, "They tell me there isn't enough staff sometimes and so I get a lick and a promise." We noted that some people's clothing were stained with food and there was no offer of a change of clothing. Continence care was not being offered regularly. There were strong odours of urine in certain rooms which staff confirmed were due to heavy incontinence. One staff member said, "There hasn't been time to wash and change them, they were got up by the night staff at 6:30 am." It was identified that it had been six hours since the person was supported with their continence needs. This impacted negatively on the persons' dignity. The clinical lead informed us, "Care staff should be recording in people's daily notes when a bath or shower is offered and why oral hygiene was not given." The sample of daily notes and personal care check lists we looked at were not consistently completed. Visitors shared concerns that baths and showers were not being offered. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower. This meant not all people's personal hygiene needs were being met consistently.

Staff were confident when talking about how they promoted people's rights to privacy and dignity. They told us they always shut curtains and doors when assisting people with personal care and made sure people were covered when having a wash, bath or shower. One member of staff told us they always covered the lower part of a person if they were washing the top. Another member of staff told us they felt it was important to "tell people what you're doing". Whilst acknowledging staff's knowledge, not all practices encouraged people's dignity. We saw people in the morning left with their breakfast cold in front of them until just before lunch was served. Another person was left with food stains on their clothing without any staff offering to assist them to change. We also saw that when one person struggled with their clothing in the lounge ,staff just adjusted the clothing without any offer of going somewhere more private. A relative told us their family member's dignity was not always kept as they had visited at times and found their loved one in a "bit of a mess" which upset them.

Staff did not always respond to people appropriately and in a caring manner. Staff talked between themselves at times and not always to people they were supporting. We saw that some tasks such as

assisting with food and drinks were undertaken with minimal interaction between the person and staff member. Conversations between staff took place over peoples' heads and they were excluded from the conversation. During the morning some people were assisted to the lounge after personal care. A member of staff supporting people asked another member of staff "Shall I sit them there?" The response was "Over there." Staff did not consult with people to find out where they wanted to sit. This did not promote dignity or respect.

Some staff spoke about people, whilst in the vicinity of them and others. One member of staff told another "X is not themselves today." Another staff member called out to another "I'm off to do X's pad now." This was in relation to supporting a person with their personal care. The comment did not show a personalised approach. We spoke to staff about a specific person who was seen to be walking in the corridors and the staff member said the person was "Very difficult and she does my head in." This comment did not demonstrate empathy or a caring approach.

People's independence was not always promoted. For example, there were people who could request attention, but had no access to a call bell to summon assistance. One person told us "I think they forgot to give it to me." One person was very distressed because she had rung for assistance to get up to go to the bathroom and was told "I will go and get someone," but they didn't return for over an hour. We went and found staff for the person due to their distress. Another person who was at Hastings Court for respite before returning home had been waiting for staff to assist them with going to the bathroom. Their relative was concerned because of the delay and went and found a hoist to try and start the move as the persons' need to go to the bathroom became urgent. The relative was concerned that having to wait would start to impact on their independence and delay their return home. The care plan for this person had no directives in place for continence promotion or for promoting and maintaining their independence prior to going home. The family also said "There has been no attempt to encourage them to stand just for a few minutes to keep a little bit of independence." We were told that people could self-medicate if they were able to do so safely. However we saw no reflection of this being offered or suggested within the care plan. Staff said it was not routinely offered but was sure if someone asked, they could." The management team team and staff acknowledged that this had not been considered. This was something that would be taken forward in future.

People were not consistently treated with dignity and respect and they were not encouraged to remain independent or to live a life of their choice. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed caring and kind exchanges between people and staff. We heard many positive comments from people and their relatives about the staff approach. One person said, "They are very busy but they often make tricky jobs easy for me, which I appreciate." Another person said, "They are mostly very kind people and some like a laugh and a joke, which is nice." A relative told us, "I have been pleased so far with what I have seen, the staff are friendly."

'Resident's and relatives meetings' were held on a regular basis. These provided people and their relatives a chance to discuss any concerns, queries or make any suggestions. Minutes from staff and relatives meetings in January and February 2017 demonstrated that staffing, new residents, activities and call bells were discussed, but no action plan or response had been put in to place by the previous appointed manager. This was no being addressed by the new appointed manager.

Relatives and visitors told us they were free to visit and keep in contact with their family members and friends. They said they were made to welcome when they visited. Throughout the inspection, we saw

relatives coming and going, spending time with their loved ones in the communal areas or the person's own bedroom.

One person said, "I know I have got a care file, I know roughly what is in it but I'm not too bothered about detail, but I could if I wanted to." Care records were stored securely. Both paper and electronic confidential information related to people's care was kept secure.

Requires Improvement

Is the service responsive?

Our findings

Whilst some people and visitors told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to peoples' individual needs. We received mixed comments which included, "Excellent staff, and really nice place to live," and "I have to wait a lot, but I suppose other people need help as well, but when I want to use the bathroom I need it now not later." We were also told, "I ring but no-one comes for ages, but it is sometimes better than other times." A visitor said, "It can be frustrating to find staff at times that can tell me what's happening, I sometimes think that no-one knows what is going on, but we have a new manager so time will tell."

Care plans and daily records were not all up to date and had not been updated as changes occurred. There were care plans that had not been updated for three months. The organisation had recently introduced 'resident of the day' which would ensure that all care plans were reviewed on a monthly basis. There were also care plans that didn't reflect people's actual health needs, missing the essential care such as catheter care. Pain assessments were not undertaken on a day to day basis or at times of symptoms, such as agitation, which could indicate pain. Records showed some people were identified as having pain but this was not defined and there was no information about the areas affected. We were told that one person spent most days on bed rest but that was not clearly documented in their care plan or a rationale for that decision.

We looked at documentation of people who had developed pressure damage (ulcer). There was a lack of preventative measures recorded. There was no evidence recorded of any action taken by staff on noticing skin changes or of physical health changes that may affect their skin, such as enforced bed rest due to health conditions. There was confusing information regarding the status of wounds. One person had contributing factors that had not been recorded or responded to, such as incontinence and immobility.

Staff were not always aware of people's needs. When asked about specific aspects such as whether a person had a fluid chart in place, many responses from staff were "I'm not sure. I don't usually work on this unit." We asked a number of staff about the reasons why one person was now staying on bed rest and were told different things. We were told 'Their health has deteriorated so they stay in bed now,' another staff member said, "They do get out of bed."

There were designated staff to arrange social activities for people. At the time of inspection, there was one full time activity co-ordinator and one part time. A second part time activity co-ordinator had been recruited and this would allow one activity person per floor. The activity co-ordinator spoke of the plans they had to improve meaningful activities for people. There were plans to use the garden areas more now that a gardener had been employed.

Activities were undertaken in the communal areas of the home and people from the different units were supported to attend if they wanted to. Staff told us in addition to group activities, "one to one" chats were undertaken with people who were unable or did not wish to participate in group activities. Staff told us this

was done to try to help prevent people from becoming socially isolated. However on both days the activity co-ordinators spent all their time in the communal lounge. People in their rooms received very little interaction apart from 'tasks' such as meal service.

Some people spent the majority of their time in the lounge areas or in their room, either sleeping or unoccupied, looking ahead but not always engaging. There was some engagement with people who were more able to participate, but there was a lack of consistent stimulation for those people who lived with dementia. One person held a sensory item but no other such equipment was seen near people or easily assessable for them. One member of staff told us social activities for everyone was an area they felt the home could improve upon. Another member of staff told us they would like to see more sensory items for people and said, "We used to have a lot more going on, not sure what's happening but we have lots of ideas." A member of staff told us trips out for people was needed, "Two people went to Rye the other week and really enjoyed it, but unless more staff available this doesn't happen often enough." The member of staff told us not everyone was offered the opportunity to go out, which they did not feel was fair.

It was acknowledged by the appointed manager that there was work to do to ensure that the décor and environment on Sunflower was suitable for those people who were mobile and lived with dementia. The décor on Poppy unit was seen as dementia friendly as bedroom doors had been painted various strong colours and resembled front doors with memory prompts for people to locate their rooms. There were few people who were independently mobile for this to be helpful, however this would have been beneficial for those who lived on Sunflower. On Sunflower one person was searching for their room continually and becoming more frustrated and agitated. Staff did at times redirect the person but it was not always a successful interaction. The staff told us that since the redecoration many rummage and memory boxes had disappeared, and agreed that these needed to be re-introduced for specific people. They also said they were going to introduce notice boards on each floor so that people, visitors and staff were aware of what was happening on a daily basis and could join if they wished.

Staff told us there was always a member of staff allocated to a lounge, to monitor people and minimise incidents. This was not always the case, we found on two occasions during the morning that people were left unattended. This was due to poor staff deployment. The staffing arrangement had changed because of staff sickness and people did not attention and interaction they required for both social and health care delivery. We also noted when there was a member of staff in the lounge, they sat next to people but did not engage with them. They had limited conversation with people and did not undertake any activity to promote involvement. This was a missed opportunity, as the time available could have been spent undertaking meaningful activity or interaction with people. The evidence above demonstrates that delivery of care in Hastings Court at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format such as large print or pictorial. We received differing views on the complaint response, which were discussed with the management team. A visitor told us "I have been to the office but I'm not sure I have been taken seriously." Another visitor said, "I am confident that I can raise any concerns or grumble and the team ensure it's dealt with." We received information from visitors that they had raised a number of complaints but the provider told us that as they had been referred to the local authority the home had not recorded them as complaints and there was no record of actions taken to resolve the complaints.

We saw that a complaint from a family member had been received in January 2017 and not responded to by the management team until March 2017. This had now been resolved. Residents meeting notes in January 2017 report the loss of jewellery had been raised with housekeeping and care staff. There was no evidence of actions taken or follow up with the resident or family. There were families that informed us that they felt their concerns and complaints had not been taken forward appropriately in December 2016 to February 2017. This was before the new manager took up post.

Visitors also said at times they felt their concerns were 'dismissed' as unimportant. The management team were aware of the concerns raised and were arranging meetings with families to improve communication at all levels. The providers' complaint procedure was not fully established and did not operate effectively. This was an area that requires improvement. We were assured by the management team that all complaints were now being dealt with immediately.

When compliments and thank you cards had been received these were shared with staff at meetings and showed staff they were appreciated.

There were facilities within the home that were available for people such as a hair dressing salon, a gym and a new beauty therapy room. The appointed manager explained that the resident of the day got the opportunity for a beauty and hair dressing session along with their monthly review.

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished.

We saw photographs that showed people enjoying visits from outside entertainers and visitors. We also saw that people's birthdays were celebrated. Families told us that the communal facilities enabled them to visit and have private times which was 'Really appreciated."

We were told that satisfaction surveys had been sent out in the beginning of 2017, and the organisation was in the process of collating them. However there had been a large amount of changes in the home, including management and staff and we were told further surveys would be sent out when changes were settled. One visitor said, "I have been asked to complete a survey but I think it was last year, but I give feedback all the time."

Inadequate

Is the service well-led?

Our findings

Feedback from people, staff and visitors about the leadership in the home was varied. Comments from visitors included, "It has gone through a really bad patch, lots of unhappy staff, staff leaving and new faces all the time," and "I feel the use of agency staff has really affected the atmosphere, the care and my fear is however nice they are, the staff don't always know the residents well enough." Staff told us, "Changes have happened, lots of issues such as bullying and underlying problems, been terrible, staff don't want to work here and just leave, no loyalty," and "Not everyone listens."

The registered manager had left in July 2016 and the deputy manager was promoted to interim manager until the post was advertised. The deputy manager (interim) manager left the service in March 2017. Since then the post has been filled and the appointed manager has submitted their application to register with CQC. Organisational quality assurance systems were in place, however they were not all fully completed and had not identified all the shortfalls we found. The newly formed management team consisting of an appointed manager, deputy manager, clinical lead and area manager agreed that the recent audits had identified that there was a lot of work to do.

These included people's safety being potentially at risk as some care plans were lacking in specific information, which had the potential to cause harm to the individual. Four care plans we looked at, had not been updated since January 2017. We are aware of the difficulties experienced in finding a care plan system that was suitable for all staff but some staff were experiencing difficulties in inputting data and this had resulted in care plans not having the information required to provide safe care. Not all staff had received essential training or received regular supervision or yearly appraisals. This meant staff were not being appropriately supported to undertake their role and improve care practices. This was confirmed by the unsafe care practices observed during the inspection process.

We identified throughout the inspection that many people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints and lack of understanding of person centred care. We also found that people's hydration needs were not being managed effectively or monitored to ensure that people had enough to drink. The provider's care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example the management of catheters, amputated limbs, vascular disease, dementia and specific breathing problems. The weight records for people were updated either two weekly or monthly depending on the level of risk identified. However the records did not identify if there was weight loss or weight gain from the previous weight recorded. As the weights had not been put in to all peoples care plans, staff were not informed if there was a risk. This meant that management of weight loss may not be started in a timely manner. Staffing levels had been a problem due to last minute sickness and staff leaving a shift early. Whilst agency staff were used when possible this had not always addressed the staffing issues.

Staff handover sheets were not always accurate and up to date: for example one persons' fluid intake on the computer care plan stated 1700 mls for 24 April 2017 but the fluid chart completed by staff stated 700 mls. We spoke with staff about how information was shared. They told us they were given updates but felt they

"Were too quick sometimes and didn't really tell them much." A further daily meeting was held with senior staff mid-morning and it is thought that this was more helpful. Staff told us they were not always informed of the status of wounds, blood sugar irregularities and which people had not been drinking and eating enough. Though they also said, "some nurses and seniors are better than others." The management had identified this as an area that required improvement and were dealing with this through meetings with staff, handover sheets and supervision.
We found that the management team were not fully aware of peoples wound status, the poor documentation in respect of diabetes, and specific health care problems and of visitor and peoples complaints and concerns. The management team also did not have a complete overview of the training programme as the system was being transferred to a new system. The copy given to CQC was incorrect and an updated training programme was sent following the inspection. People therefore had not been protected against unsafe treatment by the quality assurance systems in place and this was a breach of Regulation 17 of the Health and Social Care Act 2014.

The values of the home were not embedded into every day care practice. The philosophy statement states "At Hastings Court we offer person centred care that is of the highest standard, it is tailored to individual's specific wishes and choices." It also stated, "We have a robust induction programme," "Staff supervision and appraisal," and a "commitment to building a competent and skilled team." These had not been achieved at this time. Staff told us that they felt unsupported, had not received regular training and supervision and that the management team were not always approachable and supportive. We acknowledge that there has been a lot of staff leaving, poor morale and discontented staff. This was an area that the management team were now robustly responding to, but this had affected the running of the home and impacted on the care and support people received.

Not all staff had an understanding of the vision of the home, which was to 'treat people as an individual and give them the opportunity to be fully involved with their care, and be encouraged to lead as active a lifestyle as they choose'. From observing staff interactions with people it was clear the vision of the home was not yet fully embedded into practice, as care was task based rather than person centred. We saw poor practices which were undertaken by a small percentage of staff but not challenged by other staff. This told us that the culture of the home had still to change to ensure person centred and safe care was delivered. The management team confirmed that staffing over the past six months had been a challenge.

Communication and leadership needed to be improved within the home. People and visitors had an awareness of the management team but felt that staff turnover and use of agency had unsettled the running of the home. Due to staff deployment and the use of agency staff we saw that poor practice was accepted by staff. We saw shortcuts in care delivery such as not moving people in a safe way and not supporting them adequately with meals and drinks. These shortcuts were noted to be due to time constraints and staff deployment. People therefore did not always receive the care they wanted and required.

The appointed manager and area manager told us one of the organisational core values was to have an open and transparent service. Friends and relatives meetings were planned and surveys were to be conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. One visitor said, "I have been worried because there seemed to be a lot of unrest, I hope they get things sorted."

A staff perceptions survey in January 2017. Only 33 of 98 surveys were returned. The results indicated that 21 of the 33 felt that staff morale at the home was not good. 17 of 33 staff said that they felt concerns taken to the management team were not heard or responded to. Staff meetings had not been held regularly over the

past six months, and we were assured that regular meetings would be held whilst changes to the home and documentation continued. The area manager said, "There is a lot to change, such as the culture, but I have confidence that we will get there. There is a strong organisational team that are working with us to improve the service."

The service had not always notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. However this has improved since the new management team has been formed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured that service users received person centred care that reflected their individual needs and preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that service users were treated with dignity and had their privacy protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.