Rotherwood Healthcare (Hampton Grange) Limited

Hampton Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**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

This was an unannounced comprehensive inspection carried out on the 7 March 2018, with further announced visits on the 13 and 22 March 2018.

Hampton Grange Nursing Home is a 'care home'. People in care homes received accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hampton Grange Nursing Home accommodates up to 42 people within one adapted building, and specialises in the care of people living with dementia and older people requiring general nursing care. At the time of our inspection, 31 people were living at the home.

A registered manager was in post and present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last comprehensive inspection of the service on 1 February 2017, we found a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities).Regulations 2014. We gave the service an overall rating of Requires Improvement. This breach related to the provider's failure to assess, monitor and improve the quality and safety of the service provided. The provider sent us an action plan setting out the improvements they intended to make.

At this inspection, we found the provider was still not meeting the requirements of Regulation 17. Their quality assurance had not enabled them to effectively identify and address the significant shortfalls in quality we identified during our inspection, and they had not maintained accurate, up to date and complete records of people's care. We served the provider with a warning notice which required them to become compliant with Regulation 17 by 1 June 2018.

We also identified breaches of Regulations 9, 12 and 13 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014. These related to the failure to provide consistent personalised care in line with people's assessed needs and preferences, the failure of staff to consistently adhere to agreed plans to minimise the risks to people, and the lack of effective procedures for investigating allegations of abuse.

Communication between staff and procedures for sharing information on risks were not as effective as they needed to be. Staff did not always adhere to safe working practices. People did not always receive their medicines as prescribed and in line with the provider's procedures. The procedures for monitoring accidents, incidents and unexplained injuries needed to be improved. The investigations conducted into potential safeguarding issues and associated decision-making were not always clearly recorded. People did not always have access to appropriate equipment and their involvement in decisions about what they ate and drank was not fully promoted.

Staff did not always maintain accurate records of people's food intake in line with their care plans. Care planning and record-keeping in relation to people's day-to-day health needs required improvement. People's rights under the Mental Capacity Act 2005 were not always fully promoted. Staff did not always treat people with dignity and respect and people's care plans were not always accurate, up-to-date and complete. The registered manager did not always work in unison with, or feel fully supported by, the provider. People, their relatives and staff found the registered manager approachable, but expressed mixed views about the overall management of the service.

The risks associated with people's individual care and support needs had been assessed, recorded and reviewed. Staff understood their individual responsibility to protect people from abuse. Pre-employment checks were completed to ensure prospective staff were suitable to work with people. Measures were in place to protect people from the risk of infection.

Steps had been taken adapt the home's environment for people living with dementia. People's individual needs and requirements were assessed before they moved into the home. People had physical assistance and encouragement to eat and drink and the risks associated with their eating and drinking were assessed, with appropriate specialist input. Staff received an induction, ongoing training and regular supervisions to help them perform their duties. Staff helped people to access a range of healthcare services.

Staff responded promptly to people in distress and knew the people they supported well. People's relatives were able to express their views on the service and to participate in care planning and reviews. People had support to participate in social and recreational activities, although the opportunities for them to do so were limited at present. The provider had procedures in place to ensure complaints were recorded, investigated and responded to. People receiving palliative care were supported to access a palliative care professional.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The risks to people were not consistently managed. People did not always receive their medicines as prescribed. The procedures for investigating safeguarding issues were not as effective as they needed to be. There were enough staff to safely meet people's individual needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The risks associated with people's eating and drinking were not always minimised. People's decision-making about what they ate and drank was not fully promoted. Staff supported people to access healthcare services to ensure their health was regularly monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff responded promptly to people in distress. People's relatives felt able to share their views on the service. People's rights to dignity and respect were not always fully promoted by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care that reflected their needs and preferences. People's relatives knew how to raise concerns with the provider. The service worked with a palliative care professional to meet people's palliative care needs.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's quality assurance was still not as effective as it needed to be. People's care records were not always accurate, up to date and complete. Staff did not always have confidence in

the management of the service.

Hampton Grange Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. This inspection 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.

This was an unannounced comprehensive inspection carried out on the 7 March 2018, with further announced visits on the 13 and 22 March 2018.

This inspection team consisted of two inspectors, an Expert by Experience and a specialist advisor who is a registered mental health nurse. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection site visit, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority, the local clinical commissioning group (CCG) and Healthwatch for their views on the service. We reviewed the information the provider had sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Over the course of our inspection, we spoke with seven people who use the service, 12 relatives, a social worker, a community physiotherapist and a clinical nurse specialist in palliative care. We also spoke with the director of quality assurance, the advisor to the board, the operations manager, the registered manager, the deputy manager, two nurses, a nurse assistant, the head chef, the activities coordinator, two senior care staff and three care staff.

We looked at 13 people's care records, medicines records, incident and accident reports, three staff recruitment records, staff training and supervision records, complaints records, activities records, repositioning charts and the staff duty rota.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People's medicines were administered by trained nurses, aside from non-medicated creams and ointments which were applied by care staff. The provider had procedures in place designed to ensure people received their medicines safely. However, we found people's medicines were not safely managed in practice, and that they did not always receive their medicines as prescribed. On this subject, a nurse told us, "People [staff] are not paying the attention they should be."

A number of people had been prescribed emollients and barrier creams to protect their skin from damage and infection. The medicines records we looked at indicated staff were not applying people's creams and ointments on a consistent basis. For example, one person, who had recently developed a 'moisture lesion', had not had their daily barrier cream applied over a three-day period, based upon these records. A 'moisture lesion' refers to skin damage caused by excessive moisture, which barriers creams help to prevent. One person told us, "I have cracks in my skin and they get very sore. They [staff] do put cream on, but not enough and not often enough."

Two people who had been prescribed Oramorph, a strong oral pain killer typically used to relieve severe ongoing pain, were not receiving this as directed. One person's medicine administration record (MAR) stated Oramorph was to be given before their personal care each day. However, this had not been administered over the five-day period since it had been received by the home.

'PRN protocols' and topical medication application charts were in place to provide nurses and care staff with guidance on the expected use of people's 'as required' and topical medicines. However, the information these contained was not always as clear as it needed to be. For example, topical medication application charts did not clarify to which areas of the body creams and ointments were to be applied. 'Topical medicines' commonly refers to medicines applied externally onto the skin.

We discussed these issues with the registered manager and provider. They assured us they would immediately investigate and address the specific concerns we had identified. The provider informed us the application of people's topical medicines would now be more closely monitored by the nursing assistants, registered manager and senior management team. They explained a new clinical lead was starting work at the home in April 2018, part of whose role would be to oversee the management of people's medicines.

The risks related to people's health, safety and welfare had been assessed, recorded and kept under regular review by the management team and nurses, through the use of recognised screening and assessment tools. This included consideration of people's mobility and risk of falls, their continence needs, their susceptibility to pressure ulcers and the risks of malnutrition or dehydration. Plans were in place, designed to manage these risks.

However, we were not assured staff consistently followed these plans to minimise the risks to people. A number of people living at the home had been assessed as requiring regular support from staff with repositioning themselves, to prevent the development of pressure sores. Some were assessed as being at

high risk of pressure sores, and one person had a current pressure sore on their heel. The turning and repositioning charts we reviewed indicated people may not be receiving consistent support in this area. For example, according to these records, one person, whose care plan stated they required support with repositioning every two hours during the day, had had to wait nine hours or longer for this support on four occasions during a single week.

We discussed this issue with the registered manager and provider. The registered manager told us, "I'm repeatedly asking them [staff] to get on top of the turn charts or to bath people; It's a constant battle." They explained the role of team leader had been introduced into the home's staffing structure to help monitor staff adherence to care plans and risk assessments. The provider indicated the Wi-Fi signal within the home may be affecting the communication between the iPods staff used to record people's repositioning and the home's computer system. However, they accepted further work needed to be done to ensure people were receiving correct support with repositioning, and assured us this would be more closely monitored by the registered manager and senior management team. Following our inspection visits, the provider arranged for the home's Wi-Fi network to be upgraded to eradicate any connection issues.

Staff did not always adhere to safe working practices. We observed two staff use a 'drag lift' to transfer one person from their wheelchair into a lounge chair. A 'drag lift' is an unsafe moving and handling technique, which was not permitted under the provider's procedures. A member of staff indicated to us the use of unsanctioned techniques was not an isolated event. One person informed us that, during the previous night, their manual handling had been completed by a single member of staff when two staff were required. Their care plan confirmed two staff members were to support them with all transfers. The provider assured us they would commence an immediate investigation into these concerns.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people were receiving their medicines as directed, and that the risks to people were always minimised.

Staff understood their individual responsibilities to protect people from abuse, were aware of potential signs of abuse, and recognised the need to immediately report any concerns of this nature to the management team. The provider had procedures in place designed to ensure any witnessed or suspected abuse was reported to the appropriate external agencies, such as the local authority, police and CQC, and investigated. However, during our inspection visits, we became aware of a recent safeguarding issue involving one of the people living at the home, which had not been reported to the local safeguarding team or CQC. The provider had put measures in place to protect this person from any potential abuse. However, the registered manager was unable to provide us with evidence of their original investigation into this issue or to give us a clear rationale for the decision taken not to notify the appropriate external agencies. The provider assured us they would conduct an immediate investigation into this issue, which resulted in a referral to the local safeguarding team and notification to CQC.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We were not assured of the effectiveness of the provider's procedures for investigating and notifying allegations of abuse.

Most of the people we spoke with told us they felt safe living at Hampton Grange Nursing Home, and most people's relatives agreed people were safe there. However, one person raised concerns regarding their physical treatment by night staff, explaining they sometimes felt vulnerable at night. The provider assured us the registered manager would immediately investigate these concerns, and that the senior management team would carry out further unannounced night checks. Following our inspection visits, the registered

manager confirmed their investigation into this matter had not identified any significant concerns in relation to the conduct of night staff.

People and their relatives expressed mixed views about staffing levels at the service. One relative told us, "There is a good level of staffing. They have a lot of regular staff, and they make sure they have the numbers." Another person said, "Staff are tired and stressed and are pushed all the time. It's not their fault, but it creates a tense environment." Staff raised concerns regarding the extent to which agreed staffing levels were consistently maintained. One staff member explained, "Yesterday, we had five people [care staff] on in the afternoon. It's a really common problem and it makes a difference in people's care and recording." They explained there would normally be six care staff plus a 'team leader' (senior care staff) on duty throughout the day, in addition to two nurses. The registered manager explained staffing levels were reviewed on a monthly basis in line with the provider's dependency tool, and that regular agency staff were used, whenever possible, to cover any planned or unplanned staff absences. This promoted continuity of care for the people who lived at the home. The staff duty rota indicated staffing levels were being maintained., and we found there were enough staff on duty to meet people's care needs and respond to their requests without unreasonable delay.

The provider completed checks on all prospective staff to ensure they were safe to work with people who lived at the home. This included requesting employment references and an enhanced Disclosure and Barring Service (DBS) check. The DBS searches police records and barred list information to help employers make safer recruitment decisions.

Measures were in place to protect people from the risk of infection. Domestic staff followed cleaning checklists to maintain standards of cleanliness and hygiene, and care staff made appropriate use of personal protective equipment, such as disposable gloves and aprons. The registered manager explained they reviewed infection control measures as part of their quarterly health and safety audits.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we saw limited evidence of dementia-friendly resources or adaptations in the home's communal areas or people's bedrooms. We recommended that the service explored the relevant guidance on how to make environments used by people with dementia more dementia-friendly. At this inspection, we found the provider had taken steps to further adapt the home for people living with dementia. These included clearer signage to help people better orientate themselves within the building and additional dementia-friendly activity resources, including a 'locks and latches' board and 'rummage baskets'.

Before people moved into the home, the management team met with them, their relatives and the community professionals involved in their care to assess their individual needs and requirements. This process was designed to support the development of effective care plans, ensure positive outcomes for people and avoid any form of discrimination in the care and support provided. People and their relatives expressed mixed views about the effectiveness of the care and support provided at Hampton Grange Nursing Home. One relative told us, "The staff are fantastic with [person]. They deal with their multiple needs very well." Another relative was critical of the staff's inconsistent management of their family member's continence needs, which, they told us, affected their level of comfort.

People's involvement in decisions about what they ate and drank was not fully promoted by the service. Although staff helped people to choose between the available meal options when meals were served, no menus or other information were available to advise people of planned meals in advance. One person told us, "I have no idea what is for lunch. We don't know until it gets here usually." Another person said, "The food is very good, but the menus stopped and no one has ever explained why." The head chef informed us the displaying of menus had stopped some months ago, as kitchen staff had not been following a set menu since that time. The registered manager was aware people did not have access to menus, and told us they had attempted to address this with the kitchen staff. The provider informed us they had purchased new menu boards, to help people choose their meals, and that these would be reintroduced as a matter of priority.

Any specific risks associated with people's eating and drinking were assessed, recorded and kept under review, with appropriate input from their GP and the local speech and language therapy (SLT) team. Plans were in place to manage these risks, including the provision of texture-modified diets and monitoring of people's food and fluid intake. However, staff did not always follow these plans to minimise the risks to individuals. One person's nutritional screening tool identified they were at chronic risk of malnutrition and had experienced significant weight loss in the last six months. Their care plan stipulated staff must maintain an accurate daily record of the food they had been offered and consumed, to enable their food intake to be effectively monitored. However, whilst the provider had a good understanding of this person's history of malnutrition, we found staff were not completing their 'food charts' in the manner or detail required.

A nurse acknowledged this was an ongoing issue, which they had previously addressed with the care staff. Following our inspection visits, the provider confirmed they had reiterated to all staff the need to maintain accurate food and fluid intake records, and explained the process for doing so in people's electronic care

records. They assured us the registered manager would be monitoring this aspect of record-keeping on a daily basis. We found another person's care plan and SLT assessment contained contradictory information about their dietary needs, although they were currently receiving the correct support in this area. Upon being made aware of this issue, the provider carried out a full review, during our inspection visit, of the information held at the service in relation to people's current dietary needs. They ensured care staff and catering staff had up-to-date and accurate information in this regard.

We saw mealtimes at the home were relaxed and social events. People chose where they wanted to have their meals, and received encouragement and physical assistance from staff to eat if required. They also had access to plenty of drinks and snacks between meals. One person and a relative commented, separately, on the need for a longer interval between lunch and the evening meal. The registered manager acknowledged this issue, and informed us they were relooking at the timings of main meals.

Upon starting work at the home, new staff completed the provider's induction training to help them settle into their new roles. This incorporated the requirements of the Care Certificate, which is a set of nationally-recognised standards that should be covered in the induction of new care staff. Following induction, staff participated in a rolling programme of training, which included some classroom-based training and a number of e-learning courses. One staff member described the benefits of the 'virtual dementia' training they had attended, explaining, "It gave us insight into how a person with dementia sees the world."

Upon reviewing the provider's staff training matrix, we saw a significant number of staff had been allocated, but had yet to complete, a number of their e-learning courses. This included training on health and safety, infection control, safeguarding and the MCA. We discussed this issue with the provider's operations manager. They informed us the home's management team had not monitored staff members' completion of e-learning courses in line with the provider's expectations. They assured us appropriate monitoring of outstanding courses, and a clear training plan, were now in place. The operations manager also explained that, in addition to the appointment of a new clinical lead, the induction process for nurses and nurse assistants had recently been improved with the aim of further increasing the level of clinical expertise within the home. Aside from training, staff attended bi-monthly one-to-one meetings with their allocated supervisor to receive feedback on their work performance and identify any additional support or training they may require.

Staff and management liaised with, and supported people to access, a range of healthcare professionals and services, with the aim of ensuring their health needs were regularly monitored and met. A local GP carried out a weekly round at the home to review people's current health needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. Staff demonstrated an appropriate understanding of people's rights under the MCA, and their associated responsibilities. However, we found individual mental capacity assessments and associated best-interests decisions-making had not been routinely undertaken in relation to the decision to care for people in their beds. We discussed this issue with the registered manager, who assured us this would be addressed.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the registered manager had made applications for DoLS authorisations based upon an individual assessment of people's capacity and their care and support arrangements. Where DoLS authorisations had been granted, the registered manager was aware of the need to review any associated conditions, in order to comply with these.

Requires Improvement

Is the service caring?

Our findings

The provider had measures in place designed to protect and promote people's rights to privacy and dignity. These included arrangements for the secure storage of people's confidential personal information, and the provision of staff training on dignity and respect. A community professional told us, "They [staff] have always been extremely helpful and very respectful of the service users they are supporting." Staff gave us examples of how they respected people's privacy and dignity, on a day-to-day basis, by, for example, knocking on their bedroom doors before entering, protecting their modesty during personal care and talking people through care tasks.

However, one person complained to us about night staff's failure to treat them with dignity. They told us, "The day staff always close the door and curtains to protect my privacy. It is not the same at night." A relative was also critical of the undignified comments staff had, on a particular occasion, made about their family member, whilst attending to their continence needs. During our inspection visits, we heard a staff member discussing one person's personal care needs in an indiscreet manner in the communal lounge. The registered manager acknowledged further work needed to be done to ensure people's privacy and dignity were fully promoted by staff. They felt the newly-appointed team leaders would play a central role in monitoring and addressing any staff conduct issues in this area.

The majority of the people and relatives we spoke with felt staff adopted a caring approach towards their work. One relative said, "They [staff] seem genuinely very caring and are always quite cheerful." Another relative described how they had been impressed by the physical reassurance staff had given their family member when they became distressed at the end of their visits to the home. They told us, "I'd mark them [staff] as excellent." A community professional commented on the "overriding commitment and compassion" of staff and praised the manner in which they had 'gone the extra mile' to ensure one person's recent birthday felt special to them. However, one person and a relative raised separate concerns about the uncaring approach of some night staff, which the provider informed us would be fully investigated. Following our inspection visits, the provider confirmed they had undertaken a number of night spot checks and that these had not identified any concerns in relation to the conduct of night staff.

People were at ease in the presence of staff, who took interest in what people had to say to them and responded in a polite and professional manner. Staff showed good insight into people's personalities and individual needs. We saw staff responded promptly in the event people became distressed or needed emotional support. When one person became upset during the evening meal, a member of staff sat next to them and offered effective reassurance. Staff responded in a similarly prompt manner to another person who became distressed in their bedroom, investigating the cause of their distress and offering them a drink and pain relief.

People's care plans included information about their individual communication needs, and guidance for staff on promoting effective communication. We saw staff adjusted their communication with people to suit individual needs. The majority of the relatives we spoke with were satisfied with the support and opportunities they and their family members had to express their views, and to participate in decision-

making. The registered manager explained they intended to make monthly courtesy calls to people's relatives, going forward, as a further means of encouraging them to share their views on the service.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive person-centred care and support that reflected their needs and preferences. For example, we saw one person's care plans emphasised the importance of them being able to wash their hair regularly, as they had previously done themselves, to prevent it from becoming greasy. However, their 'hygiene charts' for the previous four weeks indicated they had not been supported to wash their hair for periods of up to 12 days. We asked staff whether this record was accurate and a staff member confirmed it was. They said, "People [staff] are not picking up on it. We have been telling care staff that [person's] hair-wash can happen later in the evening, It's not being monitored."

Another person informed us they were supposed to have a bath weekly, but were rarely supported to do so. This person's care plan indicated they were to be offered a bath twice a week. However, their 'hygiene chart' confirmed they had not been supported to bathe over the 28-day period reviewed, although they had been assisted to wash almost every day. A member of staff explained the obstacle to this person bathing was the lack of a suitable sling, and that they had a disposable sling given to them on discharge from hospital. They told us, "Baths are important to [person]." They went on to say, "They [management team] are in the process of getting [person] a new sling…They have no bathing sling. It's not safe; they slip out of it." The deputy manager informed us an order had been placed for a replacement sling, but could not provide us with a clear timescale for its delivery. The registered manager was unaware of the unsuitability of the individual's sling, but assured us they would chase up the delivery of the replacement sling. Following our inspection visits, the registered manager confirmed the replacement sling was now in use. The provider informed us their investigation into this matter had shown this person's poor health and pain levels had prevented them from bathing over the period in question.

A member of staff made us aware that a broken 'bucket chair', which had, they said, been out of use for two to three weeks, was preventing one person from accessing the home's communal areas. We saw this person's care plan referred to the use of this chair, and their enjoyment of spending time with others in communal areas. The deputy manager was aware the chair in question was out of use, but was unclear about the specific plans and timescales for repairing this. The registered manager was unaware of the faulty chair, and expressed their frustration that staff were not using other suitable chairs within the home, to enable the individual to spend time with others. Following our inspection visits, the provider confirmed the bucket chair had been repaired and was available for this person's use.

A significant number of people living at the home were cared for in their beds. We found the rationale behind this decision, and consideration given to less restrictive arrangements, were not always clearly recorded in their care plans. For example, one person's care plan stated, "[Person] is nursed mostly in bed, because their legs are stiff and it is difficult to help them transfer to other areas of the home." The registered manager acknowledged staff were not consistently supporting some people on the first floor of the home to spend time in the home's communal areas. They said they had left repeated reminders for staff in the home's diary, in an attempt to address this issue. They assured us they would review this aspect of people's care as a matter of priority.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure people received personalised care and support that met their needs and reflected their preferences.

Most people's relatives were satisfied with their current level of involvement in care planning and other decision-making that affected their family member's care and support at Hampton Grange Nursing Home. One relative told us, "They [staff and management] keep me very well informed, as I'm very hands-on." Another relative explained they had been involved in developing their family member's care plan and had attended care review meetings.

People's care plans were individual to them, covered a range of needs and included information about people's preferences and preferred daily routines. We saw care plans were accessible to staff, either on the home's computer system or the iPods staff carried which were connected to this. Staff confirmed they read and referred back to people's care plans as necessary. However, our findings indicated staff did not consistently adhere to care plans.

The registered manager was aware of people's protected characteristics under the Equality Act 2010. They assured us people's related needs, including their religious beliefs, were considered as part of the assessment and care planning processes. The registered manager showed insight into the Accessible Information Standard, and we saw people's communication needs had been assessed and recorded. They told us the provider had the facility to produce information in alternative accessible formats, if required to meet people's information and communication needs. They explained that, at present, staff were helping people to obtain audiobooks and newspapers on CDs. All providers of NHS and publicly-funded adult social care must follow the Accessible Information Standard. The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand.

The provider employed an activities coordinator to organise and undertake social and recreational activities with people on a group and one-to-one basis. They divided their time equally between the service and another home on the same site, which was also operated by the provider. The activities coordinator demonstrated clear enthusiasm for their role, good awareness into people's personal backgrounds and insight into the needs of people with dementia. For example, we saw they had provided one person, who used to work as midwife, with a box of bandages and dressings to interact with.

A weekly activities schedule was in place which, for the week reviewed, included a fun fitness class, a visit by the hairdresser, an animal workshop, arts and crafts and bingo. Representatives from a local church also visited people at the home on a weekly basis. During our inspection visits, we saw people engaged in one-to-one reminiscence work with the activities coordinator, interacting with the home's recently-hatched chicks and making pictures with pressed flowers with the help of a volunteer.

However, at other times, people appeared to have limited opportunities for stimulation and meaningful engagement with staff, particularly those nursed in bed on the home's first floor. The activities records we reviewed supported this. Some of those we spoke with expressed the view that the activities coordinator was overstretched. One person told us, "There is only one activities coordinator, which is not enough. We used to have trips out and about in the mini-bus, but I'd say we haven't done that for getting on for two years now." A member of staff said, "We need more people like the activities coordinator to bring stimulation to people in their beds." The registered manager acknowledged this issue, explaining, "They [activities coordinator] are ever so thinly spread." The provider assured us they were actively seeking to recruit a temporary activities coordinator to cover the home's second activities coordinator who had recently started

their maternity leave earlier than originally planned.

People's relatives knew how to raise any concerns and complaints about their family member's care at Hampton Grange Nursing Home. However, they expressed mixed views about the management team's response to their concerns. One relative told us, "They [management] are usually quite quick at coming back to you and providing answers." Another relative said, "When I request things [of the management team], they don't happen." The registered manager confirmed they took all complaints seriously, and were unaware of any unaddressed or unresolved issues. We saw the provider had a complaints procedure in place to encourage consistent complaints management. The service's complaints tracking system indicated complaints were logged, investigated and responded to.

At the time of our inspection visits, one person living at the home was receiving palliative care. We saw they had access to a palliative care professional and that efforts had been made to establish their preferences and choices for their end of life care. This palliative care professional talked positively about their work with the service, to date, to manage people's pain and other symptoms. They told us, "To be fair to them, if I make suggestions they [staff and management] do respond well, and they are proactive in calling me back." We found the service needed to adopt a more consistent and proactive approach to 'advance care planning' with people. 'Advance care planning' involves helping people to make plans for their future care, through discussion with them and their relatives. The registered manager acknowledged this issue, and assured us this would be addressing going forward.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we were not assured that the provider's quality assurance was as effective as it needed to be. It had not enabled the provider to identify and address the issues and concerns we identified during our inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider was still not meeting the requirements of Regulation 17. The provider had a series of audits and checks in place to help them assess, monitor and address the quality of the service people received. This included a monthly 'monitoring report' completed by the registered manager, which focused on key aspects of the service, and enabled the provider to tailor their own audits on the service. The provider's lead on medicines management also carried out monthly medication audits at the home. The senior board members held monthly senior management meetings to review clinical indicators at the service, such as falls, pressure sores and hospital admissions, and to review trends in any complaints or safeguarding issues.

Through these audits and checks, the provider had highlighted to the registered manager the need for improvement in a number of areas, such as the standard of people's care planning and medicines records, which reflected the findings our inspection. However, we found the provider's quality assurance systems and processes were still not as effective as they needed to be, as they had not enabled them to address, in a timely manner, the significant shortfalls in the quality and safety of the care people received at Hampton Grange Nursing Home. This included the inconsistencies in repositioning and the management of their medicines, and the lack of a consistent person-centred approach. This was the service's second successive overall rating of requires improvement.

The records maintained in relation to people's care and treatment were not always accurate, up to date and complete. For example, people's wound care records were not always fully and accurately completed to support the effective monitoring and treatment of wounds. Of the two wound care records we reviewed, one person's records lacked a clear and up-to-date description of the nature and size of the wound in question. One person's epilepsy care plan lacked basic information, such as the type, frequency and known triggers for their seizures, and contradicted the information recorded on the PRN protocol in place for the use of their epilepsy rescue medication. Another person's diabetes care plan lacked key information, including the type of diabetes they had , the arrangements for specialist review of their medical condition and the target blood glucose range. We looked at the blood glucose level chart completed for another person with diabetes and found this had not been completed on a consistent basis.

In addition, we found people living with persistent pain did not always have a pain management plan in place setting out how their pain was to be effectively managed. Further omissions in care planning were the lack of clear behavioural guidelines for one person who was resistant to their personal care, and the lack of an appropriate psoriasis care plan for one person living with this skin condition. Another person's care plans contained out-of-date information regarding the treatment of their cancer and use of a pressure mat to reduce the risk of falls. However, we found that care staff spoke with a good overall understanding of

people's care needs.

The registered manager acknowledged these issues should have been identified as part of the nurses' monthly review of care plans, and assured they would now be addressed without delay. Following our inspection visits, the provider confirmed a clinical governance matrix had been implemented for the service. A weekly clinical governance meeting was also now held on a weekly basis to identify people at high risk and ensure their care plans accurately reflected their needs. The provider had also made a training care plan available to all staff outlining the minimum information required in complex clinical care plans.

One person had been prescribed a steroid ointment used to treat their severely ulcerated legs, which was to be applied to their legs during dressing changes. We found this had not been signed for as administered on their MAR since 19 March 2018. The provider informed us that, based upon their investigation into the issue, this ointment had been applied as directed, but not signed for by the nurses. They assured us the registered manager and nursing assistants would be more closely monitoring the correct completion of people's MARs.

The provider had systems and procedures in place to enable staff to record and report any accidents or incidents involving people living at the home to the nurses and management team. However, we found any investigation or follow-up action completed by the nurses and management team to keep people safe following such events was not consistently recorded. The provider informed us a new system for incident and accident reporting had been introduced in January 2018, which the registered manager had not adhered to. They assured use this would be closely monitored going forward.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's quality assurance systems and processes were not as effective as they needed to be. The provider had not maintained accurate, up to date and complete records of people's care and treatment.

Following our inspection visits, we wrote to the provider to express our concerns about the inspection findings. In response, they sent us an action plan within the given timescale.

The nursing staff completed daily 'handovers' at shift changeovers, designed to provide staff arriving on duty with up-to-date information about the people in their care and any changes in needs or risks. We were not assured of the overall effectiveness of the communication procedures at the home. On more than one occasion, the nursing staff provided us with contradictory information about people's care and the administration of their medicines. We also found the head chef did not have clear insight into people's known food allergies. A relative we spoke with also raised concerns about the lack of effective communication between nurses and care staff, which had, they indicated, resulted in their family member's adjustable bed backrest being left in an unsuitable position. They told us, "When they [staff] have handover, staff should have known this." Two members of staff also raised concerns regarding the adequacy of the handovers they received. Following our inspection visits, the registered manager informed us they had introduced a weekly clinical meeting, and were making changes to the staff shift pattern, to improve communication between nursing staff. During our inspection, the provider confirmed they had undertaken a full audit of people's food allergies and distributed up-to-date details of these to both the care and kitchen staff.

During our inspection visit, we met with the registered manager who was responsible for the day-to-day management of the service and that of an associated home operated by the provider on the same site. They demonstrated a good understanding of the overall duties and responsibilities associated with their post. The registered manager explained that they kept up to date with legislative changes and current best

practice guidelines by, amongst other things, attending further training, participating in local registered manager forum meetings and accessing care websites and resources online. However, based upon our discussion with the registered manager, we were not assured they and the provider always worked in unison to provide effective leadership and management to the service, and to monitor the quality and safety of the service people received.

Following our inspection visits, the provider confirmed the registered manager had left the service and a new manager was now in post. They assured us the senior management team would be providing additional monitoring and support at the home to drive the necessary improvements in the service.

The registered manager told us they promoted an inclusive culture and 'open door approach' to the management of the service, aimed at enabling and encouraging people, their relatives, staff and community professionals to readily approach them at any time. They told us they had previously held a 'residents and relatives meeting' to engage with people and their relatives as a group, but that this had been poorly attended. They explained they had also sent out feedback surveys to capture relatives' views on the service. The registered manager said they regularly worked alongside staff, and also engaged with staff through individual and group supervisions and monthly staff meetings.

We saw people and visitors were comfortable in the presence of the registered manager, and that people enjoyed chatting with them when they spent time in the home's communal areas. Those we spoke with confirmed the registered manager was approachable. Most people's relatives were also satisfied with the open communication they had with the service, which ensured they were informed of any changes in their family member's care, health or wellbeing. One relative explained, "The communication is very good. They [staff and management] phone me if they are changing anything, or if there has been a medication change."

However, people and their relatives expressed mixed views about the overall management of the service. Some of those we spoke with talked positively about their dealings with, and confidence in, the management team. One relative told us, "They [management team] are both very hands-on, which is a good thing. I regularly see them supporting staff." They went on to say, "I can't rate them high enough. I've been very impressed with the service all the way through." However, others expressed less confidence in the management team.

Similarly, staff had mixed opinions about the management of the service and the degree to which they felt valued and supported in their roles. One staff member said, "I do think it's run alright. [Registered manager] has been very supportive towards me. They have been wonderful and so has [operations manager]. They have got our best interests at heart." Another staff member told us, "I don't feel appreciated. There's a lack of appreciation and support." Two member of staff expressed concerns about the management team's willingness to act on issues brought to their attention. One of these explained, "We go over issues with management, but nothing actually gets done."

The provider had a whistleblowing policy in place, and staff told us they would follow this, if necessary. Whistleblowing refers to when an employee tells the authorities or the public about wrongdoing in the workplace.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received personalised care and support that met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people were receiving their medicines as directed, or that the risks associated with people's care and support needs were always minimised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's procedures for investigating and notifying allegations of abuse were not as effective as they needed to be.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes were not as effective as they needed to be, and had not enabled them to address, in a timely manner, the significant shortfalls in the quality and safety of the care people received. The records maintained in relation to people's care and treatment were not always accurate, up to date and complete.

The enforcement action we took:

We served the provider with a warning notice which required them to become compliant with Regulation 17 by 1 June 2018.