Bedstone Limited

The Hockeredge

Inspection report

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05 May 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 27 and 28 April 2016 and 05 May 2016.

The service provides accommodation with nursing and personal care for up to 50 people, some of whom may be living with mental health and dementia related conditions. Bedrooms are on the ground and first floor and are all single occupancy. There is a lift to the first and second floors. There are communal lounges, a dining room and activity areas on the ground floor. There is a garden to the rear of the property. There were 42 people living at the service when we inspected.

We last inspected this service in July 2015. At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We issued two warning notices in relation to good governance and safe care and treatment. We issued requirement notices relating to person centred care, staffing, safeguarding service users from improper care and treatment and the need for consent. We asked the provider to take action and the provider sent us an action plan.

The provider had not completed all the actions they told us they would make. In particular, they had not met the requirements of the warning notices we issued following our last inspection. As a result, they were continuing to breach regulations relating to fundamental standards of care.

There was no registered manager when we visited as required by regulations. The last registered manager left the position in March 2014. 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. There was an acting manager in post who was in the process of applying to become the registered manager. The acting manager was supported by two clinical managers who were registered nurses.

People had suffered avoidable harm and pain. The nursing staff had not acted appropriately or in a timely way to make sure people were safe and getting the care and treatment that they needed. Nursing staff had not taken appropriate action when people's health deteriorated.

People were at risk of neglect and were at risk of receiving improper treatment. Risks to people were not being well managed and reduced. People's weight loss, pressure areas, diabetes and catheter care were not managed consistently. Medicines were not always available for people when they needed them.

People were not supported effectively with their health care needs. There had been delays in accessing health care specialists when they were needed. When people needed to see a doctor because their health was deteriorating the staff did not always recognise signs and symptoms of ill health and doctors or other professionals were not always contacted.

Recruitment processes were in place to check that staff were of good character. Information had been requested about staff's employment history, including gaps in employment. There were enough staff on duty to meet people's needs. Staff had not received all the training they needed to meet the needs of people. Staff did not receive the supervision and support they needed to carry out their roles effectively.

The provider had a complaints policy and process. Complaints were not always managed effectively to make sure they were responded to appropriately, in a timely manner and in line with the policy. People and their relatives told us they would speak with the acting manager or staff if they had a concern and they would be listened to.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service. There was a lack of continuity in the management of the service, which had impacted on people, staff and the quality of service provided.

Care staff were clear about their role and responsibilities but the clinical management by the registered nurses was not effective. The clinical competency and accountability of nurses was not assessed and monitored and registered nurses had not consistently completed the tasks they were accountable for.

A range of policies and procedures were available to guide staff on carrying out their roles safely and effectively. Staff knew where to access the information they needed; however, these policies were not consistently followed. People were at risk because systems for monitoring the quality of care provided were not effective. Records were not suitably detailed, or accurately maintained.

People could not be sure that when they were at the end of their life they would receive the care and support that they needed. People's care and nursing needs were not always met. People's care had not been planned or updated when there were changes in their needs.

The acting manager and some of the staff understood the requirements of the Deprivation of Liberty Safeguards. There were procedures in place in relation to the Mental Capacity Act 2005.

People were offered a choice of food and drink which they enjoyed. The food looked appetising. Staff encouraged and supported people to eat a healthy and nutritious diet. People were treated with dignity and respect. Staff were discreet and sensitive when supporting people with their personal care needs and protected their dignity.

People had some opportunities to take part in activities. Relatives told us they were able to visit when they wanted to and there were no restrictions.

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

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety and welfare were not always managed to make sure they were protected from harm.

People were not protected against the risk of abuse and improper treatment.

Medicines were not always available for people when they needed them.

There were enough staff on duty to meet people's needs. Staff were recruited safely and the provider's recruitment policy was followed.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received all the training they needed to meet people's needs. Staff did not receive the supervision and support they needed to carry out their roles effectively.

People were not supported effectively with their health care needs.

The acting manager and some of the staff understood the requirements of the Deprivation of Liberty Safeguards. There were procedures in place in relation to the Mental Capacity Act 2005.

People were offered a choice of food and drink which they enjoyed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People could not be sure that when they were at the end of their life they would receive the care and support that they needed.

People were treated with dignity and respect but were not always responded to in a way that best met their needs.

People's records were stored securely to protect their confidentiality.

Is the service responsive?

Inadequate

The service was not responsive

People's care and nursing needs were not always met. People's care had not been planned or care plans updated when there were changes in their needs.

People had some opportunities to take part in activities.

Complaints were not always managed effectively to make sure they were responded to in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service.

There was a lack of continuity in the management of the service, which had impacted on people, staff and the service provided. There was no registered manager.

Care staff were aware of their role and responsibilities but the clinical management and governance was not effective.

Systems for monitoring the quality of care provided were not effective. Records were not suitably detailed, or accurately maintained.

The Hockeredge

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 April 2016 and was unannounced. The inspection was carried out by three inspectors and a specialist advisor. The specialist advisor was someone who had clinical experience and knowledge of working with people who have complex nursing needs. On 05 May 2016 one inspector and an inspection manager met with the provider and his management team at The Hockeredge.

We did not ask the provider to complete a Provider Information Return (PIR), as we carried out this inspection at short notice because we had received concerns about the service. A PIR 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.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) and information from the local authority safeguarding team. A notification is information about important events, such as a death or a serious injury, which the provider is required to tell us about by law.

During our inspection we met with most of the people using the service, five relatives, eight members of care staff, the executive director, manager and the provider. We also spoke with five visiting health professionals.

We looked around the service and grounds. We observed the lunch time meal and observed how staff spoke and interacted with people. Some people were not able to explain their experiences of living at the service to us due to their dementia so 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. During our inspection we observed how the staff spoke to and engaged with people and their visiting relatives. We looked at how people were supported throughout the day with their daily routines and activities.

We reviewed seven care plans, and looked at a range of other records, including safety checks, records kept for people's medicines, six staff files and records about how the quality of the service was managed.

We last inspected this service in July 2015 when a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified and we took enforcement action.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2015 the provider had failed to make sure that risks to people, staff and others had been managed to protect people from harm and to ensure their safety. The provider had failed to make sure that care and treatment was provided in a safe way. We took enforcement action against the provider and issued a warning notice. The provider sent us an action plan telling us how they were going to improve. At this inspection we found that improvements had not been made in managing risks to people to make sure they were as safe as possible.

Staff were not suitably competent and skilled, so people were risk of improper treatment and people had suffered avoidable harm. The registered nurses had not acted appropriately or promptly to make sure people were safe and getting the care and treatment that they needed. Appropriate action had not been taken by registered nurses when people were unwell and when their condition was deteriorating. For example, a registered nurse had taken a person's blood pressure, temperature and pulse and they were not within the limits for good health. Nursing staff took no action. They did not contact a doctor as would be the normal procedure and the person became more unwell.

A person had fallen while away from the service and returned from hospital with cuts and bruises to their head and face. Staff contacted the acting manager. The acting manager told us that they instructed the staff to undertake 15 minute head injury checks on the person. These checks were not carried out. Instead, the staff undertook 30 minute checks to see if the person was awake or asleep throughout the night. No specialist head injury checks or observations were undertaken to assess if the person was clinically stable and to monitor for any adverse symptoms. The registered nurses on night duty failed to do any of the specialist head injury checks and observations which left the person at risk of deteriorating and further harm.

Some people had diabetes and needed their blood sugar monitoring to make sure it was within normal limits. One person's diabetes was unstable and the care plan said what action staff should take if the person's blood sugar was too high or too low. An incident occurred when the person's blood sugar went very low and they needed their prescribed medication of glucagon. There was no glucagon injection in stock. (Glucagon helps maintain glucose levels in the blood). Staff told us it had been used and not replaced. Nursing staff initially called the on –call doctor who advised to immediately call an ambulance and the person was admitted to hospital. The care plan and risk assessment did not state what to do if the blood sugar did not rise with treatment. The person had been refusing food that day and the daily notes stated they had a "low food intake and sleepy". This should have triggered concerns and the person should have been closely monitored.

Some accidents had not been recorded in the accident book. The night before the inspection a person had fallen on three separate occasions in their bedroom. These falls had not been recorded in the accident book. Night staff had informed the day staff at handover meetings but there was a risk that the information would be lost, as it was not recorded according to the provider's policies and procedures.

The provider had not ensured that care and treatment was being provided in a safe way. Risks to the health and safety of people were not being managed and when possible, mitigated. Staff were not suitably competent and skilled to manage risks to people safely. This was a continued breach of Regulation 12(1)(2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of receiving improper treatment. People's safety could not be assured. For example, one person had an in-dwelling catheter (this is an in-dwelling drainage tube for urine. It is a tube that is passed into the bladder when people cannot urinate normally). The person's care plan and risk assessment gave guidance and instruction on monitoring the person's fluid intake and output, and that the catheter bag was to be emptied. The person also had a care plan for 'infection'. This identified the signs and symptoms staff were to look for to detect infection and for the risk of developing urinary tract infections. The person's catheter had been leaking and over a few days the catheter had been changed twice. The dates for the next change of catheter were entered wrongly in the records. Catheters of that type should be changed at least every 12 weeks but records noted changes were due over 17 weeks later. We asked nursing staff why this was and they said it was wrong but "Did not know why".

When a catheter by-passes regularly it is often a sign of infection. By-passing means the urine was not flowing directly into the drainage bag. A person's catheter had been by-passing. There was no evidence and staff could not tell us if the person's urine had been checked for infection. We could find no evidence that the person's vital signs had been checked by the nursing staff, which may have given an indication of infection. On one occasion staff reported to the nurse in charge that the person had blood coming from their mouth and was very sleepy. They recorded 'had not had any food or fluids because of this'. They were advised by the nurse to 'monitor'. The daily records noted the person had a seizure. An ambulance was called and the person was taken and admitted to hospital. Following the hospital admission this person was diagnosed with a urinary tract infection and sepsis secondary to a urinary tract infection. This infection may have been avoided and should have been picked up and acted on by the registered nurses.

When people had been identified as being at high risk of weight loss staff did not follow the guidance given to them by health professionals. For example, a person had been assessed by the dietetic team and prescribed supplementary drinks twice a day to help them maintain their weight. The person was receiving the supplement drinks only once a day so not as prescribed. The person's 'eating and drinking' care plan was updated and noted that the person should be weighed every week. This had not been done. The person was not receiving the treatment, support and intervention they needed to keep them as safe and healthy as possible.

A series of blood tests taken by the registered nurses had been reported back to the doctors as, "bottles out of date". This meant that the person's blood could not be analysed for the requested checks because the bottles should not have been used as they were out of date. The registered nurses had failed to check the date on the bottles before they took blood samples. These checks were for diabetes, cholesterol, renal function and were included with the observations that usually formed part of a diabetic review. The clinical managers were aware that this had happened but the blood tests had not been repeated. The registered nurses had neglected to get a repeat test in blood containers that were in date which meant that the person's diabetic blood screening was not carried out to check their diabetes was stable and managed.

The clinical manager said that one person's blood sugars were not routinely checked at the service as they were a 'diet controlled diabetic'. This did follow National Institute for Health and Care Excellence (NICE) guidelines but made it more important that the six monthly diabetes checks were recorded, as this is a way of monitoring the blood sugar so there is an overall analysis of the amount of sugar in the blood over period of time. The staff had neglected to make sure this happened.

People's skin and pressure areas were not managed consistently. Staff had noted on a body map a person had a pressure sore on their left shoulder. Three weeks later it was identified that the person had developed another pressure sore. Registered nurses had neglected to develop and implement a care or treatment plan or risk assessments to state how the sores were being treated and managed.

Some staff had training on safeguarding adults. Staff knew the procedures in place to report any obvious suspicions of abuse or allegations but had failed to recognise forms of abuse like neglect or omission (failing to act), to give people safe care and treatment.

Staff understood the whistleblowing policy, whereby staff should be able to feel supported to report concerns about other staff in a way that protected them from discrimination. Staff were confident to whistle-blow to the acting manager or the local authority safeguarding team. Staff told us they were confident that the acting manager would deal with any concerns they raised.

The provider had not established systems and processes to protect people from abuse, harm and improper treatment. This was a continued breach of Regulation 13 (1)(2) (4) (d) and (6) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Following the inspection we raised five safeguarding alerts with the Kent local authority. This was so the local safeguarding team could investigate and take action to make sure people were safeguarded from abuse and improper treatment.

Staff had recently started using a new computerised system for the recording and monitoring of medicines. Staff said that it was an effective system and that errors when administering medicines had reduced. Medicines were stored in a locked room and were administered from a medicines trolley. The medicines trolley was clean and tidy, and was not overstocked. There was evidence of stock rotation to ensure that medicines did not go out of date. Bottles of medicines were dated when they were opened so staff were aware that these items had a shorter shelf life than other medicines. Staff checked when they were going out of date. When staff gave people their medicines they electronically signed the medicines administration records. Some people were given medication on a 'when required' basis. This included medication for if they became anxious or distressed. There were no guidelines in place for when this medication should be administered; meaning people may be given this medication unnecessarily or not soon enough.

People were at risk of experiencing unnecessary pain. A doctor had advised that pain relief should be given three times a day for five days when a person had a painful short term condition. The medicines administration record showed that this was done initially but for the last two days the medicine was out of stock and so was not given. The person's level of pain had not been assessed to see if they still required pain relief. One person was prescribed emergency medicines for their diabetes. When they urgently needed the medicine there was none available as it had not been re-ordered. This left the person at high risk of serious harm and they had to be hospitalised after becoming unwell. The fridge and room temperatures were checked daily to ensure medicines were stored at the correct temperatures.

The provider had not ensured care and treatment was provided in a safe way. They had not ensured the proper and safe management of medicines. This was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2015 the provider had not ensured that there were sufficient numbers of staff deployed to meet people's needs at all times. At this inspection there were sufficient staff on duty to meet people's needs. Relatives said, "The first thing my sister in law noticed was how many staff there are here"

and, "My relative fell in the corridor and as soon as they went down they got attention straight away." During the day there were two registered nurses on duty and nine support workers. At night there was one nurse and four support workers on duty. Care staff were not rushed and calls bells were answered promptly. On the second day of our inspection the acting manager informed us that an extra nurse had been allocated to each shift to make sure people were receiving the safe care and support they needed when they needed it.

Staff shifts were planned four weeks in advance. The acting manager used a dependency assessment tool to help determine the number of staff needed on duty to support and care for people. This was adapted to meet people's changing levels of need. Staff rotas showed that the assessed level of staffing was provided at all times. A new dependency tool had just been initiated and the acting manager had requested and received input from external health professionals. There were arrangements in place to cover unexpected shortfalls, such as, sickness. The acting manager used an agency when additional nurses were required.

Staff were recruited safely to make sure they were suitable to work with people who needed care and support. The provider's recruitment policy was followed. Application forms were completed and reasons for gaps in employment were discussed at interview. Recruitment checks were completed to make sure staff were honest, trustworthy and reliable. Information had been requested about staff's employment history, Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Checks on the identity of staff and the qualifications of nurses had been completed. Nurses' personal identification numbers (PIN) were checked to make sure they were registered with the Nursing and Midwifery Council and a note of the expiry date was kept to prompt the management team to check the PIN was in date.

The provider had a business continuity plan in place and there was guidance for staff to follow in the event of a major incident, such as, a flood or a gas leak. Each person had a personal emergency evacuation plan (PEEP) and these were kept at the nurse station so that staff could access them quickly. A PEEP sets out the specific physical and communication requirements that each person had to ensure that people could be safely evacuated from the service in the event of an emergency. Regular fire drills were completed to make sure staff knew what to do to keep people as safe as possible in an emergency. An 'emergency bag' was kept at the nurse station and included high visibility clothing, torches, a mega-phone and a first aid kit.

The staff carried out regular health and safety checks of the environment to make sure it was in good working order and safe to use, however, these checks had not identified some potential risks to people which had resulted in an injury. For example, two days before our inspection a person had burnt themselves on exposed pipes in their bedroom. Following this incident the acting manager arranged for a check of every bedroom to be completed and a further two rooms with exposed heating pipes were identified. These checks had not been completed previously. Action was taken immediately to cover the pipes. The 'bedrooms risk assessment' was updated by the acting manager to prompt maintenance staff to complete regular checks of pipes in people's bedrooms to reduce the risk of reoccurrences.

There were records to show that equipment was checked regularly and servicing, including hoists, boilers, electrical system and nurse call system were carried out. The hoists, which were used to support people to mobilise, had been serviced. Environmental risk assessments were in place to give staff guidance on what actions to take to minimise the risks to people.

Standards of hygiene and cleanliness were appropriate. Protective personal equipment such as aprons was available and staff wore these as necessary. Toilets and bathrooms were clean and had hand towels and liquid soap for people and staff to use. People's rooms were clean and tidy and well maintained.

Inadequate

Is the service effective?

Our findings

Visiting health professionals said that some staff lacked understanding and empathy about people's conditions. When people had mental health conditions staff did not always take the appropriate action to keep them safe. Risks were not consistently assessed. For example, when a person was at risk of harming themselves, the staff did not check their environment to make sure risks were reduced. Action to do this was only done when prompted by visiting health professionals. Visiting professionals also told us that the staff did not always contact them for advice and support when people's needs changed or deteriorated. They also said that registered nurses did not always act when people's needs changed and they did not always recognise changes to people's health and welfare.

Supporting people to access health care specialists was inconsistent and staff gave us contradictory information. The registered nurses told us that when people were at the end of their life they did not always contact the specialist team. The acting manager told us that they did. However, there had been incident recently when specialist advice was not sought. Sometimes there was a delay in accessing health care specialists when they were needed. When people needed to see a doctor because their health was deteriorating the staff did not always recognise signs and symptoms of ill health and doctors were not always contacted. When a person suffered a serious injury staff did not contact a doctor or emergency services. When other people's routine health checks were outside the normal limits of good health, the staff did not seek advice or help. Registered nurses did not recognise when people's health needs changed and were not taking the appropriate action to make sure people were kept as healthy and safe as possible.

People were weighed monthly and had been referred to the dietician if there were any concerns about weight loss or gain. At times the staff did not follow the instructions given by the dietician. One person was supposed to have two supplement drinks a day but at times was only receiving one supplement drink a day. When people were supposed to be weighed more frequently than once a month this was not always done.

Referrals to health professionals were sometimes made when needed, for example, to speech and language therapists and dieticians. However, some referrals, when people's health had deteriorated, were delayed. When guidance or advice had been given staff had not consistently followed this in practice. People's needs were not always met because care and treatment was not always being delivered in line with the advice given.

People were not receiving appropriate care and treatment to meet their health care needs. This is a breach of regulation 9(1)(a)(b)3(b)(c)(h)

At the last inspection in July 2015 staff had not received appropriate support, training, professional development and supervision as was necessary to enable them to carry out the duties they were employed to perform.

At this inspection there were still gaps in staff training, including basic training and training related to people's specific needs. The management team used a training schedule to monitor the training staff

completed. The training schedule included the number of employees who still needed to complete training. Less than half the staff had completed training on dementia and epilepsy and this directly related to people's needs. Some staff had not completed training on moving and handling people safely. The executive director told us that some staff had completed practical training and showed an email confirming that nine current staff completed the training in December 2015. During the inspection there were two occasions when we observed that staff did not follow safe practice when supporting people to move from their wheelchair to a chair using a hoist. A staff member had raised concerns at a staff meeting on 1 February 2016 that staff were manually handling people rather than using safe techniques including equipment.

Staff supervision was not carried out consistently and in line with the provider's policy. This shortfall had been identified by the acting manager. There was a new plan in place so that staff were on the duty rota and had time allocated for training and supervision. Out of the six staff files we looked at, three staff had not received any supervision. One member of staff had their last supervision meeting in November 2015 and two staff in August 2015. The provider's supervision policy stated that 'Under the provisions of the Health and Social Care Act 2008, all staff must attend formal supervision sessions at least 6 times a year'.

We looked at the staff files of three registered nurses. Nurses did not receive regular clinical supervision from a clinical professional. There was a record of one nurse receiving clinical supervision in January 2016. There was no record of this for the other two nurses. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.

The provider did not ensure staff had received appropriate support, training, professional development and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions, and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in July 2015 the provider had failed to protect people against potential risks of the unlawful deprivation of their liberty. At this inspection we found that the provider had made some changes and this part of the regulation was met. We checked whether the service was working within the principles of the MCA. There were nine people who had a DoLS authorisation in place. The conditions on authorisations to deprive a person of their liberty were being met. Authorisation had been sought from the local authority and the support plans clearly showed that the assessments and decisions had been made properly. Plans were in place to support people in the least restrictive way. Staff told us that they supported people to make their decisions by giving them time to understand the situation.

Staff were aware of the relevant requirements of the Mental Capacity Act. The staff understood the importance of asking people for their consent before they provided care and support. Staff were aware that some decisions made on behalf of people who lacked capacity should only be made once a best interest meeting had been held. One staff member said, "We encourage people to make decisions on a daily basis".

People said the food was good, one relative said, "The food is plain but wholesome, just what my husband likes." Another relative said, "The roast potatoes are lovely". The cook said that people were asked at residents meetings what they would like to eat, and they planned the menu accordingly. One person had asked for kippers so they had bought some in especially.

People indicated and said the meals were good and they could choose what they wanted to eat. Staff were aware of what people liked and disliked and gave people the food they wanted to eat. Staff respected people's choices about what they did eat.

The acting manager helped to serve the lunchtime meal to everyone. They said this was an opportunity to see everyone. At lunchtime there were three choices of main meal and dessert. People were asked what they would like and this was bought to them. They were also asked if they would like a hot or cold drink. People visibly enjoyed their meal and the atmosphere was relaxed with people chatting to staff and each other. Some people needed extra help with their meal and we saw staff cutting their food up into small pieces or helping them to eat. People had the choice of sitting in the dining room or eating in their room or the lounge, wherever they felt the most comfortable. As people were eating in different rooms the staff had a checklist to ensure that everyone had been offered and then eaten their meal.

When people were eating well and there were no concerns, they were supported and encouraged to eat a healthy and nutritious diet. Some people were underweight and people were offered drinks and snacks throughout the day to help them maintain a healthy weight. One relative said, "They always make sure there is something for him to eat and lots of snacks between meal times." The acting manager had implemented a system using coloured cups to show staff, at a glance, who needed extra assistance with drinking, or more encouragement to keep hydrated. Staff said this worked well and it meant they knew to keep offering drinks to certain people. However, this was not the case for everyone and some people were not receiving the diet that they needed to keep them as healthy as possible

At the last inspection in July 2015 there was on-going refurbishment programme to improve the environment. We recommended that the provider seek guidance and advice about best practice in ensuring the environment supports people living with dementia.

At this inspection there had been some refurbishment and this was on-going. The improvements had taken into consideration lighting, safety and adaptations to promote people's privacy and dignity. The premises were maintained and adapted so that people could move around and be as independent as possible. People's rooms were personalised with their own belongings. A relative commented, "I know it's only a tiny thing but I made sure he has all the pictures of important people round his room. They [staff] will rotate them so I know he's looking at them, sometimes there's one by his bed." Lounge areas were comfortable and were suitable for people to take part in social, therapeutic, cultural and daily living activities. There were signs on bathrooms and toilets and some bedrooms had people's photograph on the doors. However, there was a continued lack of suitable signage to help people to find their way around the service and remember what was in each room. This was an area for improvement.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that the staff were kind and caring. One relative said, "They go the extra mile. They're all so kind". Another commented, "I know exactly what care is like as I was a carer. [My loved one] is here and the home is excellent. The care is what is important and that is excellent". There were a number of thank you cards from relatives. One noted, "I watched and saw and was amazed at what you all do and I am truly thankful that I chose The Hockeredge for [my loved one's] final home, and that you and I did all we could for them."

People could not be sure that when they were at the end of their life they would receive the care and support that they needed. Nursing staff told us they did not work with the local hospice when people needed palliative care. If someone had an illness that could not be cured, palliative care makes them as comfortable as possible by managing pain and other distressing symptoms. Care plans did not provide guidance for staff on signs and symptoms to be aware of, such as pain, breathing changes or vomiting, some of which may occur during the end of life period.

Records for people's end of life care were not accurately completed. For example, a GP had spoken with a person's next of kin about their loved one and a decision, in their best interest, had been made for them to remain at The Hockeredge. The person did not have the capacity to be part of the decision because they were unable to process and retain information. An assessment of the person's capacity was in the care plan; however, this noted that they had capacity to make decisions.

Whilst we observed staff being kind and respectful towards people, people did not always receive the care they needed when they needed it. People were not always at the centre of the care because staff sometimes focussed on tasks rather than on people as individuals. For example, there was a member of staff in each lounge interacting with people. However, when a person needed support they had to wait while another member of staff was called. People, who were living with dementia could not always understand this and asked repeatedly for help which caused them to become distressed and agitated. Staff kept explaining they could not leave the lounge unattended and people became more agitated because the situation was not explained in a way they could understand. We observed an incident were a person was distressed and anxious. They were saying, "I am frightened, please let me go". The staff member responded, "They told me they are coming shortly, someone is on their way. I will ring the bell and someone will come. "Please sit down and I will ring the bell. Thank you." The person had to wait in a distressed state for ten minutes before another staff member came to assist. The staff member in the lounge did not reassure the person or offer them comfort to try and reassure them.

Some people became agitated and restless and exhibited behaviours that may challenge others. Care plans stated that staff were to reassure people if they did become agitated but did not explain the best way to do this and what way would suit the person best. Staff reacted quickly when one person became distressed. Staff offered them verbal reassurance but the person became more distressed and stood up wanting to leave. Staff pressed the call bell and another staff member came immediately and supported the person back to the room, talking to them quietly and gently and the person calmed down.

People and their loved ones had been involved in the planning of their care and treatment. People's preferences, such as what food they liked to eat, times to get up and go to bed, what people could do for themselves and what support was needed, were noted in the care plans. People were called by their preferred name and staff had taken the time to get to know people's lifestyle prior to moving into the service. This information was available for staff to refer to in each person's care plan. When people declined to take part in reviews of their care, this was respected and noted in the care plan.

People's care plans and associated risk assessments were stored securely in a locked office to protect confidentiality. Staff understood it was their responsibility to ensure confidential information was treated appropriately and with respect to retain people's trust and confidence.

Some people had family members to support them when they needed to make complex decisions, such as coming to live at the service or to attend health care appointments. Advocacy services and independent mental capacity advocates (IMCA) were available to people if they wanted them to be involved. An advocate is someone who supports a person to make sure their views are heard and their rights upheld. They would sometimes support people to speak for themselves and sometimes speak on their behalf.

People were treated with dignity and respect. When staff were speaking to people they knelt down so they were speaking to people on their level. Staff used calm reassuring voices when speaking to people. People were asked regularly if they would like a cup of tea or something to eat. We observed one person being supported from a chair to their wheelchair. Staff placed a hand reassuringly on the person's arm whilst explaining what they were going to do and the person appeared calm and relaxed throughout. Staff knew people well. If people were unable to communicate using speech staff were able to recognise signs through behaviours and body language, if people were upset or unhappy.

Staff were discreet and sensitive when supporting people with their personal care needs and protected their dignity. When people were supported to eat their meals in their bedroom we saw that staff closed the door to protect people's privacy and dignity. Staff knocked on people's bedroom doors and waited for signs that they were welcome before entering people's rooms. They announced themselves when they walked in, and explained why they were there. People were not rushed and staff made sure they were given the time they needed.

Staff recognised the importance of social contact and companionship. Staff supported people to develop and maintain friendships and relationships. During our inspection there were a number of visitors who called in to see their loved ones. Relatives told us that they visited when they wanted to and that there were no restrictions in place. Staff greeted visitors in a way that showed they knew them well and they had developed positive relationships. One relative commented, "I think it's the small things that matter. I asked if I should bring in a cake as it was his birthday and they said no, we'll make one." People could choose whether to spend time in their room or in communal areas and there was plenty of space for people to spend time with their loved ones. One relative said, "I'm able to come and visit any time I like."

Inadequate

Is the service responsive?

Our findings

At our last inspection in July 2015 people were not always properly assessed and peoples' assessed needs were not regularly reviewed to ensure their care plans remained current. Care plans were not updated with changes in people's needs. At this inspection we found that the breach continued and the provider had failed to properly assess people's needs and had not regularly reviewed these assessments. They had not met and completed their own action plan following the inspection of July 2015.

The acting manager told us about an incident that occurred two days before the inspection when a person had suffered a serious burn when their skin touched an unguarded hot pipe in their bedroom. The risks of scalds and burns had not been identified and action had not been taken to keep people safe from the risks of scalds from hot pipes. The registered nurses failed to complete the appropriate records and update the person's care plan and risk assessment following this injury. The registered nurses took no action; they did not recognise the seriousness or extent of the injury. It was not until the acting manager came on duty, some hours later, that action was taken.

One member of staff said, "Things are not going very well at the moment" and they said, "We're having difficulty keeping on top of it all". Before people moved to the service an assessment of their needs was undertaken. This included information regarding a person's personal care needs, physical and mental wellbeing, mobility and family. Some assessments did not contain all the information required to make sure people received the care and support they needed. For example, when people's dietary or mobility needs changed or deteriorated new assessments had not been completed and care plans had not been updated to reflect people's changing needs. Action had not been taken by staff and people were at risk of not receiving the care and support that they needed.

People were encouraged by staff to participate in and contribute to the planning of their care. Each person had a care plan which had been written with them and their relatives. Care plans contained information that was important to the person, such as their likes and dislikes, how they communicated and any preferred routines. Plans included details about people's personal care needs, communication, mental health needs, physical health and mobility needs. When people's needs changed the care plans and risk assessments were not consistently updated to reflect this and in some cases were contradictory. Staff did not have up to date guidance on how to provide the right support, treatment and care. For example, one person had been assessed as 'able to stand to transfer from wheelchair to chair'. This person had a pressure pad by their bed to alert staff if they got out of bed by themselves. However, the care plan noted a full hoist should be used for transfers and bed rails were to be used to prevent this person falling out of bed. The record was contradictory and there was a risk that staff would not support the person in the correct way.

Before our inspection we had received information of concern regarding the staff's ability to respond to people's deteriorating health needs. The local authority had undertaken an investigation into the care received by one person and found that the staff had failed to ensure that this person's needs were met. The staff had not sought medical intervention and this person's health continued to deteriorate quickly. The investigation concluded that the provider and staff had failed to respond effectively and had failed to

reassess and review the person's changing needs. The local authority concluded that the person had not been protected from harm and improper treatment before they died. The provider had not ensured that people received appropriate assessment and reassessment in order to ensure their needs could be consistently met.

People's assessed needs were not always regularly reviewed and properly assessed before they moved into the service. Care plans lacked detail and at times were contradictory. Care plans were not consistently updated when people's needs changed. This was a continued breach of regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection staff were not always responsive to people's needs. We observed one person being assisted into the lounge in the morning and they then looked at a newspaper. The person was struggling to hold the paper and it was positioned at an awkward angle so they could not read it properly. After some time a staff member assisted the person to put on a pair of glasses and brought over a high table for them to position the paper on. The person needed glasses and a table in order to read properly. When we asked why the person had not been given their glasses or the table sooner we were told they had just got up. The person had been in the lounge trying to read without their glasses for an hour and fifteen minutes before the staff responded.

People had some opportunities to take part in activities. There was a 'reminiscence lounge' with items from days gone by, such as old wash boards and sewing machines. During the inspection there were two or three people using the room at any one time. Staff told us that they were responsible for supporting people with activities. Minutes from a recent staff meeting noted a comment from the acting manager, 'When monitoring people in the lounges this is when support workers need to facilitate activities. This is part of the support workers role'. The acting manager also suggested staff support people to go out on a regular basis. Staff were encouraged to make suggestions and staff had recently discussed using an area of the service as a coffee bar. Staff told us people had enjoyed a singer coming in and some people had danced. People told us that they enjoyed doing activities and would like to do more. One person said, "I would like to go into town. I haven't been for a long time".

Although there were some activities people were left for long periods of time sitting in the communal areas and not engaging in any activity. In the larger lounge area the television was on and some people were trying to watch a programme. Next to the lounge in a smaller area there was a DVD playing loudly. No-one appeared to be watching the DVD. The volume of noise within these two areas was loud. People who were trying to watch the television appeared to struggle to hear it. There was a lack of meaningful activities provided within the service. This was an area for improvement.

People moved freely around the service and could choose whether to spend time in their room or in communal areas. Some people needed a staff member to support them whilst they walked around the service and grounds. This support was provided in a way that encouraged people to do as much for themselves as possible. Staff chatted and laughed with people, holding their hand or arm while they walked.

There was a policy in place outlining how staff should respond to complaints, suggestions and compliments. The policy stated that all complaints should be acknowledged within twenty four hours. Some complaints received by the acting manager had not been acknowledged within this time frame. One relative had complained that they had not received a response to a complaint they had made three weeks previously. The acting manager did respond after a week and had properly investigated the complaint and had made changes to the service as a result. Some people had complained about not understanding why

certain things had been purchased on behalf of their relative. In some instances the money had been refunded and the acting manager changed the policy regarding holding money for people, and no further complaints had occurred.

People and their relatives told us they would talk to the staff if they had any concerns and felt that they would be listened to. We heard staff asking people questions about the service as part of an organised activity. They asked, "Do you like being here?" and "Do staff come and speak to you?" Staff asked people questions in a straightforward way and gave people time to answer so they had an opportunity to tell staff what they thought. There were regular residents meetings where people could tell staff what they wanted to happen at the service. One relative told us, "If I had any concerns I would speak to staff." The complaints policy was not written in a way all people could understand. This was an area for improvement.

Inadequate

Is the service well-led?

Our findings

At the end of the first day of the inspection we met with the provider, manager and executive director and explained that we had serious concerns about people's physical health needs not being met. We also met with the provider and senior management team on 5 May 2016 to reiterate our concerns. We gave examples of the shortfalls identified. The provider and manager agreed they were 'worrying' and 'serious concerns'. The provider told us that there were no excuses for poor care and that he was keen to improve the service at The Hockeredge.

At the last inspection in July 2015 there was no registered manager in place. At this inspection there was still no registered manager at the service. The acting manager had notified CQC that the previous manager had left employment at The Hockeredge, and told us they were in the process of applying for their registration.

The provider had failed to have a registered manager in post. This was a breach of Regulation 5(1) of the Care Quality Commission (Registration) Regulations 2009.

At the last inspection in July 2015 some staff were not always making sure they completed the tasks they were accountable for. At this inspection the clinical staff were not completing the tasks they were accountable for safely and effectively, including ensuring medicines and in date blood sampling bottles were in stock. The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely, however, these were not consistently followed by staff. For example, staff had not followed the medicines policy and made sure people had sufficient medicines in stock. People had missed doses of their prescribed medicines, such as pain relief and medicines to help with their diabetes.

At the last inspection in July 2015 health and safety audits and checks on the quality of care provided were not always being carried out. Some audits had not identified gaps in records. At this inspection a quality assurance system had been implemented. Some audits and checks were being completed but these had not identified some of the shortfalls found during the inspection. For example, environmental audits of people's bedrooms had been completed and failed to identify exposed hot water pipes and radiators. Audit on medicines had been undertaken but the shortfalls we found had not been identified. Audits had been undertaken on people's care plans and risk assessments but the audits had not identified that they were not up to date and current.

People were at risk of not receiving the care, treatment and support that they needed in the safest way. Regular quality checks were completed on key things such as fire safety equipment, and infection control. Reports following the audits detailed any actions needed, indicated who was responsible for taking action and prioritised timelines for any work to be completed on these areas.

There was a lack of clinical oversight and governance. Two clinical managers (both were registered nurses) were in post and they had the responsibility for making sure that the nursing care people needed was delivered effectively and safely. This was not happening consistently. The clinical competency and accountability of registered nurses was not assessed and monitored and registered nurses had not

consistently completed the tasks they were accountable for. As a result people had not received safe, effective and responsive care and some people had sustained injuries and harm from improper treatment. For example, the registered nurses had failed to take appropriate action when a person showed signs of ill health. The person had to be hospitalised and suffered a seizure and had an infection.

A record was kept of most accidents and incidents that occurred at the service, but not all accidents had been recorded. Accidents were analysed to identify any trends or patterns to try and prevent them from occurring again. The manager took action when incidents occurred and some had resulted in staff disciplinary action.

It had been identified that several accidents and falls, had occurred in the lounge area. When this was looked into it was apparent that when the falls happened there had been no staff present in the lounge. Action was taken to make sure there was always a staff member in the lounge area. It was also identified that falls were happening at night and the manager increased the staffing levels. The manager told us that structured reflective practice meetings were held with staff to address incidents and to discuss what could have been done differently to have avoided or minimised risks. Records of the most recent meeting with nursing staff confirmed that these had taken place.

The provider had not ensured that the systems and processes were in operation to assess, monitor and improve the quality and safety of the service were consistently applied. This was a continued breach of regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2015 accurate and complete records in respect of each person were not maintained. Other records relating to the management of the service could not be located.

At this inspection accurate and complete records in respect of each person were not maintained. For example, when people needed to be turned, to help prevent pressure areas, a turn chart was put in place. This was so staff knew how often this turning should be done. These were not always followed and had not been completed consistently. One turn chart had not been filled in by staff for four days.

Some accidents had not been recorded in the accident book. Care plans were not consistently updated to reflect changes in people's care needs. Matters relating to decisions made during disciplinary processes were not consistently documented. There was a clear 'discipline policy and procedure' in place but the policy had not been followed in practice. The records of disciplinary meetings had not been recorded. When a staff member had been suspended and returned to work following an investigation, we were told that their competency had been checked, and that they were deemed competent to return to their usual shifts. When we asked the clinical manager how they decided that the staff member was competent to return, and to show us a record of the competency assessments and a record of the meeting held they were not able to show any record of this decision making process and assessment. Staff had not always completed records before leaving the service at the end of their shift. Staff raised concerns at a staff meeting on 14 March 2016 that some staff were completing records and charts retrospectively on behalf of colleagues when colleagues had failed to complete the records. Staff were completing the records to say they have given people care when they had not.

The provider failed to ensure accurate and complete records in respect of each person were maintained. This was a continued breach of regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager encouraged open communication with people, their relatives and with staff. The

provider had systems in place to seek the views of a range of stakeholders about their experience and views of the service. Quality assurance questionnaires were used to gain feedback from relatives, stakeholders and staff. The acting manager told us that these helped to identify areas of strength and to highlight areas for improvement.

Surveys from people living at The Hockeredge were positive. A relative had noted in their response, 'Overall we have been pleased and content with [our loved ones'] care and general life at The Hockeredge'. When a concern had been noted in relative's responses this was looked into, actions taken and a letter sent to the relative to confirm what had been done to address any issues. Further discussions took place to check that the relatives were happy that their concerns had been addressed. A member of staff had noted in a staff survey, 'There are areas that need improving – communication is one of those areas and staffing issues is another'. The acting manager told us highlighted worries and concerns from staff comments and surveys were discussed openly and honestly at staff meetings.

The management team were working with health and social care professionals to address shortfalls and to improve the quality of the service being provided. The acting manager had introduced regular staff meetings which were followed with an action plan noting actions to be taken, by whom and giving a timescale. These were updated as actions were completed. Meetings were held with people's relatives and advocates. The acting manager told us that if people were unable to attend the meeting they arranged for a copy of the minutes to be sent to keep them up to date.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The acting manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines. The provider had displayed the CQC rating from the last inspection in July 2015 on their website. A copy of the report summary was in the entrance porch.