SHC Clemsfold Group Limited

Horncastle House

Inspection report

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Date of inspection visit:
27 March 2018
29 March 2018

Date of publication:
16 May 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 27 and 29 March 2018 and was unannounced.

Horncastle House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Horncastle House accommodates up to 43 people in one adapted building. There were 30 people using the service during our inspection. Horncastle House provides nursing care to older people; some of whom are living with dementia.

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

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The former registered manager had left in September 2017 and their deputy had taken over the management of the service. This manager had applied to CQC to become registered as the manager at the time of this inspection, but no decision had yet been made about their application.

Horncastle House was last inspected in December 2015. At that inspection it was rated as 'Good' in every domain and overall. At this inspection, there had been a marked and significant deterioration in the safety and quality of the service which had not been picked up or remedied by the provider. As a result we found multiple breaches of Regulations across all areas we inspected.

Risks to people had not been robustly assessed and mitigated. This included risks associated with medical conditions, choking, challenging behaviour, the environment, fire evacuation plans, prescribed creams and falls.

Investigations into safeguarding concerns had not identified continued risks to people. Accidents and incidents were documented but follow-up actions were not consistently taken by staff in line with directions in order to reduce the risk of re-occurrence.

There were not always enough staff deployed to meet people's needs. Training and knowledge of staff deployed was lacking in some areas. Recruitment files did not contain enough information to assure the provider about staff's employment histories.

People's healthcare was not properly considered in the development of care plans. Wound care was not appropriately managed and food and fluid intake had not been monitored to ensure records about it were correct and that people remained hydrated.

The service was not meeting the requirements of the Deprivation of Liberty safeguards and Mental Capacity Act 2005 because capacity assessments for people were not decision-specific.

Although staff were kind and gentle, people's dignity had not been considered appropriately. People were not all encouraged to be independent where possible. People did not feel involved in their care planning and risk assessing.

Care planning was not person-centred in regard to people's individual health conditions or risks, but information about people's life histories had been collected. End of life care planning did not focus on people's preferences and wishes.

Although concerns were logged and investigated by the manager, the provider's complaints policy was not being operated effectively.

The provider had not ensured that feedback from CQC about some of their other services was used to improve standards as we found similar concerns at Horncastle House than had been identified at other locations operated by the provider. The manager of Horncastle House responded to our findings during and after the inspection but there had been insufficient proactive auditing to highlight any shortfalls and put them right before our inspection.

Safety checks on equipment and utilities had been regularly carried out and documented.

People had access to a range of care professionals such as podiatrists, GPs, dieticians and opticians. Adaptations had been made to the premises to make it suitable for older people/those living with dementia. Staff treated people with kindness and relatives said they felt well-informed about their loved one's care and progress. A range of activities were available to people.

Staff said they had faith in the new manager. The provider displayed their rating and made statutory notifications to the CQC. The service notified the Commission of incidents and events that they were legally required to and had displayed their CQC rating.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Known risks to people had not been minimised. This included risks associated with medical conditions, choking, challenging behaviour, the environment, fire evacuation plans, prescribed creams and falls.

Actions to investigate and follow-up safeguarding referrals had been ineffective, so there had been a lack of learning from incidents.

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

Recruitment processes were not sufficiently robust to ensure suitable staff were employed.

Safety checks on equipment and utilities had been routinely completed.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not effective in supporting them to carry out their roles.

Wound care had not been appropriately managed. Other medical conditions had not been properly assessed.

Food and fluid intake was not monitored effectively.

The service was not meeting the requirements of the Deprivation of Liberty Safeguards and Mental Capacity Act 2005.

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

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to dignity and respect had not always been fully considered.

There was limited information in care files about people's involvement in care decisions, but relatives felt well-informed. People's independence was not always encouraged and promoted.

Staff treated people with kindness and gentleness and interacted well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning was not sufficiently person-centred and inaccuracies or anomalies between sources of information had not been corrected.

End of life care planning was scant and did not place emphasis on people's preferences and wishes.

People's choices were not consistently fulfilled.

Complaints were properly logged and recorded but the provider's complaints policy had not been followed in providing written responses to complainants.

People enjoyed a variety of activities and social stimulation.

Is the service well-led?

Inadequate

The service was not well led.

There had been significant deterioration in the safety and quality of the service since our last inspection.

The provider had not ensured that feedback from CQC about some of their other services was used to improve standards.

The manager responded reactively to our findings but there was a lack of effective and proactive testing to pick up on problems and address them.

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

Staff said they had faith in the new manager.

The provider displayed their rating and made statutory notifications to the CQC.	

Horncastle House

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 29 March 2018 and was unannounced. The inspection was carried out by two inspectors, as specialist nurse advisor and an expert by experience. The expert by experience had a personal understanding of having a loved one living in a care home.

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

The inspection plan was informed, in part, by concerns that had been raised about the quality and safety of locations operated by this provider. Our planning was also informed by our findings from other locations operated by this provider in the preceding months. A number of safeguarding and quality concerns in relation to the provider, Sussex Health Care, are the subject of a police investigation and safeguarding enquiries overseen by the local authority. Prior to this inspection, we were also informed of an incident at Horncastle House which is being investigated as a safeguarding concern. This inspection did not examine the circumstances of the specific allegations made about the registered provider or about the recent incident. However, the information of concern shared with the Commission indicated potential concerns about risk management, staff training, delivery of person-centred care and good governance. Therefore we examined those themes in detail as part of this inspection.

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

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

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

We displayed posters in the communal areas of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Inadequate

Is the service safe?

Our findings

We received mixed feedback from people about the safety of the service. Most people said they generally felt safe and that staff were caring towards them. However they went on to tell us that they thought there were not enough staff, and that call bells took unreasonably long to answer. One relative commented "If two people ring their call bells at night there are not enough staff to deal with both at once". Our inspection found that the service was not adequately safe in a number of areas.

Risks to people living at Horncastle House had not been identified, assessed or minimised in a number of different situations, leaving people exposed to the possibility of harm. People's care plans contained some assessments about general aspects of their care and support such as mobility, sleeping arrangements and nutrition. However, several people living in the service had specific health needs or conditions which posed a risk to their well-being if not appropriately managed. These had not been fully assessed or guidance given to staff to mitigate risks. For example, three people had epilepsy but only one person had an assessment in place about how any seizures should be managed. This person had experienced a recent seizure but records about this were scant, incomplete and unhelpful in providing information about what happened both at the time and after the seizure. There were no epilepsy care plans for the other two people and staff and managers were unclear about which people had the condition when inspectors asked. The service was using a high proportion of agency staff, which increased the risk that people might not receive appropriate care and treatment because agency staff may not know people as well as those working in the service permanently. Epilepsy care plans were produced and put in place by the end of our inspection and following the inspection the manager contacted us to say that care plans and risk assessments had now been put in place for people's individual conditions. The care plans produced about epilepsy were sufficiently detailed and we will be checking the suitability of the other care plans going forward. However, the lack of epilepsy care plans had not been proactively identified before our inspection, leaving people with this condition at risk of harm and inappropriate care. This was concerning as concerns about missing or inadequate care plans associated with epilepsy had been highlighted on multiple occasions at several of the provider's other locations by CQC and partner agencies. This learning had not been applied at Horncastle House to mitigate risk.

Some people had other needs which had not been properly considered or risk-assessed and there were no instructions about these for staff to follow to keep people safe. Two people had choked on food recently and several others were at risk of choking due to swallowing difficulties. Although the people who had choked on food in the service had received appropriate treatment from the staff on duty at that time and had been referred to a speech and language therapist (SaLT) for advice, there were no choking assessments in place for any person to highlight the risks and the actions that should be taken to prevent it happening. In one person's bedroom we found and removed an open tub of thickening granules used for changing the consistency of drinks. There have been national safety alerts about this product following the death of people who had choked on the dry granules. These should be locked away and out of reach of people living with dementia; and any visiting children. The manager confirmed that they were aware of the risks associated with the thickener and assured us this would be locked away in future. Another person was observed drinking from a spouted cup while lying flat on their back in bed. We made staff aware of this

straight away and choking risk assessments with appropriate information were produced by the manager and put in place by the end of our inspection. This was concerning as the inappropriate management of dysphagia (difficulty swallowing) had been highlighted on multiple occasions at several of the provider's other locations by CQC and partner agencies. Allegations about the provider's safe management of dysphagia were the subject of several historical and current safeguarding investigations. This learning had not been applied at Horncastle House to mitigate risk to people.

Other people sometimes displayed behaviours that could challenge. There were no care plans or risk assessments in place to detail any triggers to these behaviours or information about how staff should manage them. Although charts were completed to record individual episodes of challenging behaviour there was no strategy documented to guide staff in appropriately supporting them. One person was placed in a room on their own to eat their meal because staff said they sometimes "Grab things". This person was leaning out of their wheelchair with their head almost touching the corner of a low table. This method of managing the person's behaviour had placed them at risk of injury and isolation. When we brought this to the attention of staff the person was moved and a staff member stayed with them to support them. Care plans about challenging behaviour were put in place following our inspection and contained information about how to manage behaviours effectively.

Incident reports had been completed when people had falls, but actions designed to prevent further occurrences had not always been effectively carried out. For example, one person had fallen frequently and their care plan stated that staff would check them hourly at night to ensure their safety. However, night checks were not always carried out every hour, with gaps of an hour and a half between some of them. A physiotherapist had recently assessed this person and recommended exercises three times daily to help their mobility and improve steadiness. However, there was only one record in staff notes to show that the person had been prompted to do their exercises in the week leading up to our inspection. Another person who had sustained an injury in an unwitnessed fall was due to be checked hourly overnight but similarly, records about these checks showed gaps of up to an hour and a half between them. Referrals to falls clinics had been made and special alarm mats had been put in place for some people to alert staff when they were mobile. However these were not effective for some people who walked around them or unplugged them; therefore the hourly night checks were especially important in those cases. Some people using the service were unable to use their call bells because they were living with dementia. Hourly night checks had also been directed for these people but did not always happen as frequently as advised in their care plans.

Some people had 'Do not attempt resuscitation' (DNAR) orders in place, in the event that they suffered cardiac arrest and it would be futile or inappropriate to resuscitate for a medical reason. These orders had been completed by a GP in consultation with people or their loved ones if people did not have the mental capacity to be involved in the decision. Although DNAR orders were held in individual care files, there was no immediate way for staff to identify which people were not for resuscitation and those who were. No information about people's DNAR status was recorded or discussed in staff handovers between shifts and not all staff could tell us which people were affected. In an emergency situation staff would need to find the person's care file to determine whether there was a DNAR order in place. This time delay could prove critical if the person did not have a DNAR and needed resuscitation to begin immediately. We brought this to the immediate attention of the manager who arranged for a quick identification system to be implemented between the first and second days of our inspection. However, we continued to find that staff handovers did not include information about people with DNARs in place. Concerns about DNAR status being unclear to staff and risks associated with this had been highlighted at recent inspections of at least two other locations operated by this provider. Following one of these inspections in November 2017, we were informed by the Head of Quality at the time that this learning had been shared with all of the managers of Sussex Health Care services and that they would be implementing an easily accessible and colour-coded reminder to alert

staff to DNAR status. However this had not been fully implemented at Horncastle House in order to keep people safe and ensure a quick response to medical emergencies.

Personal emergency evacuation plans (PEEPs) had not been updated in some cases to reflect changes in people's mobility or capacity. This created a risk that people may not receive the correct level of support if it became urgently necessary to leave the building. The manager told us that all PEEPs would be reviewed and updated as necessary and as a priority.

Environmental risks were not effectively minimised. During the inspection the doors to sluice rooms were consistently left unlocked, and one sluice contained chemical cleaning products which could be harmful to people. Another room had a pictorial sign on the door to say it was the 'Pantry'. However, a further sign showed that there was danger of 415 volts from the electrical supply there. This room was in frequent use by kitchen staff throughout the inspection as food stuffs were stored in it. Despite inspectors reporting to the manager that the room had been left unlocked on several occasions, this continued to happen across both days of the inspection. The picture sign on the pantry door increased the risk that independently mobile people may think it was acceptable to enter the room, thus exposing people to harm. We brought this to the attention of the manager who said the situation would be remedied.

People's prescribed creams had not been stored safely or consistently applied in line with the prescriber's directions. Creams such as pain relieving gel and steroid ointment were seen in easily accessible places in people's bedrooms. Many people had barrier creams in their bathrooms and bedrooms. Some people using the service were living with varying degrees of dementia or cognitive impairment. No assessments had been made about the risks of leaving these creams where people could possibly apply too much, or even ingest them.

An opened tube of cream dispensed for one person was found in the bedroom of a different person. Cream charts showed that this brand of cream had been applied to the person who had the cream in their room. We asked the manager to confirm that this person had their own supply of the cream and they showed us a new and unopened tube of it. This suggested that the person had been receiving applications of the other person's cream, which was both unhygienic and unsafe practice.

Charts in use for recording cream applications showed that in some cases people had not received them as frequently as the prescriber had intended. For example; one person was prescribed a gel for application four times daily, but charts documented that had only happened twice on six days in March 2018 and on a further seven days, no applications were recorded at all. This person was not therefore receiving the full therapeutic benefit of their prescription. The manager told us that new creams recording charts would be introduced and stored in people's bedrooms where staff would have easier access to them.

The failure to assess, monitor and mitigate risks including those associated with health conditions, the environment and medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines, with the exception of prescribed creams, were safely managed. Medicines were stored securely and kept locked in between administrations. Temperature recordings were made daily of the medicines room and fridge to ensure that medicines were kept at appropriate temperatures so that they remained effective. Medicines administration records (MAR) were consistently signed off to show when medicines had been taken as prescribed. Individual protocols were in use for medicines prescribed on an 'as needed' basis, but more detail was needed in records to show the reasons people had needed to take these medicines and whether they had been effective. This is an area we have identified for improvement.

The service appeared generally clean and tidy with soap, hand towels and antibacterial hand gel readily available for good hand hygiene. Staff wore disposable aprons and gloves when delivering personal care. The people and relatives we spoke with thought that all areas of the home were kept clean and that staff washed their hands regularly. One person said "They wash hands constantly". Two relatives told us they felt the service smelled of urine in the mornings and a response to a recent questionnaire issued by the provider noted the 'strong odour on occasions'. During the inspection we highlighted a very bad smell in one room and found that a wheelchair was soiled with faeces there. Arrangements were made for this to be cleaned immediately but odours in the service remain an area requiring improvement.

People had not been consistently protected from potential abuse or neglect by the operation of robust safeguarding systems. A safeguarding alert had appropriately been made by the manager to the local authority when a person injured themselves on an armchair. The armchair was still in place and the inspectors examined it. Although it was unclear how the chair had caused the injury, the backrest of it had come loose, exposing part of the metal mechanism. The fabric cover on an upholstered button on the chair had also come off and the innards of this were sharp and could catch on thin or frail skin. We brought this to the immediate attention of the manager and arrangements were made to replace the chair the same day. The manager had carried out their own investigation into the cause of the person's injury but had not requested a clearer explanation from the staff in attendance at the time of the injury or examined the chair for faults. This had left the person at risk of further injury until we raised the issue.

A further safeguarding referral had been made by the manager when another person fell and experienced an injury for which they needed treatment in hospital. They had been discharged back to the service with instructions to wear a special support item. During our inspection we found the support in the person's bedroom after they had been taken to the communal lounge. Staff said they "couldn't find" the support after providing personal care that morning, but it had been clearly visible in the bedroom when we checked. This person had not received consistent treatment for their injury which was neglectful of their needs.

The failure to operate safeguarding processes in such a way as to keep people safe from abuse and neglect is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deployment of staff had not been appropriately managed so that people's needs were safely and effectively met. Due to people's complex health and physical conditions, they required a range of support from staff with all of their needs, including hourly well-being checks, support to move and transfer using hoist equipment, help with continence needs, support to eat and drink, care and treatment provided in bed, end of life care with regular monitoring, one to one care, monitoring for risk of falls and increased support with health conditions such as epilepsy and dysphagia. Most people we spoke with told us that call bells took too long to answer and that this sometimes impacted on their dignity if they needed support to go to the toilet. One person told us "I use the call bell but they don't come very quickly as they are busy and so I often have to wait. I needed to go to the toilet so I pressed the bell, but someone else had pressed theirs at the same time so I had to wait quite a long time". Another person said "It takes ages to get anyone to help in the mornings or at lunchtime and you can wait over an hour".

During the inspection there were periods when call bells rang for at least eight minutes before staff attended. A call bell audit undertaken by the manager involved one bedroom bell being pressed each day and the staff response time being manually recorded. This showed the maximum time taken to respond was never above five minutes. This was at odds with our own findings and the feedback given to us by people living at Horncastle House. One person commented "There aren't enough staff; they are all too busy and they work long hours". Another added "We are definitely short of carers; they are rushed off their feet". On

the first day of our inspection there were no staff visible on the first floor for more than 20 minutes and some people waited more than 40 minutes to receive their lunches. We observed that there was just one staff member supporting people with meals on the first floor and that people received their meals one by one. Staff told us that one person "Always gets theirs last because their room is at the end of the corridor". We observed one staff member supporting a person to eat but having to interrupt the meal to attend to another person sitting at another table because other staff were engaged with different people. One staff member told us "More carers on duty would be an improvement".

At the start of the inspection the manager told us that there were two registered nurses and five care staff on duty in the mornings and afternoons and one registered nurse and three care staff overnight. The manager confirmed that no dependency tool had been used to reach conclusions about how many staff were necessary to meet people's needs. They said that staffing numbers had been based on occupancy levels and ratios of staff to people. This method did not take account of people's health conditions or risks to them from being unable to use a call bell to call for help. On the second day of our inspection a new dependency tool had been introduced and the manager told us that this had calculated that the service was in fact overstaffed. A review of the dependency tool showed that it did not take account of the high levels of agency staff usage which meant staff were not as familiar with people's needs and routines as permanent staff. Neither did the tool consider the layout of the premises, which is set over two floors, with significant distances between communal areas on the ground floor and limited visibility to be able to see what is happening in those rooms without physically visiting them.

Agency staff were frequently used in the service and sometimes made up the majority of staff on shift. The provider did not carry out any competency checks to ensure that agency staff were capable of carrying out their duties safely and effectively. We spoke with agency staff during our inspection and found that their knowledge and understanding of people's care needs was variable. For example two out of three agency staff we spoke with could not name any person with a DNAR order in place and neither could they say if anyone living in the service had epilepsy. The manager told us that the provider was actively recruiting staff but that the remote location of the service made this difficult.

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

Recruitment processes were not sufficiently robust to ensure suitable staff were employed to work with people. Disclosure and Barring Service (DBS) and identity checks had been made and documented. DBS helps employers make safer recruitment decisions. References had been sought and a recent photograph of staff members was retained on file. However, no application forms were available for two staff. One staff member had provided their CV but there was neither CV nor application form for the other. There was no information about this staff member's previous employment history so that the provider could ensure any gaps in employment had been explained. The CV for the first staff member was not sufficiently detailed to provide assurance about past employment dates and any gaps. The manager said that these staff had been recruited by the previous registered manager or in their own absence so they were unable to explain how this had happened.

The failure to operate a robust recruitment process is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safety and maintenance checks had been routinely carried out on electrical, gas and water supplies. Equipment such as hoists and the passenger lift had been serviced by a specialist contractor and fire safety items were regularly checked and documented. Fire alarms were tested on a weekly basis and fire exits were

clearly signposted.

Inadequate

Is the service effective?

Our findings

People told us that if they needed an optician, dentist or doctor "We only have to ask". One person added "They all come here to us". Another person said that their hearing aid batteries "Are changed by the staff once a week". People said they felt able to tell staff if they felt unwell and that they would receive treatment if necessary.

Our inspection findings however showed that the service was not always effective in meeting people's needs.

Staff had not received some necessary training to support them in carrying out their roles and keeping people safe. During the inspection we established that three people had epilepsy but the manager confirmed that no staff working in the service (including the manager) had received specific training about managing epilepsy and seizures. One person's medicines information showed they needed to be given a specially administered rescue drug in some circumstances during a seizure. The manager and nursing staff confirmed they had not been trained how to do this which posed a risk to the person's safety and well-being. We sought and received immediate assurances from the manager and the provider's chief operating officer that all future shifts would include at least one staff member with training in epilepsy and rescue medicines administration. Following the inspection the manager contacted us to say that epilepsy and rescue medicine training had been booked to address this knowledge gap.

Staff training records showed that some training sessions which the provider had deemed as mandatory had not been completed by staff. For example not all staff had received training about challenging behaviours or first aid and no staff had carried out end of life care training. Some people living in the service showed behaviours that challenged and one person was receiving end of life care. Several people were at risk of choking and first aid training generally includes advice about how to manage choking episodes .Only one staff member was shown to have completed equality and diversity training and care planning had not fully considered people's choices about how they wished to live their lives. This meant some staff were not fully equipped to meet people's needs.

The service used a high proportion of agency staff, and on occasions there were more agency than permanent staff on shift, including nursing staff. The manager told us that they tried to use the same agency consistently and they requested the same staff to work where possible for the sake of continuity for people. The manager had been provided by the agency with information about the training completed by the staff they supplied to the service. Some records indicated that agency staff had not received first aid training which included actions to take if a person choked. We spoke with agency staff on duty and found that their knowledge varied and in one case the staff member did not understand what the term 'choking' meant, until it was explained. Two people had experienced choking episodes recently and other people were known to be at risk of choking. The provider had not ensured that staff working with people in the service were suitably trained and competent to do so. Concerns about the skills and competencies of agency staff deployed had been raised at other Sussex Health Care locations that we have inspected and that other agencies have reviewed. However improvements to the monitoring and oversight of agency staff knowledge

and capabilities had not been applied to Horncastle House in order to ensure that staff with sufficient skills and experience were deployed to meet people's needs.

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

Permanent staff had received training in a range of mandatory areas including fire safety, dementia awareness, moving and handling and safeguarding. Some staff had received extra training in subjects such as record keeping and 'safe and enjoyable mealtimes'. All staff went through an induction programme when joining the service and staff received regular supervisions from the manager.

We received mixed feedback from people and relatives about their experiences of the meals on offer. One person told us "It's not bad, there is a good selection, but I am fed up with porridge and cornflakes for breakfast". Several people said they would like the option of a cooked breakfast instead of cereal. Although the provider's information booklet about Horncastle House stated that a cooked breakfast was available, people told us they had never been offered one and people had only cereal or porridge when we visited them in their bedrooms. People ate their breakfast in their bedrooms and we read signage which said this was the routine in the service. Although the manager said people could come to the dining room if they wished nobody did so during the two days of our inspection and people told us they did not realise they could do so. This had limited people's choice. Another person said the food "Leaves a bit to be desired. I had sausages that weren't cooked properly and the cottage pie was not good". A relative commented however that: "The standard of food is lovely".

People's eating and drinking was not always monitored in line with their care plan instructions. On the first day of our inspection we observed a person sitting in their bedroom with two open tins of biscuits in front of them. They ate several biscuits one after the other while we were with them. A later check of their food recording chart showed that the biscuits were not documented as eaten at any point during that day. As the person had been left alone by staff with free access to the biscuits they would not know how many had been eaten. This person's care plan about nutrition said that daily dietary intake must be recorded with the aim of maximising their intake and maintaining their ideal body weight.

Another person's care plan stated that they should have thickened fluids but they had a jug of unthickened water and a bottle of fruit squash in their bedroom. Thickened fluids are made using special granules which change the consistency of drinks so that they can be safely drunk by people with swallowing difficulties. The manager told us that this person did not have the ability to pour themselves a drink but having the unthickened fluids in their bedroom created an unnecessary risk that this might happen or a visitor might pour them a drink. This person had other care plans which mentioned drinks, such as 'Enjoys a cup of tea with two sugars' without saying that any drinks given must be thickened. This conflicting information posed a risk that staff might not read the details about thickening the drinks and give unthickened ones. In addition, the care plan information documented that one scoop of thickener should be used to thicken 200mls of liquid. However, a list in the dining room recorded that 'one scoop per drink' was needed. This meant that if the drink was greater than 200mls, it would not be thickened to the proper consistency and may present a choking risk to the person. This was particularly relevant given the high use of agency staff who were less familiar with people's needs and, as stated above, had variable knowledge and training.

Some people's care plans documented that they should drink a certain amount of fluid each day, usually between one and two litres. However, there were no fluid charts in use for some people with this recommendation in their care plans. Neither the manager nor nursing staff were able to tell us how they would know if people were not drinking enough, given the lack of records about intake. Other people's fluid

charts did not record the target amounts for them to drink. A person receiving end of life care had fluid charts which showed no intake at all during two mornings and another person's fluid charts showed low intake of 450mls and 520mls on two consecutive days. The manager was unable to tell us how fluid intake and charts were monitored to ensure adequate hydration for people. Staff had been reminded at a team briefing the week before our inspection to ensure fluid charts were completed, but we found that this was not being done.

Wound care had not been appropriately managed in some cases. Care files contained body maps or other references to skin issues such as moisture lesions, bruises, pressure sores and skin tears. In some cases we were unable to track the progress of these skin wounds because records about them had not been properly maintained. There were no photos, wound measurements or information about dressings in some cases and descriptions of wounds were vague. The manager assured us that these areas had healed or were healing and provided up to date photos to evidence this by the second day of our inspection. Other people had wound care plans but these had missing information including details about the site of the wound. One person's care plan about skin said that areas were 'Intact' when they had open blisters documented in another record. The lack of progress reports and accurate records posed a risk that people would not receive appropriate care and treatment.

Another person had been seen by a tissue viability nurse (TVN) on 21 March 2018 for a skin wound. They had prescribed a specific dressing but this was not in use at the time of our inspection on 29 March 2018 because the manager said the pharmacy did not stock it. In the meantime a gauze dressing was being used which can stick to the wound. No attempts had been made to contact the TVN to request a change of prescribed dressing until we raised this, so the person was not receiving the most appropriate treatment for their wound.

Other people had specific health care needs relating to ongoing medical conditions requiring specialist equipment. Care plans and risk assessments were not sufficiently detailed to ensure that all aspects of people's care and treatment were carried out and monitored. Following our inspection the manager contacted us to say that care plans had been put in place for each person affected. We will be checking this at future inspections.

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

Some people needed support to regularly reposition and relieve pressure on areas of their body. One person's care plan about skin made no mention of them needing regular repositioning, but 'Turn charts' were in place. However, the frequency of required repositioning differed between charts. The person had been regularly supported to turn but the accuracy of turn chart directions is an area for improvement. Special air mattresses were inflated to the correct levels according to people's weights, which ensured they received the therapeutic effect of the equipment.

People sitting in communal areas were offered a choice of drinks from a trolley several times a day. Jugs of water or individual drinks were seen in people's bedrooms. Where people had lost weight they had been referred for dietician input and were weighed weekly to monitor progress. For people who experienced swallowing difficulties the advice of speech and language therapists (SaLT) had been sought.

Protocols were in place for people who took blood-thinning medicines. These identified the risks and gave directions for how these could be minimised. There was a head injury protocol, which contained clear guidance for staff to follow in case people experienced such an injury. People had access to a range of care

professionals including GPs, podiatrists, TVN, SaLT, dietician and opticians. A relative told us that an optician had been to visit their loved one as well as a nutritionist. They told us that they had been kept informed about the medicines their relative was taking and said "I'm very happy with the care [Person's name] receives here and I have no complaints". Hospital 'passports' had been prepared by staff so that crucial information about people's care needs could be sent with them if they had to be admitted to hospital.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and supervision inside and outside of the service.

The service was not working in accordance with the principles of the MCA. Assessments about people's capacity were generalised and did not identify the specific decision about which the person's capacity was being assessed. No MCA assessments had been documented when bed rails, lap belts or alarm mats were used. Some people received their medicines concealed in food or drink and without their knowledge or consent (known as covert administration). This is sometimes appropriate where people lack capacity to understand the benefits and necessity of taking their medicines. In cases where giving medicines covertly is deemed to be necessary, a specific MCA assessment must be made and a best interest decision documented between the service and relevant healthcare professionals. This process had not been followed or evidenced for a person receiving their medicines covertly. The manager told us that they recognised the need for MCA assessments to be decision-specific and for properly documented best interest decisions and would begin work to make this happen immediately.

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

Deprivation of liberty safeguards had been applied for and/or authorised when people were assessed as lacking capacity to consent to living at Horncastle House. Staff had received training about MCA and DoLS and sought people's verbal or informal consent when delivering support to them. For example, "Can I hold your arm while we walk together?"

Information was held in people's care files about their communication needs in line with the Accessible Information Standard. Providers of health and social care services have new responsibilities to support people who have sensory impairments and/or learning disabilities. However, information contained in these documents was not always complete or accurate. For example one person used hearing aids but this fact was omitted from the document, even though hearing aids was given as an example of what might need to be included. Menus on lunch tables were printed in a small font when some people had reduced vision or sight impairment. This is an area we have identified as requiring improvement.

The premises had been adapted in some places to make it more suitable for people living with dementia or memory loss. Some bedroom doors had a special wrapping on them to give them the appearance of a coloured front door, complete with door knocker and letterbox. Other people had plain coloured doors but with their photo or another picture on them to help people orientate themselves around the service.

Memory boxes were in place by people's front doors and the manager said they had started to use these to create montages of items which had significance for the person using the room. Picture signage was in use to identify communal areas and toilets and there were quiet lounges and areas where people could meet with their visitors if they chose to do so. During the inspection one person's family took them for a stroll around the grounds in their wheelchair and other people told us they liked to go outside when the weather was warmer.

Requires Improvement

Is the service caring?

Our findings

Most people said that staff treated them with kindness and compassion. One person told us, "The staff treat everybody very well and they are all lovely". Another person commented "They all go out of their way to help" and a relative said "I really feel that Mum is well cared for here".

However people were not always considered with respect. Kitchen staff were heard shouting and swearing repeatedly while people were seated in the dining room. Although the swearing was not directed at people, this did not create a comfortable or friendly atmosphere for people living at Horncastle House.

People's dignity had been compromised in some cases. Laminated signs in some bedrooms gave details of people's care needs including toileting arrangements. The manager explained that these had been put up to try to ensure that people received the right support, given that agency staff sometimes made up the majority of staff on shift. However, consideration had not been given to people's right to privacy and dignity in placing these notices in prominent view of others. The manager said they would arrange for this detail to be held in individual files kept discreetly in people's rooms in future. A relative had returned a recent questionnaire response stating that their loved one was often wearing other people's clothing; despite having plenty of their own, name-labelled items. This was not respectful of this person's dignity or property.

Records of complaints made by people and their families were kept in a file by the front door; accessible to anyone entering the service. A review of these showed that they contained both people and their relatives' names together with sometimes intimate information about the complaint. The manager and administration staff explained that they believed the provider's complaints policy had instructed this mode of storage for the complaints file. However, we read the policy and in discussion with the manager could see that the policy had been misunderstood. Nonetheless, people's private information had been available to others and this was undignified for them. The complaints folder was moved into the office during the inspection.

Some people were not always supported to be as independent as possible. One person was seen without their dentures in at mealtimes on two consecutive days which made it difficult for them to eat properly. Staff told us that this person sometimes took their dentures out and they did not use them. However the manager said that staff should be supporting this person by putting their dentures in at mealtimes. There was no information in this person's care plan about when and how their dentures should be offered to them to ensure the person could eat the foods of their choice with ease.

The failure to preserve people's privacy and dignity is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people were encouraged to be independent where appropriate. There were clear records when staff had discussed the benefits and risks of people walking to the toilet without staff support, when the person had the mental capacity to decline assistance. Care plans documented which tasks people could do themselves and those that they would need support or a prompt to complete.

Relatives told us that they felt well-informed about their loved ones' care and treatment and said they were always made to feel welcome when they visited. People, however, said they did not always feel involved in decisions about their care and treatment. There was limited evidence in people's care files to demonstrate that they had been included in planning or risk assessing and this is an area requiring improvement.

Staff knocked on people's bedroom doors and waited for a response before entering. Signs on bedroom doors could be positioned to show that personal care was being carried out to avoid the risk of other staff or visitors entering the room at those times. People told us that they felt staff spoke to them appropriately and that they were listened to. Staff often referred to people as "Dear " or "darling" and people appeared to enjoy the terms of endearment and were comfortable with this.

Staff were observed engaging people in conversation by gaining eye contact and speaking clearly to them. Not all care plans held clear information about the best ways to communicate with people, however. Some agency staff on duty said they had not read care plans and were unable to describe how they would approach individual people. However, we observed many gentle and caring interactions over the two days of our inspection and permanent staff were passionate when speaking with us about the people in their care. One staff member said people were "Like family to me" and became emotional when telling us about individuals living in the service.

Questionnaire responses completed by relatives about their experiences of the service were mostly positive. One read 'This house is run very well-all staff are friendly and welcoming; the care is excellence' and another said 'I am very happy with the home. The staff and manager have been most helpful and friendly'.

Requires Improvement

Is the service responsive?

Our findings

The service was not consistently responsive to people's needs.

Many of the care files we reviewed did not contain important, specific information about people's care and health needs. In this respect, people had not been treated as individuals because care planning was mainly around the basic needs that most people would have rather than being tailored for each person. For example, most people had care plans about moving and handling, sleeping and nutrition but a person using specific medical equipment had no care plan about personal care tasks which would need to be carried out and monitored routinely as a result of its use. Although the manager told us that care plans were "a work in progress", a number of examples of insufficient care planning to meet individual needs were found during this inspection. In each instance, people had been exposed to risk because of the lack of detailed and bespoke information available to staff delivering their care and treatment.

In addition, some care plan information was contradictory or incomplete which meant that there was not an accurate or full picture of people's needs and choices. For example, one person's care plan stated that staff should look for non-verbal cues of pain, but gave no description of how this person might show that they were in discomfort. Details about skin wounds, repositioning and thickened fluids were conflicting from one document to another, posing a risk that staff may not know the correct and current situation. Another care plan gave a physical description of the person receiving care and documented their preference for male or female care staff but made no reference to the person's sexuality or life choices. The manager told us that these care plans would be removed and a new format introduced. Following the inspection the manager contacted us to say the additions and amendments had been made to care planning and we will check this at our next inspection.

Most people told us that they could choose when to get up and go to bed but that their preferences were not always observed. One person told us "I wait in the lounge quite a long time before I can go to bed, it can be a long wait" and another person who was in bed when we visited them at Midday said they would like to get up. They said "I'm all on my own up here. But I don't think it's possible to get out of bed as I can't walk on this floor. But I would like to". The manager told us that this person had chosen to be cared for in bed, but this preference could have been checked more frequently to ensure the person's wishes were being fulfilled on a day to day basis. Minutes of a team briefing held the week before our inspection specifically mentioned that this person should be encouraged out of bed.

There were no specific end of life care plans in place at the time of our inspection, even though the manager told us that one person was receiving end of life care. There was information about funeral arrangements in other documentation but no detail about this person's wishes, how care should be delivered in a dignified manner, how pain should be managed and the person's hopes for their final days. The manager contacted us after the inspection to say that end of life care plans had been introduced. We will be checking this at future inspections.

Handover meetings were held between nursing staff and at each shift, for the purpose of passing on any

important information about people's health or care needs. However, care staff were not invited to these handovers and they did not include information about people's on-going conditions, such as epilepsy or diabetes. Some care staff were not knowledgeable about people's personalities or their medical conditions and there was a missed opportunity to involve all staff in handovers to improve their understanding. Some people said that they felt staff generally knew them well but commented that agency and night staff were less knowledgeable. A relative told us "Night agency staff are not so good". The high use of agency staff, along with care guidance being inaccurate or incomplete, placed people at risk of not having their specific needs met. This was particularly concerning as issues about conflicting or inadequate care plans and care records had been highlighted as a theme of concern at several of the provider's other locations. However the feedback and learning from these services had not been shared to improve this practice at Horncastle House.

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

People who were reaching the end of their life had support from the local hospice. Medicines to make people comfortable were prescribed in advance so that there would be no delay in ensuring people received these when needed.

Complaints had not been handled in line with the provider's complaint policy. A complaints log showed that nine complaints had been received since January 2018. The complaints policy stated that 'A final written response should be sent following investigation and within 28 days'. The manager told us that no written responses had been made to complainants.

The manager had however kept a record of their actions and verbal communication with the complainants who appeared to have been satisfied with the responses received. The manager had met with staff to make them aware of complaints and involve them in making improvements for people. The provider's complaints policy was accessible to people and visitors, and people and relatives told us they would know how to complain if necessary. However, further improvement was needed to how complaints were managed in order to comply with the provider's own policy and procedures.

Compliments in the form of thank you cards and letters had been kept in a folder for people, staff and visitors to see. One of these read 'We would like to thank you for your care for my husband during his stay in the home. He was looked after to perfection.' Another said 'I looked at about eight or nine care homes before I chose Horncastle and I am pleased I chose you.'

People's need for social stimulation was met. The service employed a full-time activities coordinator and a part-time assistant who worked from Monday to Friday. The manager told us that they were actively trying to recruit activity staff to work at weekends but in the meantime the two activities staff and a receptionist covered Saturdays and Sundays to ensure people continued to receive stimulation at those times.

An activities plan was displayed on a notice board and listed upcoming entertainment and things to do. The full-time coordinator said that group activities happened in the mornings and an outside entertainer or TV and hand massages were arranged for the afternoons. During our inspection we observed people engaged in a quiz, a game of hoopla and enjoying the music of a visiting harpist. One person told us that they liked "Puzzles, crayoning, exercises, quiz, television and a man who sings". Other sessions on offer included karaoke, skittles and ball games. The activities staff said that people really enjoyed the garden and grounds of the service in the warmer weather; which were exceptionally attractive. Some outings had been successfully arranged in the last year, including a trip to a llama park and a pub.

People who were unable or did not wish to leave their bedrooms were visited by activities staff for one-to-one sessions. Records had been made to show what people had been involved in and whether they enjoyed it and would like to repeat the experience. This helped activities staff to monitor which events and sessions had been popular.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. At our last inspection in 2015 it had been rated by CQC as 'Good' in every area. At this inspection our findings showed significant deterioration in the safety and quality of the service. There had been insufficient oversight by the provider to pick up on the issues highlighted during our inspection and rectify them before they resulted in risks to people going unchecked. This was despite the provider having been repeatedly made aware by CQC and partner agencies of similar shortfalls in a number of their other services. Feedback given to the provider about changes and improvements needed had not been used to ensure that all their services were managing people's care to a safe and appropriate standard. This included areas related to risk management, management of complex health conditions (including epilepsy and dysphagia), skills and competencies of staff deployed, effective systems for safeguarding adults, accurate and clear care planning and daily care records, understanding and application of the Mental Capacity Act and systems for ensuring quality oversight and effective monitoring of quality and safety.

Although the provider had carried out some auditing of the service, this had not been effective in identifying the many breaches of Regulation seen at this inspection or ensuring that problems were promptly put right in a proactive way. A provider audit had taken place just days before our inspection but was not in-depth and had found very few areas requiring attention which was at odds with the significant failures we found at this inspection.

There was no registered manager at Horncastle House. The previous registered manager had left in September 2017 and the deputy was applying to become registered as manager with the CQC at the time of this inspection. It is a requirement of the provider's registration that there is a registered manager in place and the absence of one had impacted on the governance and oversight of the service.

The registered manager from one of the provider's local services was supporting the manager of Horncastle House in the weeks leading up to our inspection. They had begun to review some care plans and had compiled a list of changes and additions needed, including that a choking risk assessment was needed for one person. However, this had not been prioritised and there remained no choking assessment in place when we inspected. We were told that other essential amendments were "a work in progress", but people were at risk of experiencing inappropriate or unsafe care and treatment in the meantime.

Provider and manager audits had not recognised risks such as: lack of DNAR identification processes, no care planning around epilepsy or other individual medical conditions, environmental risks, recruitment documentation, prescribed cream storage and application, safeguarding follow-up actions, staff deployment and training, eating and drinking issues or wound care management. The management team reacted quickly to these issues when they were raised by inspectors and took actions to remedy a number of them. However there had been insufficient proactive checking processes by the provider and manager to enable these problems to be identified and addressed prior to the inspection.

In addition, some audits were ineffective, such as the manager's call bell checks which did not highlight any issues when almost everyone we spoke with reported that call bells took too long to answer and we

experienced this during the inspection. Bed audits did not look at whether MCA assessments and/or best interest meetings had been carried out when bed rails were in use for people who lacked mental capacity to consent to them.

Feedback had been sought from people and their relatives through the issue of a questionnaire and regular resident and relative meetings. There had been very few responses to the most recent questionnaire but those received were mainly positive about experiences of the service. There was no analysis of the questionnaire returns available to show that the detail of replies had been reviewed for any trends and to identify any actions needed. One of the returns for example, noted that call bell response times were 'unsatisfactory' in September 2017, but we still found this to be the case six months later. A relative had also commented that their loved one's denture had gone missing at Christmas and we observed this person trying to eat without dentures during the inspection. Actions resulting from feedback received is therefore an area requiring improvement.

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

Staff were open and cooperative during the inspection. They told us that they enjoyed working in the service and that the staff team worked well together. There were occasions however when call bells were sounding for several minutes and staff had to be prompted by the management team to respond to them.

Staff told us that they felt supported by the manager but most people we spoke with did not know who the manager was, saying that they believed it was "A lady", when the manager was a man. However, some people using the service were living with dementia or memory loss and may have had difficulty remembering who the manager was. People said that they did not have the opportunity to speak with the manager on a daily basis but found staff "Friendly and approachable". The manager is a registered nurse and had completed updates and refreshers in order to maintain their registration with the Nursing and Midwifery Council. The service worked in partnership with professionals such as GPs, dieticians, SaLT and mental health teams where further advice was needed about people's individual health and medical needs.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception area and on their website.

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