Hawkinge House Limited

Hawkinge House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hawkinge House is a residential care home providing personal and nursing care for up to 115 people. The service is also registered as a supported living service, extra care housing service and domiciliary care service. People were living with a range of complex health needs, including those living with dementia, brain injuries or diabetes.

At the time of our inspection there were 109 people using the service. People using the supported living service rented their accommodation and had tenancy agreements with Hawkinge House Limited. These people could choose what organisation provided their care, but they all chose to receive their care from staff employed by Hawkinge House. Everyone living at the service was entitled to the same level of 24-hour care, therefore we included everyone living in the service in our inspection.

People's experience of using this service and what we found
The provider had quality assurance processes in place but lacked robust mechanisms to address shortfalls and learn lessons to drive improvement. Plans were in place to make positive changes, but these had not yet been embedded into the service.

Risks were not always safely managed as some assessments and care plans were not up to date. Care was not always personalised, and staff did not always have detailed knowledge of the people they were supporting. One person told us, "I have heard of a care plan, but I've never seen it." Handover notes were not consistently read by staff.

There were not always enough staff deployed to meet peoples' needs and ensure people were not at risk of social isolation. There had been some changes within the staff teams, which had a negative impact on peoples' lives. People and their relatives consistently told us there was not enough going on to keep them engaged, especially for those people who needed to be nursed in bed. One relative said, "They don't seem to want to do anything with [relative]."

People told us they felt safe living in Hawkinge House and were generally happy living there. One person said, "I feel safe living here, this place saved my life." Individual staff were described as kind and caring, and peoples' privacy was respected. One person said, "They are very nice and helpful." Staff were recruited safely and had received training. Medicines were managed safely.

The service had a new manager who was aware of shortfalls in the service and was working through these with senior managers and the local authority.

We have made a recommendation about the management of records in relation to complaints.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 31 December 2019).

Why we inspected
This inspection was prompted by our data insight that assesses potential risks at services, concerns in relation to aspects of care provision and previous ratings. As a result, we undertook a comprehensive inspection. This enabled us to look at the concerns raised and review the previous ratings.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this full report. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hawkinge House on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Hawkinge House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Hawkinge House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission, although the application for the new manager was in progress. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

We used information we had received about the service since our last inspection. This includes things the provider is legally required to notify us about. We obtained feedback from the local authority and professionals who worked with the service. We sought information from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all this information to plan our inspection.

During the inspection
We spoke with ten people who were living in the service and fourteen relatives about their experience of the care provided. We spoke with 17 members of staff, including the manager, compliance manager, deputy and duty managers, care staff, housekeeping staff and activity coordinator. 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.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at six staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed, such as training data, audits and compliance reports.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at more documents including, competency checks, supervision records and health and safety records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- There weren't always enough staff deployed to meet peoples' needs. During the inspection, call bells were answered quickly, but people told us, and records confirmed that call bells are not responded to as promptly as they would like.
- Although the service used a dependency tool to work out if they had enough staff, most people we spoke to said, and their relatives agreed, there weren't always enough staff on duty to assist people, particularly at night. One person said, "Sometimes you have to wait to be helped, they could do with more staff, the other day I had to wait for an hour, usually it's at night-time you have to wait". Another person said, "Recently I had to wait 20 mins before my bell was answered and then another 20 minutes to get assistance."
- We gave this feedback to the provider as we saw no evidence staffing was insufficient to meet peoples' needs. The provider was aware this was an area for improvement and had plans in place to review staffing levels and deployment.
- Staff were recruited safely. Records were maintained to show checks had been made on employment history, references and Disclosure and Barring Service (DBS) records. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people working with people who use care and support services.
- Nurses were registered with the Nursing and Midwifery Council and the provider had made checks on their personal identification number to confirm their registration status.

Assessing risk, safety monitoring and management

- Initial risk assessments were comprehensive and contained enough information for staff to provide safe care. Significant risks were included for example, falls and skin integrity. However, not all risk assessments and care plans were up to date and there were no systems in place to ensure reviews took place. The manager had plans in place to introduce a more robust method for ensuring that regular reviews were undertaken and monitored. Monitoring charts such as weight management and repositioning were up to date.
- People had been assessed by professionals, such as Speech and Language Therapists and dieticians who recommended particular diets or modified foods and fluids to minimise the risk of choking. These instructions were passed verbally to the kitchen, but kitchen staff were not invited to daily meetings where changes could be discussed. The manager agreed that there was a potential risk that special dietary instructions may not reach the kitchen or be acted upon. We observed people were receiving the correct diets to meet their needs.
- Staff didn't always know people very well, and they were not always able to tell us about the people they were supporting. Staff told us they didn't always have time to read the care plans and risk assessments and

records showed that they didn't consistently read handover notes. This meant there was a potential risk that staff didn't have up to date information about peoples' care needs and preferences and may not be aware of changes in peoples' needs. Relatives confirmed that staff didn't always know their relatives well. This was mainly newer care staff who worked under the supervision of registered nurses (duty managers) to minimise the risk.

● The building was equipped with up to date fire systems and a fire risk assessment had been completed by an external contractor. Environmental risks were managed, including electrical, water and equipment safety. Staff had received training in fire safety, and were knowledgeable about what the emergency procedures, but there was no evidence that staff had attended fire evacuation training.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. Staff were knowledgeable about safeguarding and knew when to report issues and to whom. Staff told us, and records confirmed, they received training in safeguarding.

● Records showed staff recorded and reported allegations of abuse to the appropriate authorities. Safeguarding records were completed; the management team cooperated with investigations and put actions in place when required.

● People and relatives, we spoke to said they felt safe in the service. One person said, "I feel 100% safe living here." A relative told us, "There is a very good security system for getting into the building." Another relative said, "They were extremely safe during the pandemic."

Using medicines safely

● Medicines were managed and administered safely in accordance with national guidelines. Medicines were ordered in a timely manner and stored in locked cabinets in peoples' rooms. However, where medicines are required to be stored in temperature-controlled conditions, the temperatures were not consistently recorded. This meant that some medicines, if not stored at the right temperature persistently, may not be effective.

● Medicines were administered by nurses and care workers who had received additional training to carry out this role. Training and competency checks were up to date. There had been no recent medicine errors in the service. Where people had medicines via a skin patch there were systems in place to ensure that the administration site was rotated to prevent skin irritation.

● Medicines were audited monthly and audits had identified the issues found on inspection. There were action plans in place to address these shortfalls.

Preventing and controlling infection

● We were partially assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Effective nursing measures were not in place for a person who was showing signs of an infection. We spoke to the nurse and this was addressed immediately.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

● The provider had mechanisms in place to ensure that staff had received the relevant vaccinations to meet current legislation.

Learning lessons when things go wrong

● There was an electronic system for recording accidents and incidents and staff knew how to report them. Professional advice was sought when necessary, for example, calling the GP or emergency services.

● Accidents and incidents were analysed to determine trends and patterns, for example, the day of the week and time of the day that falls occurred. However, there was no clear action plan to show how these trends were acted upon. This was an area for improvement.

● Although we saw some evidence that lessons learned were recorded, this was not robust and did not match up to the incident. There was no mechanism in place for sharing lessons learned across the staff team or the wider organisation. The provider had recently introduced mechanisms for sharing lessons learned, but this had not been fully embedded in the service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● People weren't always supported to eat and drink enough to maintain a balanced diet. For example, emergency services had been called for a person showing signs of dehydration, which were reported to the local safeguarding authority. Views about the food were mixed with some people and their relatives saying the food was good. However, most people and relatives told us there was not enough food and there was very little choice. One person said, "There is not a lot of food."

● One relative told us, "The food isn't good, very small portions and no choices offered. They don't bother using the preferences we discussed when [relative] first came in." One person told us, "It's a long time to go from five in the evening to eight in the morning without food." At the last residents meeting, people commented that the food wasn't very hot. We did not see an action plan or evidence that this had been addressed. The last feedback from relatives stated that the food was boring, bland and lacked variety with the same menu choices every week. There was a recommendation to review the food service, but we found the same concerns during our inspection.

● Menu boards on two floors were blank and the third one was not accurate. Neither the people living in the service nor the staff on duty at lunchtime knew what was being served. Staff were not always aware of individuals' food preferences. We observed staff helping people with their meals and drinks, but there was little interaction or communication between the staff and the people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● New people moving to the service had an initial assessment undertaken to ensure that the service was able to meet the person's individual needs. The assessment documentation had been recently improved following an incident where a person's needs were not met. The new assessment document contained more detail and ensured that any staff training requirements to meet peoples' individual health needs were in place before the person moved in.

● Staff used recognised assessment tools to assess risks, for example, of malnutrition or skin damage. Initial care plans were comprehensive; they contained enough information for staff to know about peoples' individual choices, wishes, likes and dislikes. We observed that staff weren't always knowledgeable about the people they were supporting. Care staff we spoke to did not always know about peoples' medical conditions or background but were supervised by registered nurses that did.

Adapting service, design, decoration to meet people's needs

● The service was arranged across three floors with access to the upper floors via a lift. Peoples' front doors were different colours. Doors had photographs on them, and some had other pictures of interest, such as a

photograph of an aeroplane.
● The reception area was welcoming and well decorated, the corridors and peoples' rooms required updating, particularly stained carpets and other flooring. Some carpets and flooring were sticky when walking across them. Relatives told us they had noticed a big difference in the condition of the rooms when visiting was restarted after the COVID-19 restrictions were lifted.
● Some rooms were very personalised, for example, one person had brightly coloured wallpaper and furniture. People had personal bedding and personal belongings in their rooms. One person who enjoyed reading, had shelves full of books. Some rooms were less personalised and looked bland. The service accommodated people on a short-term basis whilst they were awaiting assessment, but it wasn't clear during our inspection who these people were, and staff weren't always able to tell us.
● The manager told us that there was an improvement and renovation plan in place for the service but wasn't able to confirm any specific timescales for the works to be completed.

Staff support: induction, training, skills and experience
● Staff told us, and records confirmed they had received training, including induction training. Most people and their relatives told us they thought staff were adequately trained.
● Feedback from healthcare professionals who worked with the service had identified concerns about staff knowledge in topics such as feeding tubes, wound care, nutrition, fluid intake and dementia. Nurses had recently attended training sessions in some of these subjects, and more sessions were planned. The manager told us they had consulted with specialists to advise on specific medical conditions so they could provide the right care and support for people.
● Staff told us, and records confirmed that they received supervision regularly and these were mostly up to date. During supervision sessions staff had raised concerns about lack of staff and having no time for activities.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Care plans contained health assessments and there were records of interactions with visiting health care professionals, such as Speech and Language Therapists and dieticians. Some professionals who visited the service thought staff needed more training to support people who were in Hawkinge House for short term rehabilitation so that they could better meet their needs. Further training in this area was planned.
● Most people told us they were able to see a doctor when they felt unwell, although one person told us the doctor used to visit regularly, but doesn't now, "probably because of the virus." A relative told us, "There have only been video calls with the doctor which have not been satisfactory, he hasn't seen [loved one] face to face."
● The manager told us healthcare professionals were visiting the service once a week to see people. The team consisted of a paramedic, nurse practitioner and a pharmacy technician and acted as the link between the service and the surgery. This had been in place for a short time but was seen to be beneficial. The managers also had a group telephone call with the continuing healthcare team every week.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service complied with the MCA. There were decision specific mental capacity assessments in place which were completed correctly. Where people were unable to make decisions, there were clear reasons documented and best interest meetings held.
● Applications had been made to the relevant authorities to obtain DoLS authorisations for people who lacked mental capacity so people could receive care that respected their legal rights.
● Care was provided in the least restrictive way. Consent was clearly documented in peoples' care plans and we observed staff obtaining consent from people before offering support.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- Records showed assessments considered peoples' protected characteristics. There was a weekly church service in the home. One person told us, "It's so nice to have our own church service here, I do enjoy attending." A relative told us that the vicar comes to [relatives'] room, "which she really appreciates."
- People told us they were treated respectfully. One person said, "On average they are quite nice". Another person described the staff as, 'kind and smiley'. A third person said, "The staff are kind. Some of the new staff are not as good as the older staff." Relatives confirmed that mainly staff were kind and caring.
- Peoples' preferences were respected. One person said, "I don't want male carers doing intimate things and they respect that." Another person said, "The other day, I fancied a bath and they arranged for me to have one."

Respecting and promoting people's privacy, dignity and independence

- People received care which promoted their dignity and encouraged independence. Everyone living in the service had private bathrooms. Doors to peoples' rooms were kept closed when they were receiving personal care. One person said, "They always close the door, shut the blinds and cover me with a towel as much as possible."
- Staff understood peoples' rights to privacy. People told us and our observations confirmed that staff knocked on peoples' doors before entering their room. One person said, "The staff are very respectful and always shut doors and curtains when they are doing personal care." A relative said, "They are very hot on privacy which is good to know. I have been very impressed with [relative's] care."
- We saw staff speaking to people with kindness and in a caring manner. One person told us that the regular staff were 'sound as a pound'. One relative said, "The staff are lovely, I have no problems with them." Another relative said, "The staff are very kind and friendly, they are so good to us; I cannot fault them."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Some people told us they had been involved in the planning of their care. One person said, "I was fully involved in writing my care plan and I get to check it about every three months to check that it is still up to date and relevant." A relative told us that they went through the care plan together as [relative] has capacity to decide what their care needs are. This wasn't consistent, some people told us they did not know about their care plan which may mean they did not receive care in the way they would have chosen.
- Peoples' care plans were personalised and contained information about their likes, dislikes and personal preferences. Most had a full life history including past employment, hobbies, and people and places that were important to them. However, although there was one member of staff who knew the people very well, most staff could not tell us anything personal about the people they were providing care for, despite the level of detail in their care plan.
- During the inspection one person asked us to close their curtains. They said, "They know I don't like the light as it hurts my eyes, but they just forget." One relative said, "I keep telling them that [relative] doesn't like the radio on loud, but it is always on far too loud." Another relative told us that the only stimulation in the room is a radio station that [relative] doesn't like; "they don't bother checking the details to find out what [relative] might like." A third relative said, "Lots of things worry me, what worries me most is they don't realise [relative] doesn't have dementia; [relative] has a brain injury and needs to be stimulated."
- Care records were completed using icons on a handheld device, for example, person has eaten, person has been moved from bed to chair; there was a lack of detail in the daily notes to reflect any personalisation of care. Care workers were busy and were consistently ticking icons on the handheld devices, sometimes with little interaction with people.

Failing to provide personal care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was one full time activity / wellbeing coordinator in post with a second person part time to provide support. This had been changed recently; previously there were more activity staff in post. The care workers (care companions) were expected to do activities with people. In practice this wasn't working because the care workers didn't have time. Previously there were four activity staff on every day, including weekends. The activity coordinator plans one to one time for people who are nursed in bed, but the care workers rarely have the time. They said, "It's very sad." And added, "There's no time for families anymore, either."
- Peoples' views of activities varied across the service. One person told us they didn't like to do crafts or go

out to the garden, and said, "I am an internet addict, the staff know I am happy in the life I live and let me get on with it." Another person told us they planned to see the entertainer later that day. A third person told us they enjoyed the entertainment when there was singing and liked the church service.

● We saw many people were disengaged, staring at the walls or sleeping. We saw very little meaningful interaction between staff and people. Some relatives told us that their loved ones were left in their rooms or in bed most of the time; one said they felt this was the 'easy option'. Most relatives we spoke to were disappointed with the level of activities on offer. A relative said, "[Relative] enjoys music CDs and DVDs, but staff don't put them on."

● A relative told us, "[Staff] fail to see that [relative] has come from a family and has a previous life, but they don't want to do anything with [relative]." Another relative said, "To them [relative] is just a number." Another relative said, "[Staff] don't encourage [relative] to do anything; [relative] needs more social interaction. Some of the things they do are degrading; [relative] doesn't want to play with balloons."

Failure to support people to prevent social isolation and support people to take part in activities was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People with specific communication needs had documentation in their care plans relating to this, for example, if people needed staff to speak a bit louder. People who needed glasses or hearing aids were supported to use these appropriately.

● There was clear signage around the home and on bathrooms and toilets which helped people who were mobile navigate around the building. There were clear, bright welcome signs at the entrance of the service and posters about infection control throughout the service.

Improving care quality in response to complaints or concerns

● The provider responded to complaints and concerns. People and their relatives knew how to raise concerns or complaints and would be comfortable doing so. One person said, "I would go to the office if I needed to make a complaint."

● Most people and their relatives told us that complaints were not responded to or acted upon in a timely manner. One relative said, "When we do have a little moan, we get fobbed off." Another relative said, "I think things are just brushed under the carpet and they hope you will forget." Some relatives told us they had met with the manager but were still waiting for changes to be implemented.

● Not everyone felt this way. One relative told us, "Every time I ask for something to be done, they act on it."

● Complaints were recorded on the company's electronic care planning system. There was no separate log of complaints which made it difficult for the manager to see the investigation, actions taken, whether the complainant was satisfied with the outcome or lessons learned to prevent similar complaints.

We recommend the provider seeks advice and guidance from a reputable source about the record keeping in relation to complaint management.

End of life care and support

● The service was able to provide end of life care which enabled people to remain in the service if needs increased, rather than move to a new service. Care plans included end of life plans which were developed with people and relatives if appropriate.

● Staff worked with community nurses, hospice teams and the GP to provide end of life care when required. Medicines were available to them to keep them as comfortable as possible.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Care plans were not always up to date. One relative told us they were concerned their loved one's care plan had not been updated even though their needs had changed, so staff did not have up to date information to meet their needs. The provider's compliance report confirmed this. On the daily management reports we looked at there were several care plans and assessments that had passed their due date. The provider's audit processes had documented a continuing decline in compliance with care plan and assessment reviews. The manager told us they had plans in place to address this.
- The provider had quality assurance systems in place; regular key performance indicators were measured, and internal quality audits were conducted. Shortfalls in the service were identified through these mechanisms, for example, out of date care plans and assessments and slow call bell response times. There was no robust method of assessing that actions had led to improvement. The manager told us they were introducing a resident of the day system to ensure that care plans were reviewed regularly.
- Daily records of care were lacking in detail and mainly consisted of standard phrases from a tick list that staff selected on the handheld devices. Care staff read handover notes on the handheld devices and the manager was alerted if staff hadn't ticked to say they had read them. There was evidence that the staff didn't always read handover notes, this meant there was a potential risk they did not have up to date information about the people they were supporting, although we saw no evidence that people had been harmed because of this. This was not an effective system for keeping staff updated. The manager was aware of this shortfall and was putting plans in place to strengthen the handover process.
- The manager met daily with the deputy managers and registered nurses (duty managers) to discuss the daily management report. Topics covered included changes in peoples' needs, outstanding care plan reviews and supervisions due. These meetings were not documented, which meant there was a potential risk that required actions were not followed up or monitored. There were no other clinical meetings for nurses to discuss issues such as wound care or complex health needs.
- The service lacked robust procedures for ensuring staff, including kitchen staff, knew about peoples' likes, dislikes, food allergies and intolerances and peoples' modified diets. A healthcare professional told us that staff were not always able to spot signs of dehydration which could lead to preventable health conditions. Further training had been arranged for staff.
- The provider and manager were aware of the shortfalls in the service and had plans in place to make positive changes to drive improvement. Some of these changes were either in the process of being implemented or have been implemented recently. These improvements were not yet fully embedded into

the service.

Peoples' care plans and risk assessments were not always up to date, and the provider did not have robust mechanisms in place to monitor the safety and quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services providing health and social care to people are required to inform the CQC of important events that happen in the service. This is so we can check appropriate action has been taken. The manager had correctly submitted notifications to CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was a meeting for people who lived on the ground floor of the service recently, attended by five people. The notes from the meeting contained people's views and detailed the actions that the manager had taken or planned to take. There were over one hundred people living in the service at the time of our inspection and we did not see any evidence that other people had been given the chance to air their views. People told us they had not been asked for their feedback on the service, nor had they been given any questionnaires.

● The last care home satisfaction survey for relatives was over 18 months ago. Relatives told us they used to have meetings and a newsletter, but both had stopped. They thought the meetings had stopped because of the COVID-19 pandemic. The manager told us that the newsletters were being restarted and a December newsletter had been sent out. This contained details about December's planned activities and names of people who had birthdays during the month. There was no update on staffing, management changes or any planned improvements, and no invitation for them to share their experiences.

● There had not been a staff meeting for over six months. The manager told us they needed a structured staff meeting to make sure their views were heard. The manager planned to start these. A staff survey had been undertaken this year and the comments were mostly positive. Negative aspects included staffing levels, especially at night, lack of training and standards of care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not always receive good quality care which achieved good outcomes for them. People and relatives consistently reported incidents of poor standards of care and hygiene, lack of meaningful activities, not enough staff, lost property and poor communication.

● People and their relatives consistently told us that communication was a problem. One relative said, "Communication could be better." Another relative said, "Some staff do not speak good English." A third relative said, "my [relative] does struggle to understand some of the staff."

● The manager was new in post and had created an open-door culture. Staff told us the manager was supportive and listened to them. One staff member said, "At first I thought she was a bit scary, but she is absolutely lovely. I get a lot of support from her." Other staff members also told us that the manager was very supportive. The manager was actively working through some of the shortfalls in the service.

● People and their relatives knew there was a new manager, but not all had met her or knew her name. People described the atmosphere as 'happy', 'friendly' and 'one of kindness'. One person said, "I have seen the new manager once or twice, she seems very nice." Another person said, "The new manager pops in often, I think she is the best manager they have had since I've been here."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The Care Quality Commission (CQC) sets out specific requirements providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing support, truthful information and an apology. The provider understood their responsibility.

Working in partnership with others

● The service worked in partnership with other health and social care professionals, such as safeguarding teams, doctors and community nurses.

● There were cluster calls with the Continuing Healthcare team every Tuesday and once a week the Primary Healthcare team visited; this was a nurse, paramedic and pharmacy technician.

● The provider held management meetings with managers from all homes in the group. This was an opportunity to share best practice and to provide mutual support.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that peoples' care was personalised to meet their individual needs; the provider failed to ensure that people were not at risk of social isolation or support people to take part in activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Peoples' care plans and risk assessments were not always up to date. The provider did not have robust mechanisms in place to monitor the safety and quality of the service.