Hailsham House (New Road) Limited

Hailsham House

Inspection report

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Date of inspection visit:
13 January 2016
18 January 2016

Date of publication:
12 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hailsham House provides nursing care and accommodation for up to 87 people who live with a dementia type illness, for example Korsokoffs disease and Dementia with Lewy bodies or/and a mental health illness, such as Bipolar disease and Schizophrenia. The home also provided care and support for people with Multiple Sclerosis and Parkinson's disease and end of life care. The home is divided in to three units,(Holly, Willow and Orchard) each with their own lounge and dining areas. A separate building (Beech) at this location accommodated up to 31 people who had a tenancy agreement for their care suite and who received 24 hour personal and nursing care by a separate team of staff. Some people who live in Beech Unit have care staff from an external domiciliary care agency of their choice to deliver care in their care suite. This unannounced inspection took place on the 13 and 18 January 2016. There were 111 people being supported at this time. Currently there are 25 people living on Holly Unit, 24 people in Orchard Unit, 32 people on Willow Unit, and 31 on Beech Unit.

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

People and visitors spoke well of the home and commented they felt safe. Our own observations and the records we looked at did not always reflect the positive comments some people had made.

At our last inspection in November 2014 we found Breaches of Regulation of the Health and Social care Act 2008 (Regulated activities) Regulations 2010. We undertook this inspection on the 13 and 18 January 2016 in response to complaints received about the service and to follow up on whether the required actions had been taken to address the previous breaches identified.

This inspection found that whilst quality assurance systems were in place they had not always identified the shortfalls we found in the care delivery and records. We found that equipment in place to mitigate potential pressure damage had not been checked by staff, and were not set correctly for specific people. This had placed people at risk from pressure damage. Discrepancies in people's weights were found and there was no audit trail as to why records stated different weights. This had the potential to impact on safe care and treatment of people in the home. There was no clear overview of accidents that had occurred and what action had been taken to prevent a re-occurrence. There was no evidence of learning taken forward to drive improvement and to promote peoples safety.

The management style of the service was not always open and transparent. Two nurses stated that they felt disempowered as they did not have autonomy to adjust care delivery when they felt it was required. One nurse said, "It's been challenging as a health professional to put views on care forward." Another said "It can be difficult to suggest change as I'm still new, but we as a team are getting stronger."

We spent time on all units in the service. We found Holly unit predominately to be lacking in leadership from nurses and was not delivering safe, and person centred care. Whilst staffing levels were appropriate and in line with assessed needs throughout Hailsham House, the deployment of staff on Holly unit impacted negatively on people who remained in their room and on continued bed rest. People were found isolated without access to a call bell or regular checks in place. On the other units only three people remained in their rooms and we observed checking these people regularly and reflecting these checks on the daily charts.

Care plans contained risk assessments specific to health needs such as mental capacity, mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. However on Holly unit we found that not everyone's health, safety and wellbeing was assessed and protected.

Medication administration practices on Holly unit did not ensure people's safety and well-being. We looked at the management of medicines and found irregularities in records and medicine administration that had the potential to impact on the safety and health of people. On the other three units, people's medicines were stored safely and in line with legal regulations.

Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). Staff were unable to tell us about how certain decisions were made such as, covert and crushed medicines, where people spent their time, or about whether people could use a call bell.

There was a lack of clarity in respect of Deprivation of Liberty Safeguards (DoLS). We found that some were classed as 'historic' and some expired. Staff were unaware of whether a DoLS was in place for people.

At our last inspection we found that the delivery of care suited staff routine rather than individual choice. This inspection found that there was some very person specific care being delivered to people on three of the four units.. However this was not found for people who remained in their room on Holly unit.

At our last inspection we found that not everyone had been happy with the food provided and the dining experience had not been a social and enjoyable experience for people. This inspection found that whilst improvements had been made and that people had the opportunity to eat in dining areas that were comfortable and social. We found people who remained on bed rest in the afternoon were not always encouraged to get up to join a communal evening meal.

Safe recruitment procedures were followed and appropriate pre-employment checks had been made including evidence of identity and satisfactory written references. Appropriate checks were also undertaken to ensure new staff were safe to work within the care sector.

People received care and support from staff who were appropriately trained, to meet their individual needs. They were able to access health, social and medical care, as required.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. However we also saw that many people were supported with little verbal interaction and many people spent time isolated in their room due to time pressure despite the best intentions of the staff.

Feedback had been sought from people, relatives and staff, although three members of staff said managers did not always welcome or encourage their ideas. Residents' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. Incidents were recorded, and

consistently investigated and acted on.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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

Hailsham House was not safe. Risk assessments were devised and reviewed monthly. However, management of people's individual risk assessments to maintain their health, safety and well-being were not in place for everyone on Holly unit and therefore this placed people at risk.

People were placed at risk by in effective management of specialised pressure relieving equipment which was not set correctly for their individual needs.

The deployment of staff within the service had not ensured people's health and social needs were being met.

Medicines were stored safely. However poor recording and unsafe administration of medicines placed people at risk of not receiving their prescribed medicines. Recording of skin creams, medicines, dietary supplements and as required medication was inconsistent. on Holly unit.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe

Staffing arrangements were flexible to provide additional cover when needed, for example during staff sickness or when people's needs increased.

Is the service effective?

Requires Improvement

Hailsham House was not consistently effective. Mental capacity assessments did not meet with the principles of the Mental Capacity Act 2005.

There was a lack of clarity between staff in respect of Deprivation of Liberty safeguards and what was in place for people.

People were seen to enjoy the meals provided. Whilst nutritional needs were regularly assessed, inconsistencies in methods of recording were found in food and fluid charts.

Staff were well trained, supported, informed and supervised to

carry out their roles effectively. We found however that this was not always put in to practice by staff as we found that safe care delivery was not consistent throughout the service.

Staff recognised changes in people's health and made sure other health and social care professionals were involved when necessary.

Is the service caring?

Requires Improvement

Hailsham House was not consistently caring. People were positive about the care they received, but this was not supported by some of our observations.

People who remained in their room on one unit were isolated and did not receive consistent interaction from staff. There were times when people were calling out for attention and were not reassured by staff.

People's bedrooms were personalised and people were encouraged to bring in items that were meaningful to them.

Staff knew people well and had good relationships with them. People were treated with respect.

Relatives were positive about the care provided by staff

Is the service responsive?

Requires Improvement

Hailsham House was not consistently responsive to people's individual needs.

People told us that they were able to make everyday choices, and we saw that this was the case on three of the four units. Some people on one unit were isolated whilst they remained in their bedroom and received very little attention.

There was a robust complaint policy and procedure in place that ensured people's complaints were investigated and responded to.

Is the service well-led?

Requires Improvement

Hailsham House was not consistently well led. People were put at risk because systems for monitoring the quality of the service delivery were not fully effective. Audits had not identified that medicine practices were unsafe or that records were not consistently recorded by staff.

The culture in the home between staff and management was not always open and transparent.

The home had a vision and values statement, and staff were clear on the home's direction but observed practices told us this was not being delivered consistently by all staff.

Visitors and people were invited to regular meetings and to feedback on the service received.

People and visitors had an awareness of the management team and felt they were approachable.

Hailsham 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 and in response to information of concern we had recieved. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 and 18 January 2016 and was unannounced.

The inspection team consisted of five inspectors and an Expert by Experience (Ex by Ex). An Ex by Ex is a person who has personal experience of using or caring for someone who uses this type of care service.

Not everyone who lived in Hailsham House was able to share their experiences with us verbally so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with 21 people, 6 visitors, 12 care staff, the registered manager and the deputy manager. We observed the care and support given by staff in the communal areas and looked around the home, which included bedrooms, bathrooms, kitchen, the dining areas, lounges and garden.

We reviewed 20 care plans, the quality assurance audits pertaining to cleaning, medication, environmental and people's care, health and welfare document, such as medicine administration records. We also looked at the organisational policies together with general information available for staff such as safeguarding, infection control and medication administration policies.

Before our inspection, we reviewed all the information we held about the home. This included notifications of events that have affected the service, safeguarding alerts, incidents, accidents and deaths. We contacted social services and two GP's from the local surgery. We also had feedback from the community psychiatric nurses and a dietician who had visited the home. We used the information shared to assist our inspection.

Inadequate

Is the service safe?

Our findings

Many people were unable to tell us their experiences of Hailsham House but we observed that people responded to staff in a way that showed us they felt secure and safe in the home. We observed people approach staff when they were anxious and needed reassurance or direction. One visiting relative told us, "I think It's a good home, I keep a close eye on things." Another relative said, "I trust staff here." However we found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

Peoples' risk assessments did not always reflect their actual needs and some lacked sufficient information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mental capacity, mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. However we found that not everyone's health, safety and wellbeing was assessed and protected. For example, we found that people on Holly unit were isolated in their room without a call bell to summon assistance. For those people who were unable to use a call bell due to their physical and mental health there was no risk assessment that provided guidance on how staff were to ensure they were safe. One person we met was on continuous bed rest and their door was closed. We heard the person banging on the table to gain attention. We alerted staff who told us that they would go and check the person. They said that this person always wanted attention and was 'fine'. We asked the staff how they would know this as there was no safety personal check list in place for staff to follow to ensure the persons had been checked regularly. Staff said they checked people in their rooms throughout the day.

Another person on the second floor of Holly unit was found by inspectors at 09:30 calling for help. The bedroom door was open and after asking if we could enter the person was sitting on the bed but trying to stand using their Zimmer. The person was struggling repeatedly to do this and we said we would find care staff to help them. The person replied "There's no point." The room was seen as a potential to risk of falls as there was debris (newspapers and packets of food) on the floor. Care staff were not visible upstairs and it took over 15 minutes for staff to answer the call bell. The person was very isolated in their room on the second floor as staff were elsewhere for the majority of the inspection. Although staff said the person was able to use a call bell, they said they didn't always. Staff had not identified this as a risk to their personal safety. There were no records of room checks to ensure the person's well-being and mobility safety. We reported to nursing staff that we had observed this person (on separate occasions) leaning right over in their chair with their arms hanging down to the floor. Staff did not seem to be concerned by this. The nurse told us that five people were "Bed-bound" on Holly Unit and unable to use call bells. The RN confirmed that there was no system in place to ensure regular checks on these people. Physical checks of their rooms by an inspector found that the doors were closed on all five at 15:30. We saw their beds were a distance from the doors and people may not be able to be heard if they call out. We spoke with the manager and deputy manager who were disappointed that staff had not used the form available. They acknowledged that the nurse was lacking in confidence and knowledge as they were still fairly new to the Hailsham House staff team. We received information on the first day of the inspection that the staff member would not be in charge of Holly unit until they had received further support and training.

Risk associated with use of pressure relieving equipment and the use of bedrails had not always been

assessed and used appropriately. For example, twelve pressure relieving mattresses were found to be set on the wrong setting. One mattress was set on 60 kgs when the persons' weight was 39kgs. This person was on continuous bed rest. Another person who was 53 kgs was sitting on a pressure cushion set at 75kgs. We identified this twice during the inspection and no action was taken until we asked a third time. A further mattress was found set on 120 kgs when the person's weight was 63.1 kgs. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. Staff on two units had no record of what the pressure mattresses in use should be set on and no check list to make sure they were correctly set. On Willow unit there were photographs of the pressure mattresses and the setting required but these had not been checked since September 2015 and were not all correct. We also found bed rails being used with pressure relieving mattresses. The risks associated with their use had not been assessed and did not comply with safety guidelines as the space between the mattress and the top of the bed rails were less than that recommended by the health and safety executive. People were therefore at risk from falling. These were discussed immediately with the manager who told us that they would ask the maintenance team to immediately check the identified beds.

Before our inspection we received concerns in respect of people's weight records being inaccurate. Information we looked at inspection confirmed this. We looked at the records of people's weights. We were told by staff that people were weighed towards the end of each month over a three day period. We asked staff to access peoples weight records on the individual files as we were told they did not keep hand written records as they gave the records to the registered manager to input in to individual care plans. Four staff including two trained staff were unable to locate people's weights. We asked how they kept informed of weight loss and how they checked the pressure mattress settings. They said they relied on handovers and information from the registered manager. We found the December 2015 hand written weight records on Willow Unit and checked them against the weight matrix kept by the registered manager. There were discrepancies noted. For example the computer held weight matrix stated for one person a weight of 67.5 kgs whereas the care staff handwritten notes stated 60.0kgs, another stated 54kgs and handwritten notes stated 50.8kgs, and another stated 68.2 kgs whilst the care staff handwritten notes stated 60.2 kgs. These were significant differences. We asked the registered manager why these records were so different. The registered manager told us that if he identified a big difference to the previous month's weight, he asked staff to reweigh the person. There was no audit trail or explanation written for the discrepancies we found. We found that there was no procedure in place to guide staff in weighing people consistently, such as being weighed on the same machine, at the same time of day and in similar clothing. Inaccurate recording of weights potentially placed people at risk from malnutrition and other related health implications and of not being referred for specialist advice for weight loss in a timely manner. Following the inspection the provider informed us that an independent consultant had re-weighed people in the home and the weights consistent (within 1kg) with the computer records.

Risk assessments did not include sufficient guidance for care staff to provide safe care and other care plans were not being followed. For example, good skin care involves good management of people's continence and regular change of position. There was guidance for people who stayed in bed to receive two or four hourly position changes and the use of a pressure mattress. However for people sitting in chairs or wheelchairs there was no change of position or toilet breaks in their care planning for staff to follow. We identified during the inspection people had not been assisted to access the toilet or offered a change of position for up to five hours whilst sitting in a communal area. Another person we visited had sat in their room in the same position for approximately four hours including the lunchtime period. The staff told us that they had not had time to go back to offer a change of position or a bathroom visit.

A person at risk of choking had received unsafe care which put them at risk of aspiration and choking: We observed staff giving them some help to eat before assisting the person to lie down before they had finished

swallowing. The care plan stated the person was at high risk of choking/aspiration and this would not have been an optimum position for a person with this identified level of risk straight after having a meal.

People at risk of pressure wounds did not have their needs met. We asked staff about wounds and pressure damage. We got conflicting information from staff. One nurse told us that there was no one at present on Holly unit with pressure damage. Care staff however told us of people with pressure damage on this unit. One person's care plan for 'Skin' showed they were prone to soreness and skin breakdowns and is 'Nursed on an air mattress set to their weight". The care plan noted on 6/1/1/6 that the person 'Has a small superficial skin break on L and R buttocks'. 'Reposition every 2 hours'. The nurse said that a turn chart had not been started for the week of the 13/1/16. Charts for previous dates were reviewed (9-12/1/16). These showed that the person had been repositioned every 2 hours most of the time, but there were occasions when this had happened 3-3 1/2 hours apart. We found on other units that not all staff were aware of pressure damage to people's skin and therefore staff were not ensuring that safe care was being delivered to prevent further deterioration. Turning charts were not all completed and for two people on continuous bed rest there were no records kept.

Personal emergency evacuation plans (PEEPs) were in place. The PEEPs were found lacking in guidance for safe evacuation as they did not give the support required such as equipment or number of staff required to evacuate individual people. There was no further information to guide staff in the safe evacuation of each person. Staffing levels especially at night would not be able to respond to the actions detailed, due to the layout of the home, number of staff and the number of people that would require staff assistance to remain safe. This placed people at risk from failed emergency evacuations.

Whilst infection control measures were in place, there were some specific areas that we identified to staff that were odorous. Chairs in bedrooms and communal areas were not all clean. In one bedroom there were visible stains on the chair along with an offensive aroma. We were told that these had not been reported but would be addressed immediately.

Medication administration practices did not ensure people's safety and well-being. We looked at the management of medicines and found irregularities in records and medicine administration that had the potential to impact on the safety and health of people. The medicines administration records (MAR) charts stated no administration times just morning, lunch, tea and bed. The morning medication on Holly was still being administered at 11:30 am and the lunch time medications were administered at 12:00 am. The timing of medicines could not be guaranteed to be given as prescribed by the doctor, for example four hourly, as no specific times were recorded.

To protect people with limited capacity to make decisions about their care and treatment the service had a process for staff to follow to give people their medicines without their knowing. This is known as covert administration. However, the provider's recorded actions did not reflect current legislation and guidance. For example, on one unit we were shown records for people where staff had instruction to give medicines covertly following a best interest decision by the psychiatrist or GP and with family agreement but the records did not show us if/how the provider had assessed the person's mental capacity. Staff told us covert administration of medicines was not always required as the person sometimes took the medicines but this was also not recorded.

Covert and crushed medicine was widely used in the home. There was a generic document in place that stated that the person's medicines could be crushed and given covertly. However the document lacked specific individual clarity of the reasons for this procedure and of whether it was required continuously. We saw on Holly unit that all medicines were crushed even those that the pharmacy said must not be crushed

as this reduced the effectiveness of the medicine. This was identified to the management team who took appropriate action. Immediately following the inspection we received written confirmation that the nurse had been taken off the rota to receive further training and supervision until deemed competent to administer medicines safely.

The provider did not have a PRN protocol (as and when required medicines) for when staff should consider administering specific medicines. This could potentially mean people received PRN medicines inconsistently. We also noted the times of when PRN medicines were given were not documented and this could mean there may be inconsistent gaps between administrations of medicines. For example paracetemol x 2 prescribed four times daily. The MAR for 13/1/16 showed 2 paracetamol administered 'Morning' but no time recorded, a second dose administered 'Tea', again with no time recorded. There were no entries on MAR to show that PRNs had been offered/refused at other times, nor notes on the MAR reverse about why pain relief given. We asked a nurse how she would know from looking at MAR at lunch time (12am) that the person had only had a dose of Paracetemol at 10:15, she conceded that she could only know this from memory. This was the same for all PRN medicines including sedation and anti-anxiety medicines.

People were prescribed emollients 'To be applied daily as directed'. A nurse told us that topical creams were stored in people's wardrobes on Holly unit and that there was no risk assessment in place about their storage. For example could the creams be stored at that room temperature and was the person able to access the creams and potentially ingest. She also said that creams were applied by care staff during personal care. There were no 'Topical MAR' sheets or similar in use to record the applications. Creams were listed on the MAR and the RN said that the MAR was signed retrospectively by nursing staff, "On trust" that creams had been applied by care staff.

The failure to ensure that people received safe care and treatment in respect of their health, safety and welfare are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst staffing levels were sufficient in numbers, the deployment of staff had not ensured that people's needs were met consistently on all units. We asked how staffing levels were managed to make sure people were kept safe. The registered manager explained how they assessed people's dependency on a daily basis and if a person was distressed, agitated or had an outing or hospital appointment; additional staff would be brought in to meet people's individual needs. We were given examples of when extra staff had been brought in, such as for continuous one to one support. This had been required in recent months and it was clear from documentation provided that when a person had been unwell and needed more support it had been provided. Staff felt that the staffing levels were sufficient at all times to deliver a good standard of care. One staff member said, "We know who needs more supervision and we prioritise." Another staff member said, "We would request more staff if we felt it was unsafe." People told us, "There are staff on duty during the day and at night and they are always willing to help if you need their assistance," "I feel very safe and happy here, don't want to live anywhere else," and "Always someone to talk to, or help me." However the staff deployment on Holly unit in particular had not ensured that people received the care and support they needed. Staff seemed to prioritise the people in communal areas and people who remained in their room did not receive the supervision and attention required. We saw examples where people were isolated and calling for assistance. We saw that for up to two hours staff did not return to peoples who were in their rooms despite being unable to call for assistance. This was identified to the management team during our inspection and we were told that this would be investigated.

The failure to ensure appropriate deployment of staff to ensure peoples safety and well being is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Medicines on Beech, Willow and Orchard unit were kept securely. We observed staff locked the medicine cupboard and clinical room and the keys were stored safely when they went to give people their medicines. Staff recorded the medicine fridge temperatures to check they were within standard guidelines. Staff had access to the most up to date British National Formulary (BNF) which meant staff could access current information about medicines and side effects.

Medicine administration records were signed by staff and whilst there were six gaps in recording for the month of records we were shown on Willow Unit, these had been identified through peer audits and followed up by the lead nurse. The provider recorded staff signatures and this meant the provider could audit which staff had administered medicines.

Staff received regular fire training and fire emergency evacuation training. There was fire fighting equipment placed around the home that had been recently checked and was ready for use. We saw that the fire emergency evacuation procedure was displayed throughout the home. The emergency plan had comprehensive policies relating to adverse events such as utility failure, accidents and the outbreak of disease. The plan included the contact numbers of local services including doctor surgeries, home managers out of hours contact details, emergency services and utility providers.

We looked at incidents records and audits. We saw accurate recording of incidents between people and these had been referred to social services and CQC in a timely manner.

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Before the inspection we received concerns about 'pest' infestation. Hailsham House is in a rural location with farm land to the rear of the property. There was a report of rats being seen in close proximity to the house. This had been managed by external contractors and records were available from 2014 to present day. The management of waste had been monitored by the management team and there were now systems in place that had managed the pests. We found that this had been managed appropriately.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they

suspected abuse had taken place. One staff member said "I have raised concerns before and the previous manager sent an alert to social services, I wouldn't hesitate to do it again, people need us to be alert and knowledgeable."

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in November 2014, the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because mealtimes were not an enjoyable experience and we also could not be assured that people's nutritional needs were met.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 September 2015. At this inspection we found improvements had been made and the provider was meeting regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors spoke positively about the home and the care and support provided by the team of staff. Comments included, "I have great faith in the staff," and "Staff are very good and provide good care." One visitor said "They (the staff) manage very well, but sometimes I think it's sometimes disorganised and staff don't always know what's happening." We found that Hailsham House did not consistently provide care that was effective.

Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. Staff told us, "It's about asking them and making sure it is what they want." Staff however were unable to tell us about how certain decisions were made such as, covert and crushed medicines, where people spent their time, or about whether people could use a call bell. We also saw a person moved with a hoist (moving equipment) where the staff moved the person whilst they were distressed and unhappy with the manoeuvre. There was no rationale given as to why or what alternative could be put in to place. Staff knew this person did not like to be moved with the equipment. This told us mental capacity assessments whilst undertaken, were not decision specific and were not recorded in line with legal requirements.

Staff had attended training in Deprivation of Liberty Safeguards (DoLS), which is part of the MCA framework. The purpose of DoLS is to ensure someone, in this case, living in a care home is only deprived of their liberty in a safe and appropriate way. This is only done when it is in the best interest of the person, and has been agreed by relatives, health and social care professionals and there is no other way of safely supporting them. Staff were aware the locked front door, which prevents people entering and leaving the home, was a form of restraint and we were told applications had been made to the local authority under DoLS about this. Staff were not clear if DoLS had been applied for, they said that this managed by the deputy manager. We found that records identified some DoLS were not in place, others had expired and we found one entry in the care plan, 'historically had one in place'. And 'staff always aware of his whereabouts.' It was unclear therefore whether people had a DoLS in place or if they had been applied for. Therefore, although staff had an awareness of not depriving someone of their liberty a system was not in place to prevent people being restricted unlawfully.

Whilst staff told us people should be encouraged to make choices we didn't observe that people were actively encouraged to make choices or that staff effectively delivered care according to people's preferences.. For example breakfast or beverages. A list of what people were to have for breakfast was used every morning with no choice offered. Staff said, "We know their preferences, we give them what they always have." We saw that food protectors were put on people without being asked or consulted. We also saw staff decided where people sat and when they were taken back to their room. We observed people were not always asked for their consent before interventions. On one occasion we observed staff make a decision to turn off the music and to put a film on without inviting a discussion about people's views.

At the last inspection we found that people were not always offered choices of where and how they spent their time. This inspection found that most people were offered choices and enabled to make safe use of all communal areas of the home. Where people had remained in bed or in their room they were now offered opportunities of visiting communal areas, joining activities and of visiting the main lounges to meet people. However it was noted on Holly Unit that five people who had remained in their room all day were in bed by 3:30pm with their door closed. These people were unable to use a call bell facility. Staff told that this was their preference as they got very tired by that time. This was not seen to be a choice as this was not reflected in their care plan nor were there any management plans in place for staff to return later after the person was rested offer the opportunity to get up again and eat their supper at a table.

Care and treatment was provided without consent which is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Before the inspection we received concerns that the food at Hailsham House was reheated and not freshly prepared, and that people receiving a pureed food diet were given leftover food from the previous day. These concerns were not found during our inspection. The environmental health officer also visited the service and found no relabelled out of date food or food that was below the required standard.

At the last inspection the meal service was a solitary experience for some people and we also could not be assured that people's nutritional needs were met. This inspection found that people were encouraged and supported to eat at dining tables. The food was delivered in hot trollies to the units where staff served the food. We saw that pureed food was attractively presented and recognisable as meat, vegetables and potato but prior to assisting people to eat staff mixed the food together and placed in a beaker. People were then unable to identify the food they were eating. The nurse told us that this was advice from the speech and language therapist (SaLT) but was unable to provide us with these specific directives. They confirmed that they would check with the SaLT and ensure that this was recorded in the peoples care plans.

We observed the midday meal service on three units. On all units people were encouraged to sit together at tables to eat their meal. The staff put the television on mute and there was soft music playing in the background. We saw that when staff assisted people there was good eye contact and conversation and people were invited to talk and so the meal was an enjoyable experience for people. There was a choice of lunch time meals offered. As part of the improvement plan, menus had been reviewed and demonstrated a varied and nutritious diet. The staff were aware of people's preferences and the chef had a good understanding people's needs and their likes and dislikes.

We saw that people were encouraged to drink fluids. In the communal areas there were jugs of fluids that staff used to offer regular drinks to people. This was in addition to servings of tea and coffee. Staff were focused on ensuring that specific people had drinks offered 'little and often' if they were struggling to drink enough fluids. One staff member said, "We offer drinks regularly and always make sure they can reach their drinks if it safe for them. Some residents need our assistance so we offer a drink regularly".

We looked at people's food and fluid records. The care plans directed staff to monitor people's food and fluid intake when it had been identified the person was at risk from dehydration and malnutrition. There were food diaries for those identified to be at risk from malnutrition and fluid charts for those whose intake needed to be monitored. Some charts were not as well completed and lacked amounts and there was no clear recording method, for example some staff record 'cup of tea' some staff recorded in millilitres (mls), for food some staff had written all eaten but no reflection of whether it was a small medium or large meal. This had been identified by the nurse and appropriate training was being provided and was on-going. We were provided evidence of the action taken to improve the completion of charts. This included reference to staff individual supervision sessions. All fluid charts viewed were totalled at end of day, any concerns regarding peoples intake was highlighted on handover sheets and recorded in daily records. We were able to confirm this from the records viewed. Food and fluid charts were used for new admissions until it was clear that there was no need to monitor. We found that whilst there had been improvements in meeting nutritional and hydration needs, further embedding of practices were needed.

All the staff we spoke with told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. The training matrix supported this. Staff received an induction programme and on-going training support. This gave them the skills to carry out their duties and responsibilities. Newly appointed staff shadowed other experienced members of staff until they and the service felt they were competent in their role. This was confirmed by a member of staff who said, "The induction process was really good, I learnt a lot." Another said, "I am gaining confidence, really good support." There was a wide range of specialist training available to staff in managing the complex needs of the people they cared for. Such as managing challenging behaviour, care of people with dementia and of specific mental health illnesses. We also saw training topics included diabetes, end of life and wound care.

Supervision was up to date for all staff and was undertaken three monthly. Supervision had helped identify gaps in their knowledge, which was supported by additional training. Staff said "We all get supervision and support." We were also told that for staff whose first language was not English that English lessons were provided.

Staff told us, daily handovers and supervision helped them feel supported and encouraged learning to take place. For example, handovers gave them an opportunity to discuss people's change in needs and anybody that was unwell and how they should be cared for.

People had an initial needs assessment when they moved in to Hailsham House. The care plans recorded and contained clear instructions as to the health care needs of the individual. They included information about the needs of each person relating to their mental health, medication, communication and nutritional needs. Reviews were done monthly or more often if there was a significant change to people's needs, for example an infection which affected the effect of their medicines. Where appropriate, specialist advice and support had been sought in relation to meeting people's needs and this advice was included in care plans. We saw advice from speech and language therapists, dieticians, and community mental health nurses. There was a clear process for managing any deterioration in mental health of people with emergency guidelines to follow, such as contact details of the community mental health team. Staff were able to tell us who they would contact in the event of a medical emergency and were aware of where to find contact numbers. Incident records were reviewed by the management on a monthly basis, or more regularly if a person's mental health deteriorated, or if there were arguments between people resulting in injury or psychological harm.

For one person who was suffering with weight loss due to their specific form of dementia, we saw recent input from Psychiatry and Nutrition and dietetics. We saw the person was receiving a fortified diet, with milk,

cream, full fat milk, and milkshakes. Staff said they valued input from external health specialists and enjoyed learning from them. One said, "It's always good to learn about the care we can give, very rewarding."

Staff told us they kept families involved and always tried to sit down with them when care changed. Two relatives told us, "I am kept involved and updated, really good team here," and "They ring and let me know if there's any changes."

Requires Improvement

Is the service caring?

Our findings

At the last inspection in November 2014, the provider was in breach of Regulations 17 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010 which now corresponds to Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not always listened to and involved people in their care delivery or lifestyle choices and this had had a negative effect on people's individual needs and wellbeing. People had not always been treated with respect and had their dignity protected.

An action plan was submitted by the provider detailing how they would meet the legal requirements by 30 September 2015. Improvements had been made and the provider was now meeting the requirements of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However these improvements were not, as yet, fully embedded in practice and need further time to be fully established in to everyday care delivery. This was because deployment of staff mentioned in the safe question had a negative impact on the interaction between staff and people who lived on Holly unit. There were times when people did not
receive the care and support they needed.

People were positive about the care they or their loved one received. Relatives told us, "I am impressed with the staff, kind and gentle" and "I think staffing can be stretched at times but that's because people can be challenging and so the quiet ones get less input."

Staff told us they promoted people's independence and respected their privacy and dignity. Staff knocked on bedroom doors and waited for a response before they entered. Staff also greeted people respectfully and used people's preferred names when supporting them. We saw instances where staff acted quickly to ensure people's dignity was upheld. For example when they need clothing changed.

We saw some very nice interaction between staff and people, however we also found that people who remained in their rooms either for health reasons or by choice were isolated with only care tasks being undertaken. We spoke with social assistants who told us, "We are working with the in-reach team to develop strategies to ensure that everyone gets one to one time." Staff acknowledged that the time went too quick sometimes and that despite their best intentions they didn't always get to spend time with people outside of routine tasks. The care teams were very open when we spoke with them and told us, "Every day presents a new challenge and we are really working to improve how we work." It was acknowledged that there was still areas to improve but staff were committed to those improvements.

We saw that people were comfortable with staff, they approached staff for reassurance. We saw one member of staff take time to sit with one person who was exhausted and the person leant against the staff member and was totally relaxed and at peace. We saw that behaviours that may cause distress to people were managed in a way that was professional and individual to that person. Staff spoke to people in a calm and soft manner that did not cause conflict. we saw intervene between two people who were distressed and resolved the situation with expertise and kindness.

People were treated with respect. People's preferences for personal care were recorded and followed. We looked at a sample of notes, which included documentation on when people received oral hygiene, bath and showers. Documentation showed that people received personal care in the way they wished. People confirmed that they had regular baths and showers offered and received care in a way that they wanted. One person said, "They know how I want my care given." Care plans detailed how staff were to manage continence. This included providing assistance taking people to the toilet on waking or prompting to use the bathroom throughout the day. Throughout our inspection on three of the four units, we observed that people were prompted and offered the opportunity to visit the bathroom. People who were not independently mobile were taken regularly to bathrooms. One visitor told us, "Can't fault them, very good staff." Attention had been given to people's personal appearance we saw that many people were dressed smartly and that people were supported with make-up if that was their preference.

Staff demonstrated they had a good understanding of the people they were supporting and they were able to meet their various needs. One staff member told us, "All our residents are different and we treat them as individuals, knowing their little ways helps." Staff were clear on their roles and responsibilities and the importance of promoting people to maintain their independence as long as possible. One staff member told us, "We always try and keep people to be independent. We'll always support people to go out if they want to and invite their friends in." One person showed us her room which was very personalised with equipment such as a kettle and drink making facilities. We saw staff walking alongside people throughout the day to offer support and reassurance. People were supported to maintain their mobility and therefore a degree of independence was also maintained.

Bedrooms were clean and homely, many contained family photographs and personal ornaments. Communal areas had changed since our last inspection and were seen to be comfortable and homely. The staff had looked into peoples' past interests and included themes in bedroom to encourage people's happy memories. To link in with the tenancy agreements now offered, some rooms contained sinks, fridges, kettles and a small dining table. Rooms were furnished according to people's individual tastes and many were seen to be very personalised.

Care plans showed that family and people's involvement had been sought where possible, and personal preferences had been recorded when people had moved in. These set out people's preferences within an activity plan based on the activities of their life before arriving in the home and their wishes when they reached the end of their life. We saw that people's food choices reflected their culture and religious choices. People's personal preferences for lifestyle choices, such as food and drink, activities and interests were being updated to reflect changes to their health and well-being.

The manager told us that an advocate would be found if required to assist people in making decisions. They also told us they had information to give to people and families about how they could find one if it became necessary. This ensured people would be helped to contact advocacy services.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. The manager told us, "There are no restrictions on visitors". A visitor said, "I come in most days and I'm always greeted with a smile."

Requires Improvement

Is the service responsive?

Our findings

The opportunity to take part in activities that help to maintain or improve health and mental wellbeing can be integral to the promotion of wellbeing for older people. At the last inspection, we found concerns with the lack of opportunities for social engagement and activities for people. It was recommended that the service sought expert advice from the in–reach dementia team. The in reach team are currently working with the service for 16 weeks. Visitors told us, "Social assistants are great, they are welcoming, approachable and the home seems busy and full of activity."

Care records contained information about people's health and social care needs. They were regularly reviewed in order to respond to people's changing needs. However we found that one person who had specific health needs such as recurrent urinary tract infections (UTI) with particular trends of behaviours did not have a care plan and risk assessment in place to manage this. For example, ensuring plenty of fluids and monitoring to prevent a UTI. There was no fluid monitoring chart in place. The nurse told us that this person had recently had a UTI. For another person there was evidence of historic risk of malnutrition in January 2015, but was seen by the Speech and language therapist in April 2015 and prescribed fortified food and drinks and for a review in three months (July 2015). There was no follow up documented and staff were unaware of any further directives from the speech and language therapist. This person's weight had decreased in November 2015 (43.7kgs) and staff had identified a risk of malnutrition but we saw that there was no food monitoring in place and no record of whether this person was receiving fortified food and drink. Staff therefore were not responsive to this person's nutritional needs and this was a risk to their health and well-being. We found three other clear examples of the care delivery not being responsive to peoples changing needs in respect of weight loss, skin integrity and social well-being. We identified that Holly unit in particular that was not as responsive to peoples changings needs. This was discussed with the registered manager. Immediate plans were put in to place to provide support and guidance to this unit. This was an area that requires improvement.

On other units we found that care records contained information about people's health and social care needs. The home used a computerised care plan system, which was written with the person's input whenever possible and reflected how they wished to receive their care and support. We saw that families had been asked to be involved and were asked to read the care plan every three months to ensure all was as they expected. Records were clear and gave guidance to staff on how best to support people. Individual physical needs were regularly assessed, so that care was planned to provide people with the support they needed to maintain their health. One nurse had expressed concerns about certain people's medication as it was found to affect their daily life. Reviews had been undertaken by a GP and we were told that this had considerably improved certain people's quality of life. Staff had responded to peoples changing needs in a way that had benefitted their health and well –being.

People were encouraged and supported to maintain links with their families to help ensure they were not socially isolated or restricted due to their disabilities. The home invited families and friends in to their home for social events that were held.

There were meaningful activities for people living with dementia. People's care plans had a section about social interaction.The amount of information held varied from person to person but overall highlighted the things people liked to do. We saw that people in communal areas enjoyed the planned activity or were involved in one to one sessions. There were musical sessions in the afternoon of one day we visited and the musicians visited each unit. Board games, arts and crafts were available on others. We spoke with the activities staff who confirmed that they had had training in providing meaningful activities for people living with dementia. They also told us that the NHS in reach dementia team were involved with the home spending four weeks on each unit. Social assistants told us, "It has really been helpful and we are really moving forward with ideas."

There were a number of people who showed behaviours that challenged; and appropriate stimulation and distraction had helped to reduce people's restlessness. The provider told us that he had approached a specialist service called 'Ladder to the moon' with a view to them developing staff knowledge and improving the quality of activities available to people; but this had yet to be implemented.

On Orchard unit there were a number of people who had one to one with staff and we saw staff engage positively with people. We saw staff reading newspapers with people and playing board games. There were also games and puzzles available for people to use if they wished. There were photo montages on display which showed people engaged in various hobbies and activities.

The provider had a policy and procedure in place for dealing with complaints. This was made easily available. The policy was placed in each individuals service user pack and clearly displayed around the home. People knew who to contact if they needed to raise a concern or make a complaint. People who had raised concerns confirmed the issues were dealt with to their satisfaction. One relative said, "I have made a complaint in person and it was dealt with immediately." Another relative told us; "I know how to complain, but I would talk it through with staff first to see if it could be resolved."

We looked at formal complaints made to the home. Each complaint had been responded to in a timely manner and thoroughly investigated in line with their own policy. Appropriate action had been taken and the outcome had been recorded and feedback. The registered manager told us, they used monthly audits to monitor concerns and complaints. Appropriate action was then taken to improve their service and raise standards of care. For example, one relative told us that the bedroom was left untidy following personal care and since it was addressed with staff there was now a "definite improvement."

Requires Improvement

Is the service well-led?

Our findings

People told us they liked living at Hailsham House. Visitors said they were satisfied that the home was well managed. One relative said, "I have faith in the staff, the manager is visible." Comments reflected on the approachability of the managers and senior staff working in the home and the belief that they listened to their feedback.

However we found that the service had a lack of overall leadership throughout the four units. Staff recorded weights of people but there was no feedback to the staff in respect of changes to these records when given to the registered manager. Staff were not all aware of how to access people's weights and kept referring to the fact that the registered manager had them. This meant staff were not fully informed of changes and placed people at risk from uninformed staff. Staff told us that their autonomy to act on people's changing needs was not always accepted by the management team and felt disempowered to make changes. One nurse said, "It was a challenge for the nurses' voice to be heard." Therefore the management style did not allow for the sharing of information to promote best practice.

During our inspection we identified that there were 12 pressure relieving mattresses and cushions that were set incorrectly. Staff did not have a system in place to monitor that these were correct and that people's skin integrity was protected. Staff told us it was written in the care plan but this was not the case. We could not find records in individual care plans that told staff what the mattress setting should be on to prevent pressure damage to people identified at risk. .

Accident and incident reports identified that whilst recorded accurately and inputted in the care plan there was no clear overview on the audits to identify patterns, trends and actions taken. We talked to one nurse about a persons' falls history and they were unaware of how often these had occurred or if preventative measures had been put into place. Learning from these incidents had not been taken forward. For example the possible need for further training to reduce the number of injuries and implementation of strategies to respond to people when their mobility deteriorated.

Whilst there were quality assurance systems in place they had not identified that people's nutritional and changing needs were being consistently met. We identified throughout the inspection that there were people who were isolated at times with out being able to call for assistance. These areas had not been identified through the provider's quality assurance systems.

We identified that one unit, Holly, lacked leadership and that care delivery was not person centred. For example we saw that people were left in their rooms for long period of times without appropriate support. The staff had not identified this as an issue or put systems in place to ensure that they were safe and comfortable. Charts that would ensure that people were checked regularly to ensure their needs were being met had not been put in place. The management had not identified that the Holly unit were not providing responsive person centred care delivery to meet peoples needs.

The lack of an effective system to identify and act on shortfalls are a breach of Regulation 17 of the Health

and Social Care Act 2008 (Regulated Activities) 2014.
Staff showed a lack of accountability when being asked questions about people's care or their needs. There were many occasions during the inspection when staff would refer us to others who, in turn, passed us on to different staff. This was particularly evident when we tried to establish how air pressures were set on people's mattresses, peoples weights and when asking for care records. This situation was made more difficult by the fact that care plans were maintained electronically and staff were not able to locate the information requested. There were often delays when we asked either staff for records; and when they were produced, they were often not those requested or were incomplete. This made it difficult to properly track people's care to gain a full picture of their needs and how they were being met.

The provider, the registered manager and the deputy manager took an active role within the running of the home and had good knowledge of the staff and the people they supported. There was as There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

The registered manager told us one of their core values was to have an open and transparent service for people and their families. The provider sought feedback from people and those who mattered to them. Friends and relatives meetings were regularly held and surveys conducted that encouraged people to be involved and raise ideas that could be implemented into practice. For example, visitors and people had meetings to discuss meals and activities within the home. People and relatives told us they felt their views were respected and had noted positive changes based on their suggestions.

Information following safeguarding investigations were used to aid learning and drive quality across the service. Daily handovers, supervision and meetings were used to reflect on standard practice and challenge current procedures. For example, management of behaviours that distress for one person had been reviewed and as a result staff had increased their knowledge and skills in managing these situations effectively by appropriate intervention..

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not effectively assessed and monitored the quality of service provision in respect of service user's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	The provider had failed to ensure appropriate deployment of staff to ensure peoples safety and well being.