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

Summary of findings

Overall summary

This inspection took place on 9 and 10 November 2016 and was unannounced. Hawkinge House is a purpose-built modern building and provides accommodation and nursing care for up to 80 people; a total of 92 people can live and receive support within the same building. The service also provides personal care and nursing care for people who rent or buy their accommodation within Hawkinge House. There were 87 people living at Hawkinge House during our inspection; of which 22 were receiving accommodation and nursing care. The service provides nursing care on the ground floor, the first and second floors supports adults living with dementia or mental health needs, some of whom also require nursing.

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

Hawkinge House was last inspected in January 2016 where a number of breaches of the regulations were identified and it was rated Requires Improvement. The provider sent us an action plan to tell us what actions they were taking to implement those improvements. At this inspection we found that changes had not been fully implemented to address all of the issues, leaving some people exposed to the risk of harm. Further areas of concern were also identified at this inspection.

There continued to be areas of medicines management that required improvement in order to make them safe. Most people received their medicines when they should. There were continued shortfalls in the recording of transdermal patch administration and recording and in medicines that are prescribed to be taken 'As required'.

Staffing levels were not sufficient to meet people's needs; assessed levels were not always available on duty. We found recruitment processes were robust.

Essential training had been completed by the majority of staff, and some staff had completed additional training in some topics. Staff told us they were able to request additional training if they wished to develop a particular area of knowledge. Staff were provided with the opportunity to undertake a qualification relevant to their role to further develop their knowledge.

Most people reported to enjoy the food however we found people's hydration and nutritional needs continued to be monitored inadequately, placing people at risk of not receiving sufficient amounts to eat and drink. People had access to healthcare services however, a lack of effective recording meant advice was sometimes not followed through by staff.

Complaints and incidents were not consistently recorded and monitored in line with policy.

People were kept safe from abuse as staff were aware of safeguarding procedures and we saw these were followed when abuse was alleged or suspected.

Staff treated people with kindness, compassion and respect. Staff took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives, although this was not always reflected in care plans, where there was little reference to people's preferences and wishes. Social assistants had developed good relationships with people and ensured that a range of activities were available for people if they wished to participate.

People had a choice of meals, snacks and drinks, and could choose where they would like to eat. Staff encouraged people to eat their meals and gave assistance to those that required it.

Staff understood the basic principles of the Mental Capacity Act and knew how to support people who were not able to make their own decisions. People's rights were protected.

Most staff reported that they were clear about their roles and felt well supported by the registered manager. Although this was not consistent across all staff. Audits and checks were in place but were not effective in identifying shortfalls or areas for improvement.
We found a number of new and continued 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 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?

Requires Improvement

The service was not consistently safe.

There was not sufficient, suitable staff deployed throughout the service to meet people's care and treatment needs.

Medicines were not consistently managed appropriately.

People were protected by robust systems for recruiting new staff.

Staff were clear about whistleblowing procedures, and understood how to protect people from abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were at risk of receiving inconsistent care as there was not always clear guidance for staff to follow.

People's fluid and nutritional needs were not monitored effectively.

The majority of staff had completed suitable training to enable them to do their job effectively.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Requires Improvement

The service was not always caring.

Care records did not consistently reflect peoples' preferences and wishes. End of Life care planning was not always person centred.

Staff were kind, caring and compassionate with people.

People's privacy and dignity was respected and their right to privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans lacked detailed information about people's preferences and wishes in relation to how they wanted to receive their care and support.

Concerns were not consistently responded to in line with policy. Although, people knew how to make concerns known and most felt they would be properly responded to.

Activities were planned into each day and people told us how staff helped them spend their time.

Is the service well-led?

Inadequate

The service was not well-led.

Although systems were in place to monitor the quality of the service, they continued to remain inadequate in identifying shortfalls.

Events had been appropriately reported to the Commission.

Most staff were clear about their roles and responsibilities and most staff felt supported.

Hawkinge 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 received. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 10 November 2016 and was unannounced. The inspection was carried out by four inspectors, specialist advisor, who had clinical nursing knowledge and experience, and an expert 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.

Before our inspection we reviewed the information we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to tell us about by law. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider was asked to send us some further information after the inspection, which they did.

We spoke with 17 people who lived at Hawkinge House. Not everyone was able to verbally share with us their experiences of life at the service as they were living with dementia. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We inspected the environment, including communal areas and some people's bedrooms. We spoke with nine care workers; three registered nurses, a team leader, eight relatives, the provider's consultant and the registered manager.

During the inspection visit, we reviewed a variety of documents. These included 19 care plans, staffing rotas, staff recruitment files, medicine administration records, activities records, minutes from staff meetings, audits, maintenance records, risk assessments, health and safety records, training and supervision records and quality assurance surveys.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe using the service. One person told us, "There is good food and it is safe, I try to do the most I can to stay well and staff help me." Another commented, "The staff are caring and attentive, but there are slight things I would improve. A few of the staff could take more time to listen and understand what I am saying." One relative said, "Dad is happy. He's well cared for." However, we identified a number of areas where people did not receive safe care.

Staffing levels were the same for each of the three floors, the registered manager told us that they 'keep an eye on levels and listen to team leaders'. Staffing levels were not assessed based on people's varying needs. The provider did not use bank or agency staffing to cover gaps on the rota, the registered manager told us that staff cover gaps and they are always covered. Staff told us that sometimes gaps could not be covered, one member of staff commented, "We do sometimes have to run short, you just have to step up and work harder, we have never been at the stage where we can't cope". Another member of staff told us, "Sometimes we can be two staff down, that can be difficult. We try to get help from other floors but it is not possible." The registered manager told us that, on each floor, there were six care staff on a morning shift and five on an afternoon/evening shift. Rotas did not always reflect this; for example, during October on the first floor there were 12 morning shifts with five care staff and 11 afternoon shifts with four care staff and one afternoon shift with three care staff. There was also three nights where there was one night carer, rather than two and one night where there was no nurse. Where there were gaps from sickness or annual leave, some shifts were covered and others were not. We were told that at times, the social assistants would cover and help out; however, this meant that they would be taken away from their social role.

People told us that sometimes they had to wait for long periods until they got the support they needed and that at times, they had to wait for their medicines. One person commented, "The staff are not as regular as I would like with my medication, this makes me not able to cope as well in managing activities and food." Another told us, "The staff are rushing around all of the time, but are really kind." Staff told us that when they are fully staffed it takes until around 10.30-11am to get everybody up and dressed but when short staffed it could take up to midday when lunch was served. Many people required the support of two carers for tasks such as moving and handling or personal care. On one floor, 16 out of 28 people required support from two care staff. When there was four care staff on duty, this meant that at times only two people could receive assistance at the same time, potentially leaving 26 people without support. Staff told us that at weekends there was increased pressure as there were no social assistants. We checked rotas for the four weeks leading to the inspection and saw that no social assistants were on rota to work.

Some people were not able to use their call bells, and would call out for assistance. The layout of Hawkinge House meant that people could be in their rooms, calling for assistance for a significant length of time before they were heard. People who could not use call bells had extra checks by staff and some had pendants. One person we spoke to in their room could not locate their call bell or pendant so would not have been able to call for help if needed. Checks were not consistently recorded. This meant it was difficult for us to be certain that people received regular checks.People told us they often found others walking into their rooms uninvited which they found upsetting. One person told us "Other people turn my room upside

down – so I make sure I am here. They are difficult, taking my things and my property." For people who were nursed in bed there were alarms that alerted staff when this happened. However these were not in place for other people. The registered manager told us that they get a report from the call bell system. This included how often a person presses their call bell, how often staff go into bedrooms and an average response time. The registered manager told us that they did not analyse response times.

The provider had failed to have in place a systematic approach to determine staffing levels that were sufficient to meet people's assessed need or regularly and adapt levels in response to changing needs. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

On each floor staff were deployed by the person in charge so that they were responsible for a number of rooms and tasks each per day. For example, we saw whiteboards within the nurse's office on each floor which showed who had been allocated which people and which tasks, such as taking the lead on meal service. Each floor had a housekeeper and social assistant who had their own areas of responsibility.

Staff recruitment practices were sufficient to ensure appropriate staff were employed. Staff records showed that before new members of staff were allowed to start work, checks were made on their previous employment. Files had copies of documents which verified people's identity and checks were made with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support.

Potential employees were interviewed by the registered manager to ensure they were suitable for the role. New staff were required to undergo a three month probationary period and there was a disciplinary procedure in place to respond to any poor practice. This meant that people were only supported by staff who had been checked to ensure they were safe and suitable to work with them. The registered manager checked the details of all the nurses who were on the Nursing and Midwifery Council (NMC) register to ensure they were safe to practice and held a valid registration.

At the last inspection medicines management was not always safe in particular the use of transdermal patches and the lack of guidance for staff in the use of 'As required' (PRN) medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that sufficient improvements had not been made to address these concerns.

Medicines were administered by the nurse on each floor, other than on the second floor where a team leader, who had received additional training, also administered people's medicines. We observed medicines being given in a gentle and unobtrusive way. Generally, medicines were stored securely and were dated when opened to ensure they would be disposed according to best practice guidance. Medicines that required refrigeration were stored correctly. Pain assessment charts were routinely completed to assess pain; this is good practice in dementia care as pain can be a common cause of distress. Records for the monitoring of health conditions such as diabetes were clear, as were records for people who were prescribed medicines that required close monitoring, for example, anti-coagulants. During the first day of the inspection a medicine room was not locked, one cabinet was locked within the room; however another was not, leaving free access to anyone who entered the room. The nurse on duty told us that they had only been out of the room for a few minutes however there was a risk that medicines could be accessed within that time.

PRN protocols were still not consistently in place. This meant that people continued to be at risk of not receiving these medicines consistently or safely. We saw that one person had some guidance on when their 'as required' medicine would be required. The way in which PRN medicines were administered was not

always consistent. Records showed that most nurses consistently gave PRN medicines prescribed as 'up to three times daily' at every dose. The provider told us following inspection that nurses assessed people at each round to see if they needed the PRN medicine and only gave it if it was required.'

Risk assessments had been completed to manage and reduce risks to individuals as part of their care plan. However, they did not consistently provide clear or accurate guidance for staff. Guidelines for staff about how to support a person who had epileptic seizures stated, 'call 999 if seizure lasts 2 minutes longer than normal (there was no guidance on what 'normal' would look like) or after 5 minutes if you don't know what normal is.' There was no description on the type of seizure this person had.

Fire evacuation plans were in place, people were assessed by their level of need and allocated a level of red, amber or green. This then correlated to the services fire emergency plan which gives instructions to staff as to what level of support each group of people would require in an emergency. Staff understood the support individual people needed to evacuate the building in the event of an emergency. However the fire emergency plan contained contradictory guidance to the fire drills policy regarding routine drills for staff; the policy stated 12 monthly and the emergency plan 3 monthly. We recommend that the provider reviews these documents to ensure that guidance is consistent.

The service had a continuity plan in place for emergencies; however this was not always followed by senior staff and incidents were not consistently recorded in the 'incident log' as specified in the emergency plan. For example, one person had been left without a backup oxygen supply during a power cut; this had not been recorded as an incident. This meant that people could be placed at increased risk, for example if they had specific needs in the case of a power cut. The lack of a record meant that the registered manager or provider would not able to identify lessons to be learned or potential training needs of staff.

Other accidents and incidents were documented; for example a falls analysis was used to identify preventative measures that could be used to reduce the risk of reoccurrence. Handover sheets were used by staff on each floor and recorded any particular risks to people; such as whether people had urine infections; which could make them more prone to falling or feeling confused, or people that required closer monitoring. This gave staff had an up-to-date picture of needs; which helped them be aware of important factors in people's care. Staff were able to tell us what action they should take to record incidents and escalate concerns.

We previously reported that settings of some pressure reliving equipment were not always set to the correct measurement. At this inspection we found that this had improved and records of checks and settings were kept with people medicines records. This helped to reduce the risk of people developing pressure areas.

Staff understood how to keep people safe from abuse and gave examples of how they did this. Most had completed training in how to recognise and respond to the signs of abuse. Staff gave examples of how they managed incidents between people who were agitated. They said they used distraction techniques and provided comfort. Staff knew how to report concerns about people's safety to their manager and told us that they were confident to do so. One staff said "I would report to my team leader first, and then go the manager if needed I would go to KCC." The service had a whistleblowing procedure available and staff were clear on how to use this when they saw poor practice. Safeguarding concerns had been referred appropriately, for example to the local authority to identify if further investigations were required. The monthly management report provided an overview of accidents, incidents and safeguarding referrals.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they were happy with Hawkinge House, comments included, "It is very good here, it has good facilities" and "The care is first class, the space is lovely. It offers me choice and is easy to move around." However, not all feedback was positive, some people and relatives felt that communication from management could be improved and that staff training and knowledge did not always meet people's needs.

The majority of staff had completed essential training they required to safely and effectively meet people's needs. Most training at the service was delivered by e-learning, some training was also provided in a classroom environment such as moving and handling, fire and first aid training. Training in additional subjects had also been completed by some staff, for example, challenging behaviour, end of life care and nutrition, hydration and health. Staff were required to complete competency checks following training. The provider had stored the answers to these checks on their website. We pointed this out during the inspection and recommend that these should be removed.

There were team meetings for each floor; each staff member was requested to sign the minutes if they attended or not. The registered manager told us that they sometimes attended these meetings. The meetings provided each team opportunity to discuss current issues on each floor and discuss changes to practice. For example, one record showed that fluid charts had been discussed, and the importance of them being completed accurately. However, these meetings were not wholly effective as fluid charts continued to be inaccurate.

New staff enrolled onto the Care Certificate that was introduced in April 2015. This certificate is designed for new staff to complete when they start work in care services and sets out the learning outcomes, competencies and standard of care that is expected of them. Nurses and senior staff were responsible for verifying this work. Many care staff had achieved level 2 or 3 health and social care qualifications and some staff were working on these qualifications.

People had access to healthcare and multidisciplinary professionals; this was documented within care records. One person had been referred to a Speech and Language Therapist (SaLT), they were seen in May 2016, however there was no guidance or recommendations on file for staff to follow. A regular GP and nurse practitioner visited the service, they were provided with a list of people who the service had identified as needing to be seen by a GP or nurse. prior to their weekly visits. They recorded their visits onto the providers' electronic records; however it was not always clear why a specific decision had been made. For example, one person was discharged from hospital with a specific medicine, which the GP stopped a few days later, the nurse was not able to tell us why and it was not clear from the notes. Posters advertising a visiting chiropodist were on noticeboards and people had access to opticians. Staff were able to tell us about people's ongoing health needs and understood what action they needed to take to meet these needs. People were weighed monthly, and where concerns had been identified, this was increased to weekly. Those identified as requiring closer monitoring were highlighted on the whiteboard in the nurses' office. Concerns were highlighted to the visiting GP and nurse practitioner, and where required referrals to

appropriate health professionals were made. Weights were also monitored through the monthly management report where it was highlighted if any weight losses or anomalies had not had appropriate actions recorded. For example the report from October 2016 stated, 'the recording in care plans was variable'. The registered manager had responded, 'All floors have been reminded to cross reference weight recordings with any action and/or non action.'

Staff understood the principles of the Mental Capacity Act (MCA) 2005. They described how they supported people to make their own decisions and understood what they needed to do when people could not make a decision themselves. However, capacity assessments were still not always decision specific. For example, one person's capacity assessment stated the decision was, 'To make informed decisions regarding activities of daily living.' In care plans, we saw reference to people's capacity and their ability to make decisions around daily tasks. Some people had lasting Power of Attorney arrangements in place; this was documented within their care plans. Where best interest meetings had been held, they were recorded within care plans. Signed consent forms were in people's files for care plans, treatment and photography. We observed staff knocking people's doors before entering. Staff understood that people had a right to refuse help with their personal care. They told us that if a person refused care they respected their decision, and would offer the care again under different circumstances. This may be at a later time or by a different member of care staff.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The registered manager and staff understood what was meant by a deprivation of a person's liberty. Where required, DoLS applications had been made for people to ensure that they were not deprived of their liberty unnecessarily. Some of these had been authorised by the DoLS office and others were awaiting assessment. We observed that some DoLS authorisations had expired and applications for a new authorisation had not been completed until sometime after. One person's authorisation had been expired for more than six months before a further application had been submitted.

The premises had been designed and decorated to meet the needs of people living with dementia. People's bedroom doors were painted different colours and had pictures of things they like to do on some or their name on others, people's bedrooms had been personalised with their belongings and decorated to their taste. Toilet doors were either painted red or had clear signage, to help people identify where the toilet was. Each of the three floors were uniquely decorated, for example, the second floor had organised their dining area to represent a café and had sensory areas at the end of each corridor, there were objects for people to pick up and touch and along corridors there was artwork displayed for people to look at. We observed people freely and easily moving around the floors, making use of the different spaces available to them. On each floor there were noticeboards with photographs of activities that had taken place at Hawkinge House.

Most people and visitors were complimentary about the food and told us that they had enough to eat. However, some people commented that the food could be a "little bland". One person told us, "I have meals which are blended; sometimes the meals are bland and could have slightly more flavour. I have enough to eat and drink." We observed meal times on both days of the inspection. On the first floor, meals were all served in bowls, although it was not reflected in people's care plans that this was their preferred choice. Meals were served by the staff team, with people having made their menu choices the previous day supported by the social assistants. At the last inspection we reported that this is not best practice for people living with dementia who may not remember the choices they have made. If people declined their meal they were offered an alternative, such as a sandwich. Throughout meal times we observed thoughtful interactions between people and staff. For some, meal times were a social occasion where people chose to eat in the dining room. Many others ate their meals in their suites. People told us that they could choose

where they wanted to eat. People were supported to eat a varied diet and they were provided with plenty to eat and drink throughout the day.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were complimentary of the staff team; they told us that staff were supportive and caring. One relative commented, "I am able to be with my wife. I know she is looked after. I am able to have meals here, which helps us spend time as a couple." One person told us, "The staff are very caring and are excellent, they do care here."

At our last inspection we reported that end of life care plans were limited and there was little evidence of advance care planning. During this inspection we found that this had not improved sufficiently. End of life care plans focussed on a person's needs after death, rather than about supporting people with a dignified and comfortable end of life. Most end of life care plans contained generic statements regarding resuscitation and whether or not a person should be admitted to hospital. There was little evidence of meaningful conversations with people or their relatives regarding their wishes or how they would prefer to be supported. Care plans stated that their objective was for the person to have dignity at the end of their life. However, most plans did not state how a person's dignity would be upheld or what their wishes or preferences were. The provider's policy stated, 'On admission to the home, every effort is made to gather as much information as possible as to the resident's wishes on all aspects of dying.'
People who had been assessed as requiring end of life care were reviewed more frequently by the visiting GP. We were told it was the policy of the service for people to be reviewed every two weeks by the GP. One member of staff told us, "I don't have the chance to input what people would like at the end of their life, it's a shame because we get to know them so well." Another member of staff commented, "we could really contribute to what is important to them and the little details that make a difference." Monthly management reports completed by a consultant employed by the provider had continually identified ongoing shortfalls in end of life care planning. Anticipatory medication was available for people who were on an end of life pathway and DNACPR (an anticipatory decision about whether or not resuscitation should be attempted for an individual) were completed and in most cases these involved the appropriate people.

The provider had failed to provide people with appropriate person-centred care plans to reflect their preferences. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other care plans staff had recorded some detail of people's future preferences and wishes, for example; a person's beliefs or what clothes they would wear after their death.

On each floor throughout the inspection we observed many kind, caring and thoughtful interactions between staff and people. Staff approached people in a kind and caring manner. We heard staff and people chatting together about what was for lunch and what plans people had. Staff supported people in a gentle manner, for example we saw one person link arms with several members of staff and walk around, looking out of the window and talking about what they could see. Staff were patient and spent time with people whilst they expressed themselves. We saw that staff communicated well with people, sharing jokes and light humour where appropriate. People appeared relaxed in the company of staff.

At our last inspection we reported that people's privacy and dignity was not always protected by staff. At this inspection, staff were mindful to ensure that people were treated with dignity and respect. We observed a person being supported to go to a hospital appointment. The senior carer ensured that the person had a coat and blanket to protect them.

We observed staff ensuring people understood what care and treatment was going to be delivered before commencing a task, such as moving a person in a hoist or assisting each other to turn someone in bed. During meal times, we observed that people who needed support to eat were supported with kindness; staff took time and did not rush the people they were supporting. One member of staff used their knowledge of a person's history and work life to generate conversation.

Relatives told us they were able to visit when they wanted. One relative said, "I can come at any time." There were many visitors throughout the inspection; all were made to feel welcome by staff. Where they wished, visitors could take part in activities or eat a meal with their loved ones.

We were shown complimentary comments from relatives and some people about the service provided. Staff spoke with passion about the people they supported. One member of staff commented, "Nothing is too much trouble, it's not a home, it's a hotel for the elderly. There's lots of laughter."

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that staff knew them well and that they knew what was important to them. One person commented, "The staff know me, they know where I lived previously and most of the time they are helpful." One relative told us, "The staff are available to talk to and we can always find out information."

At the last inspection we reported that care plans lacked detailed information about people's preferences and wishes in relation to how they wanted to receive their care and support. We found at this inspection that care plans continued to lack detail, which meant that people may not receive care and support that reflected their assessed needs and preferences. For example, one person used a machine for pain relief, the care plan directed staff to 'apply pads as per instructions', however there were no instructions given to guide them. Care plans often referred to 'adequate fluids' but did not identify what was adequate. One person's nutrition care plan stated, not keen on milk. A little further down it stated, offer a glass of milk prior to bed. There was no evidence in fluid charts of milk being offered.

One nurse told us, "The care plans are reviewed daily. All staff look at them and raise concerns or any changes. The people they are about have no involvement, it is a staff job." Care plans continued to contain contradictory information. One person's records referred to them receiving respite care and living at home in places, and in other places referred to their permanent placement at Hawkinge House. Another person's records, which had been recently reviewed, contained reference to their wife's' visits and completing a menu choice each week for them. It had not been updated to reflect that their wife had passed away. One person's records stated that they had a sensory impairment – 'X used to wear glasses however these have been misplaced, referral to be made to the opticians.' There was no evidence of a referral having been made. They had also been assessed as having reduced hearing; however, the care plan had been updated in April 2016, stating that their hearing aid had been misplaced. There was no reference to further action. Their plan also guided staff to use pictorial information to aid understanding, during the inspection we did not observe this to happen.

The provider had failed to ensure that care plans reflected people's assessed needs. This is a continued breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints policy and people said they knew how to make a complaint if they needed to. Some people and relatives told us they would feel comfortable to do so; however some relatives felt that there could be repercussions for their loved ones if they were to complain. One relative told us, "I'm worried about how my mother will be treated if I make a complaint whilst she is still residing at Hawkinge House." People told us they would speak to the nurse or the manager and most were confident issues would be resolved. Two complaints had been recorded since the last inspection. These had been responded to by the registered manager; one had been responded to, with the complainants concerns not being considered appropriately. We saw that not all complaints had been recorded as such. We were shown a complaint that had been sent to the registered provider; this was passed to the registered manager who in turn passed to a nurse to deal with 'informally', despite it having been marked as a formal complaint. The complainant had not been satisfied with their complaint had been responded to. The registered manager told us there were

quarterly family support groups where people could air their concerns. They felt this may be why there were so few complaints.

The provider failed to maintain a record of all complaints. This is a breach of Regulation 16 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take part in a range of group activities and could choose where they wanted to spend their time. Throughout the service there were noticeboards of activities and photographs of people taking in part in activities and events. During the inspection we saw planned group activities taking place such as the services choir practice, which was made up of people, family, friends and staff. Activities on each floor took place, for example, on one floor there was a church service which people from other floors also attended. There were also activities with musical instruments and quizzes. People were supported to paint poppies in preparation of Remembrance Sunday. Other activities such as visiting singers, bingo and keep fit were advertised. A team of social assistants worked hard to plan activities and ensure that all people were included. One social assistant told us that they aimed to spend time with each person each day. Hand massage; nail painting and one to one time for chats were offered to people. Some people had been supported to go swimming; the feedback we received was that this was very successful and popular. There was a hairdresser's salon at the service where people could go to have their hair cut or styled. One person commented, "The activities are normally during the day and though there are things to do, there could be more things to do during the evening to pass the time."

People had an assessment of their needs before they moved into the service. Relatives and professionals were involved by the service in the gathering of information about people and their life histories. Care plans contained information about people's personal hygiene, getting up and going to bed, continence/toileting management, mobility, activities, communication, medication, medical history, mental capacity and dietary needs. Most contained statements that were often similar and task focussed. However, some care plans contained good step by step guidance and specific detail about people's preferences. For example, one care plan referred to a person liking their room to be dimly lit and warm at night to aid sleep. Staff that we spoke with knew what was important to people and were able to describe their preferred routines.

People and their relatives had opportunities to provide feedback about the service provided. The registered manager told us that an independent company sent out customer satisfaction surveys annually to relatives and collated the responses. We were provided with an overview analysis of the results of the most recent survey in June 2016. We couldn't see people's individual responses from this, but could see that there had been a mixture of positive compliments and suggestions of where improvements could be made. The analysis did not tell us what changes had been made as a result of the survey responses. At the last inspection we were told that there had been little interest in residents meetings, this continued to be the case. The registered manager told us that there were quarterly family support groups; however, there were no minutes or records available of these meetings.

Inadequate

Is the service well-led?

Our findings

The service was not always well led. Breaches at the last inspection of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 had not been fully addressed and people continued to be at risk of receiving care and support that was not always safe and did not always meet their needs. At this inspection the registered manager told us, "I expect you to find we have tightened up on all that and addressed it all", when asked about improvements that had been made since we inspected in January 2016.

At the last inspection we reported that audits and checks had not always been effective in identifying the shortfalls highlighted during our inspection. This continued to be the case at this inspection.

In their action plan, the provider reported that additional checks had been added to the monthly medicines audit; however, these checks had not been effective in identifying ongoing shortfalls in medicines management. During this inspection we found that some transdermal patches were used on different areas of the skin, although the recording of where these were was not always easy to read from the abbreviated code on the Medication Administration Record (MAR) charts. Others medicines, for example, Buprenorphine patches, did not have them placed on different areas of the skin, on one MAR chart it was recorded; 'right shoulder, left shoulder, right shoulder'. This meant the same application site was returned to within three weeks which increased the risk of skin irritation. Other people's records did not show the site the patches should be placed, so we were unable to tell if they had been used in different places on the skin. This is not in line with best practice guidance.

At our last inspection we reported that food and fluid recording charts were not effective in monitoring people's intake. In their action plan, the provider told us that they had issued standard food and fluid charts throughout the service. During this inspection we found that the recording of information on food and fluid intake charts remained inconsistent and did not provide staff with an accurate oversight of people's intake. The registered manager had advised staff to use food and fluid charts 'where absolutely necessary.' One person was consistently recorded as having an intake of around 700-800ml per day when the nurse told us that it should be 1500ml per day. They told us it was not essential for this person to have their fluid intake monitored despite them having less than half the recommended amount of fluid over a period of time. This had not been highlighted by the nursing or care staff as an issue, and placed people who had been assessed as requiring monitoring at risk of not receiving the correct support or input from health professionals. Other people who required monitoring had charts in place but these were not consistently completed and had little meaningful information. For example, some staff - recorded sips or cups whilst others recorded in millilitres. Often staff did not total the amount of fluid intake at the end of each day.

At the last inspection we reported that people at risk of developing pressure sores were not always recorded as being turned at the stated interval, we found that this was still the case at this inspection. Care records had contradictory information in them. One person's care record stated they should be checked every two hours during the night and repositioned every four hours. Records stated they should be checked every four hours during the night. A whiteboard in the nurse's office stated that they should be turned every two to three hours. This provided conflicting and confusing information for staff to follow and increased the risk of

this person not being repositioned correctly. Recording charts showed that turns were inconsistent, with them being recorded between every two to five hours.

Monthly management audits and reports were completed by a consultant employed by the provider. We reviewed these, and saw that they had identified and reported shortfalls in care plans and other areas that we had identified. However, these had also failed to bring about sufficient improvements. For example in August 2016, the consultant had reported there needed to be 'further improvement' in End of Life care planning. In this report they had identified three people with shortfalls in end of life care planning. A response from the registered manager stated they agreed with this finding. They said that "There often appears to be a disconnect with what actually happens evidenced by daily reports in Residata and what's in the care plan." The consultant had consistently identified shortfalls in end of life care planning, directing the registered manager to follow the Common Core Principals for End of Life Care. We were told that these were used as tools for management meetings with the provider and that they were used to address any concerns. However, there was no comment, or evidence of any action taken from the registered provider.

Most staff were clear about their roles and told us that they felt supported. Although some staff reported that they had not received any supervision. One member of staff told us, "Never had supervision, not 100% clear on who I report to." We were told by the registered manager that clinical staff received a written supervision every two months by the same supervisor, where possible, and that other staff, such as housekeeping and kitchen staff received supervision as part of their 'day to day role.' It was not possible to determine whether all staff had received adequate supervision in the service from the documents provided. Not all staff were recorded on the document and figures were not accurate, the registered manager explained that entries made in error could not be deleted from their system which meant it was not possible to determine who had received a supervision accurately. For example, in February 2016 one member of staff was recorded as having received six supervisions; however three of these were inaccurate entries. In addition, following the inspection the registered manager sent records to us relating to staff training, these documents did not contain accurate data, we were later provided with up to date records.

Regular staff meetings were held on each floor; these were chaired by the lead nurse on each floor and were an opportunity to share information and to involve staff in improving the quality of care. The registered manager told us that at times they attended meetings on each floor. We saw minutes from meetings that they held on each floor in July 2016. We did not see any evidence of senior team meetings or whole team meetings held by the registered manager. They told us, that they were not good at monitoring their own meetings and may not have a record of dates. Although senior staff told us meetings took place.

The service had a number of policies and procedures available for staff, some of which had been recently reviewed. At the last inspection we recommended that the provider reviewed some policies to ensure that they were in line with best practice guidance. At this inspection, we saw that this had still not been done. The services' restraint and dealing with violence and aggression policies still did not refer to current best practice.

We identified four breaches of regulations that should have been identified by effective quality assurance systems being in place. There was a lack of oversight by the registered provider and registered manager which meant that the service had not made the necessary improvements.

The failure to ensure effective quality and safety assurance systems and lack of clear records is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The monthly management reports had consistently identified caring and compassionate interactions from

staff and effective team working on each of the floors.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes any allegation of abuse, any serious injury to a person and Deprivation of Liberty applications and their outcomes. The registered manager was aware of their responsibility and had notified us about deaths, allegations of abuse and serious injuries to people. At the last inspection we reported that the registered manager had not notified us of any Deprivation of Liberty applications and their outcomes, at this inspection, statutory notifications had been submitted as required.

We were told about an annual event that the service holds, 'Respect, Privacy and Dignity week', which aims to increase awareness in this area by increasing knowledge and understanding of what respect, privacy and dignity means to individuals. Links with the local community had been developed; there were regular visits from churches to meet people's spiritual needs. School children made occasional visits and the service had sponsored a local youth football team.

The registered manager told us they received support from the registered provider and their consultant/auditor. They told us that they communicated what was going well or not well by email. The registered manager reported directly to the registered provider. The registered manager told us that they were always on call, although was rarely contacted out of hours. They told us that staff usually emailed anything they needed to know. The registered manager did not receive any clinical supervision and told us that they met with other managers of the group twice a year and at the Graham Care awards. These are annual staff achievement award. Nominations were made by people and their relatives. Some staff from Hawkinge House had also been nominated for awards, they told us they were looking forward to this event.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide people with appropriate person-centred care plans to reflect their preferences. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that care plans reflected people's assessed needs. This is a continued breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to maintain a record of all complaints. This is a breach of Regulation 16 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to have in place a systematic approach to determine staffing levels that were sufficient to meet people's assessed need or regularly and adapt levels in response to changing needs. This is a breach of Regulation 18 of the Health &

Treatment of disease, disorder or injury	Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to ensure effective quality and safety assurance systems and lack of clear records is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice