The Park Gate Care Home LLP

Hamble Heights

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Hamble Heights is a residential care home which was providing personal and nursing care to 50 people aged 65 and over at the time of the inspection. The service can support up to 60 people. Hamble Heights provides care for people over four floors, each floor providing specialist care to people living with different needs, for example, one floor delivers specialist dementia care and another residential care.

People's experience of using this service and what we found
Systems were in place to protect people from abuse and staff told us they would report concerns to management. Relatives had mixed opinions about the safety of their family members at Hamble Heights, some believed them to be entirely safe and others were concerned about safety issues. The premises were safely maintained however staff were concerned with risk levels at times, particularly at night. Several relatives had not yet been into the premises due to the pandemic so were unable to feedback about it.

The provider's records for medicines administration, did not give assurance that medicines were administered as the prescriber intended. Medicine incidents reported were not appropriately investigated and actioned to prevent repeats of these incidents. Learning from audits and incidents were not embedded into practice. This was a breach of regulations.

Staff were safely recruited, and we only received positive feedback about Hamble Heights staff members. Both staff and relatives felt there were not always sufficient staff on duty as family members had long waits for assistance from staff.

We were assured that infection prevention and control practices were in line with current guidance.

There were care plans covering a range of areas however these were not regularly reviewed. Care plans lacked a person-centred focus.

There was a training plan and records showed that most staff were up to date with essential training. There had not been sufficient support in the form of supervision or one-to-one sessions with staff.

People's nutritional needs were assessed, and their requirements were shared with the catering team. Not all needs had been communicated accurately which could cause significant risk of harm to people.

The service was supported by a local GP surgery, mainly through video calls during the pandemic.

The premises were purpose built and accessible to people. We received several comments about a lack of stable wi-fi provision in the service which had a detrimental effect on video calls.
People were usually supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service

supported this practice. Some relatives had felt excluded from decision making even when they held a relevant power of attorney.

The provider did not have an embedded and effective audit process in place to ensure provision was monitored and improved. This was a breach of regulations.

The culture at Hamble Heights was not positive when we inspected. The management team were not visible on the floor of the service and we received many concerns from relatives about a lack of regular communication.

We were not assured that the provider understood the duty of candour and relatives were concerned they were not contacted when incidents involving their family member occurred.

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

Rating at last inspection
The last rating for this service was good (published 11 November 2020).

Why we inspected
We had received several concerns in relation to medicines, care of people living with specific conditions and there had been several changes to the management team. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to the how the provider monitored the service and records at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Hamble Heights

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.
As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors, two attended the location and one completed an inspection of medicines remotely.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we already held about the service including notifications, complaints and information received from health and social care professionals. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with ten members of staff including the interim manager, interim clinical lead, a director of care, care workers, housekeepers, maintenance staff and the chef.
We reviewed a range of records, including medicines administration records (MARs), care plans, daily notes and risk assessments. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the governance and management of the service, including training records, audits, policies and procedures were also reviewed.

After the inspection
We continued to seek clarification and records from the manager. We contacted the staff team and relatives of people living at Hamble Heights by email to obtain their views of the service. We received 42 responses to our feedback requests.

Requires Improvement

Is the service safe?

Our findings

Using medicines safely
• The systems in place did not ensure the safe and proper use of medicines.
• Medicine Administration Records (MAR) showed that record keeping, and stock management were inconsistent. On occasions, it was unclear if medicines had been administered, posing a risk that people either did not receive their medicines or received more than the intended dose. We saw incident reports completed reflecting possible missed medicines, gaps in MARs that could not be explained by reviewing running balances of medicines.
• Physical health monitoring was not including within care planning and / or was not always undertaken and recorded. This may put people at risk of receiving a medicine when it was not appropriate. For example, some medicines require a pulse rate to be taken before administration. If taken, these were not recorded.
• Information and planning for people needing support with long term conditions or high-risk medicines was not always consistent. For example, diabetes plans did not have actions to take should blood glucose levels be very high. There were also references to staff having an awareness of a rescue medicine protocol for low blood glucose levels which was neither prescribed nor had an associated protocol.

We recommend the provider takes the following steps:
The provider should ensure that there is appropriate care planning for people requiring physical health monitoring, those who are prescribed high risk medicines and / or those with long term conditions
The provider should have a process to audit and ensure people are given their medicines as prescribed and maintain accurate records

• The provider had a new strategy for medicines which included staff completing a specific range of training courses, observing a best practice medicines round and being assessed for their competency in medicines administration. This was being introduced at the time of our inspection.
• Stock management and record keeping were poor. The controlled medicines register had not always been updated to reflect the disposal of medicines. We saw pain relief patches that were no longer in use and in addition, there were some liquid medicines that had been open and in use for longer than recommended by the manufacturer.

Staffing and recruitment
• There were not always sufficient staff deployed to meet people's needs. We looked at staff rotas from the month before our inspection and, though the night shifts were mostly adequately covered, the day shifts were not always well staffed.
• There was significant use of agency staff at Hamble Heights, at night there were occasions where more agency staff than staff employed by Hamble Heights. However, the provider assured us that agency staff had been booked well in advance when possible to ensure that staff known to Hamble Heights and who were familiar with people were deployed.
• During our inspection a number of staff were working their notice periods after their roles had been made redundant by the provider. This was a decision based solely on economies in the housekeeping, administration and catering teams. No care or nursing staff were affected by the redundancies. We were

careful when evaluating feedback received from staff to account for the strength of feeling as a result of this.
• Concerns about staffing were raised by staff and most of the relatives we spoke with. They told us this was impacting upon safety and the quality of care being provided. One relative said, "No there are not [sufficient staff]. There has been lots of turnover [of staff] and agency staff. Lots of managers." Another relative said, "I am aware there have been several occasions that my relative has had to wait for a considerable amount of time for the commode after it has been requested".
• Another relative told us, "My relative is unable to weight bare so needs a stand aid to help them onto a commode, bed or into a chair. There have been multiple times we have had a call in the morning from our family member, in distress, because they had made a call in the night wanting to use the toilet and has been told to wait because staff are on their break, to help, or to use their [incontinence] pad in bed and staff will come to clean them after. They are nearly 90 years old, but do not have dementia and being told to wet or soil themselves is very distressing for them and embarrassing. It is completely unacceptable how this has happened more than once during nights." Other relatives shared similar experiences and raised concerns about the extent to which agency staff were required.
• Staff also raised concerns about staffing levels. One staff member said, "No! Lots of sickness. Rota allocations are not always appropriate, and there are too many agency [staff]". Inductions for agency staff need improving. There are also too many changes to rotas, without plenty of notice and informing staff." We reviewed the induction for agency staff and, if fully completed, were assured that due care was taken to ensure they had been properly inducted.
• Another staff member said, "The nurses work hard to keep records up to date but again, there never seem to be enough staff on day shifts… due to the pandemic, especially this latest period. More and more agency staff called in… There seems to be no one to answer phones on the floors when medicines are being done, a big problem now so with just one person [staff member] in reception it could get worse." A staff member was particularly concerned about staffing in the dementia specialist areas of the service. They told us, "I know (a manager) also contacted [senior management] recommending that this floor should never have agency allocated due to the complex needs of the residents and their high dependencies. It should always, wherever practicable, have in house staff that know the residents well. This does not always happen, we are often working with agency and now following a [reduction in numbers of people] are back down to having four care staff each shift." They went on to tell us that this was a particular problem as vulnerable, confused and complex people were left unattended as, when there were four staff members, communal areas were left without staff supervision as they would be supporting people with care.
• We noted one theme running through the feedback from relatives. Relatives believed that Hamble Heights own staff members were kind and caring.
• Staff were safely recruited and all Schedule three requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014 had been met.

Assessing risk, safety monitoring and management
• Peoples care records contained risk assessments covering a wide range of aspects of their care needs. However, we received mixed feedback about how some risks were being managed within the service. Some relatives gave positive feedback. One relative told us, "Yes I believe my relative is safe at Hamble Heights as I have always been notified straight away of any difficulties they have had, and the action that's been taken has always been reassuring." Another said, "I do not have any concerns about my relative's safety." A third relative told us, "When my relative first moved in and we, as a family had a concern, I felt that it was dealt with immediately however the follow up information was never received."
• Feedback received from other relatives and staff indicated that some risks were not always well managed. Staff told us they were not able, for example, to manage risk of falls effectively due to how staff were being deployed. Relatives raised concerns about skin integrity risks not being managed due to there not being enough staff to attend to assist their family member with toileting or personal care in a timely manner. A final comment read, "Currently most staff don't feel the service is as safe as it could be, especially at night."

Please see the staffing section of this report for more detail.
• The premises were safely managed. Maintenance staff provided us with records of health and safety checks completed by the provider and by outside contractors. Some checks had been delayed due to the pandemic; however, we were satisfied that the environment and equipment was well maintained.
• Personal emergency egress plans, (PEEP's) had been completed for all residents and regular fire evacuation drills or simulations took place.

Preventing and controlling infection
• Records did not provide assurances that cleaning was always taking place as planned. For example, cleaning schedules had not always been completed.
• Following the inspection, there was a reduction in housekeeping hours. The manager told us this would not mean there would be a reduction in the standard of hygiene. They said the provider was investing in new equipment and technology and had devised improved cleaning schedules that they believed would improve hygiene.
• However, staff have since raised concerns with us about the cleanliness of the home. For example, one staff member told us, "Infection prevention and control is a big issue. Recently the housekeeping hours have been cut by the higher management and staff have been made redundant. This means that on some days there is no cleaning on the floor. Residents rooms and bathrooms are uncleaned. There have been additional hand sanitising stations sited near the lift areas but not at the ends of the floors where they are needed. The floor is dirty at times, the kitchen falling apart and resident's rooms needing more than a quick brush over." We reviewed supplied housekeeping rotas. These showed that usually there were three or four housekeepers deployed however there were occasions when just two staff were deployed which would reduce the capacity of the team.
• There were control measures in use to minimise the introduction of COVID-19 into the location. All visiting professionals had their temperature checked, used hand sanitiser gel, wore appropriate PPE according to the risk level within the service, and were provided with polythene booties to reduce the possibility of transmission from shoes. Track and trace was also in use as contact details for all visitors was taken.
• Relatives told us, "I have noticed every member of staff that I have come across wearing protective clothing." "Since the lockdown, we have been impressed by the care that has gone into safety; temperature checks for visitors and all staff and visitors wear masks, aprons and gloves as well as using hand sanitiser and having wipes available."
• The provider had added COVID-19 secure visiting 'pods' to facilitate visits inside to people. As in many care homes, visits were initially conducted outside however a room with external access was allocated as a pod and a screen set up to safely facilitate visits.
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were partially assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
• Accidents and incidents were reviewed to look for patterns and themes to minimise future incidents. However, we were not assured that safety related concerns were always addressed quickly enough. There had been several errors in giving time sensitive medicines for specific medical conditions during the months

prior to the inspection. Improvements had been made by setting alarms for staff, so they did not miss the time to administer, however this had not been until after several late or omitted doses. Late administration of medicines for some conditions can cause people to experience unnecessary increased pain and discomfort.
• Staff were not confident in the way that learning about incidents was shared. They told us, "Themes of incidences do not seem to be shared on a wide basis with staff. A lot of what is picked up is almost done through hearsay."
• There was also concern from relatives that they learned about incidents involving their family members such as falls either from their family member or during conversations with staff, about other matters. The provider did not routinely inform relatives of accidents involving their family members.

Systems and processes to safeguard people from the risk of abuse
• Staff understood their duty to report any concerns they had about people. They understood how to identify different types of abuse and who they should report it to.
• A staff member told us, "I am fully aware of my accountability and responsibilities with the Nursing and Midwifery Council (NMC), and know how to report any concerns and incidents that may occur… I have no problem approaching or reporting staff if I feel that something is not right."
• Another staff member told us, "I believe we protect our residents to the best of our ability, from any types of abuse. If we suspected abuse it would be reported to the manager, and then the necessary authorities, with full documentation and reports having been written, making sure at all times the resident is top priority and protected."
• Incidents of a safeguarding nature had been escalated to the local authority safeguarding team and required investigations carried out by the provider.

Requires Improvement

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care plans covered a wide range of needs. These had not all been reviewed in a timely way and were not always person-centred. Care plans were generic and did not focus on the individual persons preferences.
• There was insufficient evidence of people and their relatives being consistently involved in the development of care plans and this is an area that could improve. One relative told us, "We have never seen her care plan,"
• Another family told us, "We could contribute at the start, but sadly as our relative's condition has deteriorated, we have seen very little in the terms of reviews and care plans."
• One relative had a positive experience of the assessment and care planning at Hamble Heights telling us, "Yes. I have attended a meeting recently with a specialist nurse from the Clinical Commissioning Group, (CCG), together with one of the nurses from the home, and I was reassured that the home has a care plan in place to manage my relative's complex needs. I have provided [equipment] and I am pleased that the home staff are now sorting this out, and the care plan includes strategies to avoid pressure sores."

Staff support: induction, training, skills and experience
• Records showed that most staff had completed an induction on commencing in post, and training and updates took place at intervals. We saw training matrices that showed from 80 percent to over 90 percent of staff were up to date in mandatory training courses such as food and hygiene, infection prevention and control and safeguarding.
• One relative felt that their family members were not always appropriately supported due to a lack of understanding of specific conditions.
• Records showed that staff had not been receiving regular supervision. This is important because staff need to feel supported and have regular conversations with their line managers to maintain working relationships, discuss concerns and address training needs.
• Some staff members told us they did not feel supported as they had not had one-to-one supervision with their line managers for some time. One staff member told us, "I used to have regular supervision, but my last one was in September. I have felt supported in past times, but don't feel supported by the current management or senior management at all".

Supporting people to eat and drink enough to maintain a balanced diet
• People were assessed to ensure they received meals and fluids prepared in the most appropriate way to meet their needs. In most cases, these needs were shared with care staff, chef's and kitchen staff to ensure that everyone involved was aware of their needs.

• We did note that one person's nutritional needs had not been shared correctly with catering staff and they had not been receiving meals prepared to the texture they were assessed to need. In this instance, the impact on the person was not as serious as it potentially could be. They had been given food that was pureed more than necessary. If they had been given food less pureed than needed, they would have been at risk of choking.
• One relative told us, "Regarding food; my relative says that it neither looks or tastes appetising and is often not cooked properly." Another told us, "We often get calls to tell us that they have just had a sandwich that day because of not liking the food choices…. They are never offered something more substantial that they would like [instead]."
• A staff member told us, "Our chefs used to speak to residents and ask them their likes and dislikes, to build the menu, but now we have two new catering managers, who are managing menus for the homes. Chefs have a limited amount of stock, so although residents might be able to request alternatives, they might not always get it. Currently they are having to use up stock, so on the menu it just says soups and dessert of the day, so it's potluck! Not very person centred, or value for money. Residents don't have much to look forward to, so the dining experience should be top notch."
• Other relatives were positive about the food provided. One said, "I have not actually seen it [the food], although the activities officer regularly posts photos on the relatives Facebook page and it looks extremely good. They also have regular themed days involving food. My relative appears to enjoy the food and would find a way of letting me know if it wasn't up to standard".

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• There was evidence that staff liaised with healthcare professionals to meet people's needs.
• We saw examples, where staff had worked hard to overcome barriers to joint working during the pandemic to ensure people's health care needs were met. This was commented on a number of relatives. For example, one relative said, "Yes, several times the GP has come out to the home." Another said, "I believe that my relatives medical needs have been met during these difficult times and they were even able to have an independent person come in to sort [a specific problem]." A third relative told us, "Definitely [am informed]. If there is an issue, I am consulted about it".
• Some relatives were concerned that people's health had not always been well managed. One relative was concerned that physiotherapy, as recommended by specialists, was not being provided to their relative. Another relative was concerned that they were not always informed about their relative's health. They told us, "The sharing of information about my relative's health has not been consistent and it is often my relative that makes me aware of issues rather than staff. I do have authorisation for all information to be shared with me." A third relative told us, "Definitely [am informed]. If there is an issue, I am consulted about it".

Adapting service, design, decoration to meet people's needs
• The service was purpose built and accessible to people. We did not access all areas of the service as during our inspection, some areas were isolated due to a small number of people testing positive for COVID-19.
• Several relatives were concerned about the wi-fi provision in the service. While this would not usually have been a concern to them, the COVID-19 pandemic meant that most 'visits' were conducted using a tablet. The lack of wi-fi access meant it was not always possible to participate in calls. This had been the case since the start of the pandemic, approximately 10 months ago. Staff shared these concerns. A staff member told us, "Technology, systems, wi-fi, is very lacking in our home. No centralised systems, and we are very dated. We cannot rely on the wi-fi. We are supposed to be getting electronic systems in place, for rotas and care planning, but this has been talked about for at least two years but not put in place."
• Following the inspection, the provider informed us they had allocated significant funds to improving the connectivity of the service and had engaged engineers to investigate the cause of the poor wi-fi and upgrade the system.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• Staff had been trained in the MCA and DoLS and supported people to make day-to-day choices and decisions.
• However, relatives had several different experiences of how their family member's capacity had been addressed and the extent to which they had been involved or consulted despite, in some cases, being the person's legal representative for decision making about their health and welfare.
• One relative had been consulted when a 'do not attempt cardiopulmonary resuscitation', (DNACPR) was being considered for their family member. They told us, "We had a chat when our relative was really ill with COVID-19 as to what our plans were." Another relative had a similarly positive experience, they said, "[Relative] has no capacity to make their own decisions, however we are always consulted regarding their health issues with regard to the home and GP's recommendations."
• Some experiences were less positive and had caused relatives some distress. One relative told us, "It doesn't feel like I have been included." Another relative said, "No contribution sought. No condition updates… lasting power of attorney in place but no communication." They felt they had not even been regularly updated on their family members well-being.
• Another relative found that a DoLS authorisation for their family member had expired four months before being noted by a social care professional. An updated application has now been submitted.

Requires Improvement

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• Previous medicines audits identified issues that we also found at the time of inspection. This suggested that actions from audits were not effective at implementing learning and appropriate changes to practice to prevent reoccurrence of an issue.
• Learning was taken from incidents and accidents however it was not clear how this was cascaded through the relevant staff teams.
• Care plans were not always person-centred and were not subject to regular review and audits.
• Notifications were submitted by the provider however we have needed to clarify what should be notified in terms of injuries and safeguarding incidents. For example, several medicines errors that could have left a person in pain and discomfort had not been notified.

This demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Since we last inspected Hamble Heights there had been a change in the management team, and when we inspected there was an interim manager and an interim clinical lead. Due to the changes the culture in the service was not positive, staff were experiencing low morale and we spoke with several staff members who were considering leaving the service. Work was needed to improve the culture and wellbeing of staff. One staff member told us, "Very aware of what the visions were, but I think some have lost sight and faith in these visions and values of the service of late. Most of us work towards a common goal and are a good staff team."
• Since the staffing review at Hamble Heights and after our inspection, the provider lunched an 'Unsung Hero' award for staff to improve staff morale. Staff were nominated by people living at Hamble Heights for recognition of the efforts they made over and above their duties. The well-being manager received 12 nominations due to their commitment to enhancing the life experiences of peoples living in the service.
• Staff members told us they did not feel listened to by management teams and were reluctant to raise concerns as they believed this would not be well received. One staff member said, "No, no one feels safe or protected to say anything. Anytime someone has, it has backfired on them". Another comment stated, "No [management are] not always very approachable. And definitely don't treat staff with much respect or support. It's different depending on the staff member and situation".
• Another comment from staff was, "I think mostly the manager is aware, but I've not seen them working on

the floor when we are short staffed. The manager does go to the floors to check everyone is ok, but it's not done as regularly as it could be." Another staff member told us, "When I first started at Hamble Heights our then manager and clinical lead used to regularly work on the floor. They would check in all the time to see if all was ok, would check out before they left to see if there was anything needed. The current management team doesn't. In fact, it's very rare for the current management team to appear on the floor. They will come up when asked but do not necessarily volunteer that visit. That being said, they do seem approachable, will listen to concerns, but to date I do not see concerns being addressed."
• Relatives did not always find the provider to be open and inclusive. One relative told us, "At one point I was getting weekly updates about my relatives wellbeing and health, however these have not happened for some time. We also used to get weekly newsletters, but I have not had one for at least a couple of months." Another comment read, "No. Several managers back we used to receive weekly emails about what is happening. This stopped once they left so we have no idea what is happening in the home. There have been no family meetings since COVID-19, which could have been on 'Zoom' once a month to ease relatives worry while we aren't allowed to visit."
• One relative was happy with the management team telling us, "Definitely. The home phone me, usually each week, to confirm all is well with my relative and that they are happy and comfortable." Relatives would benefit from a more consistent approach by the provider to information sharing.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• We were not assured that the provider understood their responsibility under the duty of candour. When certain safety related incidents occurred, relevant family members had not always been notified, or given an account of what had happened. A relative said, "My relative recently fell during the night, despite being bedbound. I was notified when I rang on an unrelated issue the following afternoon."
• Another relative had needed to raise concerns about a matter and told us, "No. A recent complaint over an incident concerning [relatives] care has never been responded to or resolved in a satisfactory manner." Since the inspection, this complaint has been resolved. The provider advised us there had been confusion about who should respond to the complainant following the complaint being raised in December 2020.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider was not engaging well with relatives and during the exceptional period of lockdown this had caused distress and a feeling on behalf of relatives of being excluded. Understandably, during the lockdown, traditional meetings had not been possible however several relatives commented to us that they would have welcomed an opportunity to participate in online meetings, so they felt more involved and part of their relative's life.
• A staff member told us, "Towards the end of the summer things seemed to "fall apart" initially, with a change of management… Since that time, only one staff meeting has taken place virtually. We are still awaiting minutes and not all staff attended." The manager provided us with evidence to demonstrate that they were taking action to schedule regular staff, clinical, residents and relative's meetings throughout 2021.
• Many relatives raised concerns with us about not being able to get through the home by telephone. One relative told us, "Despite trying to comply with convenient times to call I am often left feeling frustrated that the phone doesn't get answered, it's not charged and goes straight to answer phone, or I get told that I will be called back and never receive a call. I am aware that the staff work incredibly hard so providing a telephone service is an additional role for them to take on however it is the only way that I can have communication with my relative during these difficult times."
• The provider acknowledged they were aware of the problems with relatives contacting people by telephone. They had implemented a change to the phone system to direct calls to the correct floor minimising pressure on reception staff and were intending to add an answerphone to each floor.

• Several relatives were concerned about the wi-fi provision in the service. While this would not usually have been a concern to them, the COVID-19 pandemic meant that most 'visits' were conducted using a tablet. The lack of wi-fi access meant it was not always possible to participate in calls. This had been the case since the start of the pandemic, approximately 10 months ago. Staff shared these concerns. A staff member told us, "Technology, systems, wi-fi, is very lacking in our home. No centralised systems, and we are very dated. We cannot rely on the wi-fi. We are supposed to be getting electronic systems in place, for rotas and care planning, but this has been talked about for at least two years but not put in place."
•Following the inspection, the provider informed us they had allocated significant funds to improving the connectivity of the service and had engaged engineers to investigate the cause of the poor wi-fi and upgrade the system.
• Another relative felt detached from the service telling us, "I think a major concern is that we have no idea what is going on in the home. The communication between management and relatives is non-existent. We are not provided with any updates, notice of staff changes, COVID-19 updates etc."
• One relative described a meeting where they and their relative did not appear to be a priority even though the meeting should have been focussed on them. A nurse had been tasked to attend from Hamble Heights however had not worked with the person or even on the floor they lived on. The nurse also left the meeting to administer medicines midway through the meeting.
• One positive area that many relatives complimented was the work being done by the activities officer on social media. This was the main source of information for many relatives who took great comfort from seeing photographs of relatives enjoying activities. One relative tempered this by telling us that their relative, a gentleman, wasn't often interested in activities such as nail care and art and crafts so wasn't in photos much, and another relative, though comforted by the photos told us, "It's not the same as somebody telling you that your family member is ok, or that they have had a bad day, either with a cold or just felt that they needed a hug."

Working in partnership with others
• The provider worked with health and social care professionals. During the pandemic there had been additional links forged with organisations such as CCG's and Public Health England.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor and improve the quality of provision or share learning with the staff team.