Hawkinge House Limited

Hawkinge House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected the service on 10 September 2018 and 11 September 2018. The inspection was unannounced.

Hawkinge House is registered as a community healthcare service, domiciliary care agency, an extra-care housing service, a supported living service and a care home. A community healthcare service provides nursing and other clinical resources to people who live in their own homes. A domiciliary care agency provides personal care to people living in their own homes. A supported living service provides care and support to people living in supported living settings so that they can live as independently as possible. Under this arrangement people's care and housing are provided under separate contractual agreements. An extra care housing service provides care and support to people living in 'extra care' housing. Extra care housing is purpose built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. In both supported living services and extra care housing services people's care and housing is provided under separate contractual agreements. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. In this case the Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Hawkinge House is registered to provide accommodation, nursing and personal care for 115 people. It can accommodate younger adults, older people and people who live with dementia. It can also provide care for people who need support to maintain their mental health and/or who have physical adaptive needs.

Most of the people who were living in the service at the time of our inspection had rented their accommodation in Hawkinge House. All of these people in practice received their nursing and personal care from members of staff employed by Hawkinge House Limited who was the registered provider. A small number of people received both their accommodation and care as part of a single package that was also delivered by the registered provider.

There were 89 people living in the service at the time of our inspection. The accommodation was provided on four floors called Nightingale, Eden, Phoenix and Jasmine. Each person who lived in the service had their own bedroom with a full ensuite bathroom.

There was a registered manager in post. 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 2008 and associated regulations about how the service is run. In this report when we speak about both the company and the registered manager we refer to them as being, 'the registered persons'.

At the last comprehensive inspection on 20 July 2017 the overall rating of the service was, 'Requires Improvement'. We found that there were two breaches of regulations. The first breach was because the registered persons had not reliably ensured that people who lived in the service consistently received safe

care and treatment. The second breach was because the registered persons did not have robust systems and processes in place to assess, monitor and improve the quality and safety of the service. This shortfall had resulted in problems in the provision of safe care and treatment not being quickly identified and resolved.

We told the registered persons to send us an action plan stating what improvements they intended to make and by when to address our concerns and to improve the key questions of 'Safe' and 'Well led' back to at least, 'Good'. After the inspection the registered persons told us that they had made the necessary improvements.

At the present inspection we found that sufficient steps had still not been taken to address either of these breaches. This was because people had not consistently received safe care and treatment. In particular, lessons had not been learned when things had gone wrong. As a result, people had not been fully protected from the risk of injury resulting from accidents and untoward events. Furthermore, the registered persons had still not established robust arrangements to supervise the operation of the service so that people consistently received the high-quality care they needed and had the right to expect.

There were six additional breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because robust arrangements had not been made to reliably safeguard people from situations in which they may be at risk of experiencing abuse. In addition to this, the registered persons had not deployed enough nurses and care staff. Recruitment checks had not been completed in the right way to ensure that only suitable people were employed to work in the service. People had not always received care that was respectful, promoted their dignity and was person-centred. Complaints had not been managed in a robust way that provided people with reassurance. In addition to these shortfalls, there was one breach of the Care Quality Commission Registration Regulations 2009. This was because the registered persons had failed to submit statutory notifications in line with our guidance.

As a result of these continuing and new breaches of regulations the overall rating for this service is 'Inadequate' and the service is therefore in, 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the registered persons' registration of the service, will be inspected again within six months. The expectation is that registered persons found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of 'Inadequate' for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the registered persons from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. When necessary another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of 'Inadequate' for any key question or overall, we will take action to prevent the registered persons from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about the Care Quality Commission's regulatory response will be added to our report after any representations and appeals have been concluded.

We found an addition shortfall in the service in relation to which we have made a recommendation. This was because nurses had not been fully supported to care in the right way for two people who were at risk of

becoming dehydrated.

Our other findings were as follows: There were shortfalls in the maintenance and decoration of the accommodation including the provision that had been made to prevent and control the risk of infection. Medicines were managed safely. Suitable arrangements were in place to obtain consent so that people only received lawful care. People had received coordinated care when they moved between different services and they had been helped to obtain any healthcare they needed. People had been supported to make decisions about things that were important to them. Arrangements had been made to promote equality and diversity. Provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Nurses and care staff recognised the importance of speaking out if they had concerns about the wellbeing of a person who lived in the service. The registered persons were working in partnership with other agencies to promote the delivery of joined-up care. The quality rating that we gave the service at out last inspection had been displayed in the service and on the registered provider's website.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People had not consistently received safe care and treatment. This was because lessons had not been learned when things had gone wrong so that people were protected from the risk of injury resulting from accidents and untoward events.

People had not been safeguarded from the risk of abuse.

Sufficient nurses and care staff had not been always been deployed to enable people to receive the care they needed.

Pre-employment checks had not been completed in the right way before a new nurse and two care staff were appointed.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Suitable arrangements had not been made to ensure that two people had enough to drink.

Nurses and care staff had not been fully supported to deliver care in line with national guidance.

There were shortfalls in the maintenance of the accommodation.

There were suitable arrangements to obtain consent to care and treatment in line with legislation.

People were supported to receive coordinated care when they used different services.

People had been enabled to receive on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive care that was respectful and which promoted their dignity.

People were supported to make decisions about things that were important to them.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not been fully supported to make and review decisions about their care.

Some people had not been offered sufficient opportunities to pursue their hobbies and interests and to take part in a range of social activities.

The system used to manage complaints was not robust.

Suitable arrangements had been made to promote equality and diversity.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Inadequate

The service was not well led.

There were multiple and serious shortfalls in the systems and processes used to assess, monitor and improve the quality and safety of the service.

Three statutory notifications had not been submitted to us in line with our guidance.

Although there was a registered manager they had not fully supported nurses and care staff to understand their responsibilities to meet regulatory requirements.

Members of staff knew how to whistle-blow if they had concerns.

The registered persons were working in partnership with other agencies to promote the delivery of joined-up care.

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. This inspection was planned to check whether the registered persons continued to meet 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.

We used information the registered persons sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

We visited the service on 10 September 2018 and 11 September 2018 and the inspection was unannounced. During this inspection we were told about an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk to people's health, safety and well-being. This inspection examined those risks.

The inspection team consisted of two inspectors, an inspector assistant, a specialist professional advisor and two experts by experience. The specialist professional advisor was a nurse. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

During the inspection visit we spoke with 23 people who lived in the service and nine relatives. We also spoke with two nurses, seven care staff, a social assistant and the family and social activities coordinator. In addition to this, we met with the chief executive officer of the registered provider, two deputy managers and the registered manager. We observed care that was provided in communal areas and looked at the care records for 10 people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of three people who lived with dementia and who could not speak with us.

After the inspection we spoke by telephone with two further relatives.

Inadequate

Is the service safe?

Our findings

At our inspection on 20 July 2017 we found that the registered persons had not established suitable arrangements to assess, manage and reduce risks to people's health and safety so that they consistently received safe care and treatment. This was because sufficient steps had not been taken to reduce the risk of a person falling and sustaining an injury. In addition to this, suitable healthcare assistance had not been provided to two other people after they had sustained injuries following an accident. After the inspection the registered persons wrote to us and said that they had made a number of improvements to ensure that people received safe care and treatment. At this inspection we found these improvements had not been sufficiently implemented or sustained: people had not been protected from harm and they did not receive safe care which met their needs.

We were told that robust measures were in place to reduce the likelihood of people having falls and sustaining a preventable injury. This included the introduction of a new falls risk assessment tool. This was completed when a person first went to live in the service. It was designed to enable nurses and care staff to identify what assistance (including special equipment) needed to be provided to reduce the risk of falls occurring. We were also told that nurses and care staff had been given detailed guidance about how best to support people who were at high risk of falling. However, we found that in practice nurses and care staff had not been given enough guidance to safely assist a person whom the registered manager said had experienced the most falls during 2018.This was because the person's care plan did not provide nurses and care staff with a clear account of the action to take. As a result, nurses and care staff had adopted individual approaches that were inconsistent and some of which were ineffective. We noted that the person had complex needs for care because they lived with dementia and often expressed themselves in ways that placed themselves and other people around them at risk of harm.

We were concerned to witness an occasion on which the person had been calling out for a period of 20 minutes to indicate that they were distressed. We asked a nurse and member of care staff to visit the person who was in their bedroom. The person was upset and uncomfortable and had slid down their chair. They were balanced at the edge of the seat from where they were at risk of falling on to the floor. The nurse and the member of care staff discounted the need to follow the usual arrangement that was to have an additional member of care staff present. This was because there were no other members of staff who were immediately available to assist them. As a result they adopted another approach to reassure the person. This was the case even though the member of care staff advised the nurse that the proposed approach had not been helpful when adopted in the past. Unfortunately, this remained the case as we saw that the person did not receive the reassurance they needed and became increasingly distressed. We were concerned to see the nurse and member of care staff deciding to leave the person in their original position without their distress having been resolved and the risk of them falling reduced. Although we were shown correspondence from two healthcare professionals and one of the person's relatives stating that they were satisfied with the care provided, we concluded that on this occasion the person had not received the care they needed to enable them to live with their dementia in a dignified way.

We were also told that there were robust arrangements in place to ensure that accidents and near misses

were carefully analysed to find out what had gone wrong and what could be done better in the future. These arrangements included the completion of daily and monthly audits completed by the registered manager and the deputy managers. However, we found that in practice these arrangements were poorly managed, inadequately recorded and largely ineffective. This was because the events were not described in sufficient detail and records often just repeated what had been said before. In addition to this, very little consideration had been given to how things could be done better in the future. One person had experienced three falls in September, October and December 2017. The incident records for each of these falls were incomplete and in many places, had not been completed at all. No analysis had taken place to determine the cause of the falls, or what could be put in place to mitigate the risk of further falls. Despite this, all of these forms had been signed off for closure by the registered manager.

Failure to assess and take all practicable steps to reduce risks to people's health and safety had resulted in people not consistently receiving safe care and treatment. This was a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they felt safe when in the company of staff. One person said, "I feel safe because there is always someone around you push a button and they are here." Another person remarked, "Staff always have a chat with me and they're just lovely people." Relatives were also complimentary about care staff. One relative said, "I can't praise the staff enough for all of their kindness." Despite these positive comments we found that the service was not safe.

We found that suitable steps had not always been taken to safeguard people from situations in which they had experienced abuse and had been at risk of further abuse. Records showed that on 22 June 2018 and 23 July 2018 two people who lived in the service had been assaulted by another person who also lived in the service. We asked the registered manager what action had been taken to notify the local safeguarding authority about these injuries. This should have been done so that the authority could decide how best to protect the people concerned from being at risk of experiencing further abuse. We were concerned to learn that the registered manager had not been made aware that the incidents had occurred. Consequently, they had not been able to make any enquiries to establish what may have caused them. In addition to this, the registered manager had not recognised that incidents of this kind should have immediately been referred to the local safeguarding authority. We informed the registered manager about the need to notify the authority and were assured that this would be done as soon as possible.

Failure to ensure that people were safeguarded from abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they had carefully calculated the minimum number of nurses and care staff who needed to be on duty to enable people to safely and promptly receive all the care they needed. They said that this had been done using a nationally recognised tool. We examined records of how many nurses and care staff had been deployed in the service during the two weeks preceding our inspection. We found that it exceeded the minimum level indicated as being necessary by the tool. However, although on both days of our inspection the service was fully staffed we concluded that there were not enough nurses and care staff on duty. This was because we saw important examples of people not promptly being given all the care they needed and wanted to receive. One of these examples was the occasion we have described above involving a person who needed special assistance to sit safely that was not given in the right way because there were insufficient care staff available. Another example is described in our domain 'Caring' in that the registered persons' had failed to provide sufficient care staff to support three people one of whom became distressed as a result of the oversight.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that there were robust arrangements in place to ensure that only suitable people were employed to work in the service. However, we found that there were significant shortfalls in the pre-employment checks that the registered persons had completed when appointing a new nurse and two care staff. In each case a suitably detailed statement of the applicants' employment history had not been obtained. These oversights had reduced the registered persons' ability to determine what assurances they needed to seek about the applicants' previous good conduct. In addition to this, even when three of the previous employers for two of the applicants had not supplied all the information for which they had been asked records did not show that any action had been taken to address the omissions.

We raised our concerns about these oversights with the registered manager. After our inspection the registered manager sent us additional information that they said demonstrated that all the necessary pre-employment checks had indeed been completed. We examined the information and found that it did not give us the assurances we needed that there were suitable arrangements in place to ensure that only fit and proper people were employed to work in the service. This was because the new information did not clearly show us that the recruitment process had indeed resulted in pre-employment checks being completed in the right way.

Failure to operate robust systems to ensure that only fit and proper people were employed to work in the service was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered persons had taken other steps to keep people safe. The service was fitted with a modern fire safety system that was designed to detect and contain fires so that people could be moved to a safe area or evacuated from the building. In addition to this there was a range of equipment such as specialist hoists for use when supporting people who lived with reduced mobility.

Suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines. There was a sufficient supply of medicines that were stored securely. Everyone had asked the service to manage their medicines on their behalf. Medicines were only administered by nurses who had been provided with written guidance about factors such as a person's allergies and any special instructions about using medicines received from doctors. Nurses had received training and had been assessed by the registered manager to be competent to safely administer medicines. We saw nurses administering medicines in the right way and records showed that people had been given the right medicines at the right times.

Requires Improvement

Is the service effective?

Our findings

We found that there were significant shortfalls in the arrangements that had been made to support two people who were at risk of not drinking enough. This had occurred because nurses had not been given the guidance they needed and did not have the necessary competencies to correctly assess the care needed by two people who were at risk of becoming dehydrated. As a result of this situation they had wrongly concluded that special provision did not need to be made to ensure that they drank enough. This had led to care staff not carefully checking and recording how much these people had been drinking each day. In turn, this had reduced the service's ability to establish if any further action needed to be taken to ensure that each person was having enough hydration to maintain their health. This was the case even though the registered manager described the weather at the time of our inspection as being a, 'heatwave'.

However, we noted that in practice care staff were encouraging everyone to drink enough. In addition to this, we found that nurses and care staff knew how to recognise the signs of someone becoming dehydrated and the action to take. We raised our concerns about the provision in place for the two people in question with the registered manager. They said that they had not been aware of the shortfall. They assured us that steps would immediately be taken to ensure that nurses and care staff monitored and recorded how much each of them was drinking each day.

We recommend that when doing this the registered persons consult national guidance about how to assess and manage occasions when people may be at risk of not drinking enough to maintain their health.

Nevertheless, people were positive in their comments about the catering arrangements. A person said, "The meals here are excellent and I always have more than enough to eat and drink." Relatives were also complimentary. A relative said, "My family member is a fussy eater so sometimes the menu doesn't suit them but the staff always offer an alternative. The staff do try to encourage them to eat but they know when to stop. The staff individualise the drinks, they know my family member likes their tea weak and they make every effort to please."

People could choose to have their meals in one of the dining rooms or they could dine in the privacy of their bedroom. The dining rooms were attractive and welcoming spaces with the tables being neatly laid out to promote a dignified dining experience. The menu showed that there was a choice of dishes served at each meal time. The meals that we saw served at lunchtime were attractively presented and the portions were a reasonable size. People dined at their own pace and individual assistance was provided for those people who had difficulty holding cutlery or who needed other help.

Records showed that there was provision for people to be offered the opportunity to have their body weight measured. This is sometimes necessary so that any significant changes can be referred to a healthcare professional who may need to prescribe a food supplement to help a person to increase and/or maintain their weight.

Although people told us they were confident that the nurses and care staff had the knowledge and skills

they needed, we were concerned to find that nurses and care staff had not been fully supported to consistently provide care in line with national guidance. Records showed that nurses and care staff had received introductory training before they provided care. For care staff this training included completing the care certificate. This is a nationally recognised system for helping to ensure that care staff know how to provide care in the right way. In addition to this, nurses and care staff had received refresher training in key subjects. This included how to safely assist people who live with reduced mobility and how to prevent and control infection. Furthermore, nurses and care staff had regularly met with a senior colleague to review their work and to plan for their professional development.

However, this training and guidance had not provided nurses and care staff with all the competencies needed to meet the needs of the people living in the service at the time of our inspection. This was because they had not been suitably equipped to effectively manage and respond to risks resulting from accidents and untoward events. There were also shortfalls in the knowledge and skills nurses and care staff used when supporting people who lived with dementia. Furthermore, sufficient steps had not been taken to ensure that suitable provision was in place to follow national guidance when assisting people who were at risk of not taking enough hydration. This was because suitable provision had not been made to carefully monitor how much each person had drunk. This was necessary to help nurses and care staff to quickly identify if additional steps needed to be taken to help to maintain each person's hydration.

We raised our concerns about these shortfalls with the registered manager. They assured us that the oversights in question would quickly be put right by the provision of more training and guidance. However, after our inspection the registered manager sent us additional information. They said it showed that nurses and care staff had been given all the resources they needed to provide the right care for the person who lived with dementia to whom we have referred above. We examined this information and concluded that it did not address the concerns we had raised and did not provide us with the assurance we needed.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The accommodation was not fully designed, adapted and decorated to meet people's needs and expectations. This was the case even though there was enough space and most areas were well decorated. In addition to this, the accommodation had some innovative features including mood lighting, the option to have music playing in en-suite bathrooms, nail bar, coffee shop, games room and an area set up to be a public house. However, in some places the painted plaster finish in hallways and bedrooms was marked, scuffed and looked unsightly. A person commented on this to us saying, "I've been in my room for a number of years and it hasn't had a lick of paint." There were also shortfalls in the maintenance of the grounds in that some of the lawns were overgrown. We asked the registered manager about this matter. They told us that the lawns were usually well maintained and would be so again in the near future as soon as the service's lawn mower could be repaired. In the grounds in the front by the side of the front door there was a skip full of old furniture. Although the skip was only directly visible from three bedrooms it was easily seen by people who lived in the service and their visitors as they came and went from the site. In this area there were also some old mattresses that were awaiting disposal. Furthermore, in a service area to one side of the front door there was a disused refrigerator that was being stored until it could be safely decommissioned.

We also found shortfalls in the arrangements that had been made to promote good standards of hygiene. Although suitable food handling arrangements were being maintained in the kitchen, the carpet immediately outside the kitchen and across the foyer was heavily stained and so was dirty. We identified this shortfall to the registered manager who assured us that arrangements had been made to replace the carpet as soon as possible. They also showed us other carpets near to the foyer that had already been replaced.

On the second day of the inspection we also found the floor in the passenger lift to be stained and dirty to the extent of people's feet sticking to it: a drink had been spilt in the lift and had not been cleared up. This made the flooring sticky and potentially hazardous to people. We highlighted these shortfalls in the management of the accommodation to the registered manager. They assured us that plans were in place to replace the carpet in the foyer. They also said that each of the other defects would also be addressed without delay.

National guidelines had been followed to promote positive outcomes for people by seeking consent to care and treatment in line with legislation. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There were suitable arrangements to obtain consent to care and treatment in line with legislation and guidance. The registered manager, nurses and care staff were supporting people to make decisions for themselves whenever possible. Also, when people lacked mental capacity the registered manager had ensured that decisions were made in people's best interests. An example of this was the registered manager liaising with relatives and healthcare professionals when a decision needed to be made about people having rails fitted to the side of their bed. These are sometimes necessary so that a person can rest safely in bed without accidentally slipping and falling onto the floor.

The registered persons had made the necessary applications for DoLS authorisations. Furthermore, they had checked to make sure that any conditions placed on the authorisations were being met. These measures helped to ensure that people who lived in the service only received lawful care that was the least restrictive possible.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. This included nurses and care staff preparing written information likely to be useful to hospital staff when providing medical treatment. Another example of this was the registered manager offering to arrange for people to be accompanied to hospital appointments so that important information could be passed on to healthcare professionals.

People were supported to receive on-going healthcare support. This included nurses referring people to see their doctor if they were not well. During our inspection we noted that a nurse telephoned a person's doctor. This was because they were concerned that the person was not responding well to the treatment prescribed for them. Records also showed that arrangements had been made for people to have consultations with professionals such as dentists, physiotherapists and opticians.

Requires Improvement

Is the service caring?

Our findings

Although people told us that they received courteous assistance we found that the registered persons had not given nurses and care staff all the resources they needed to consistently provide people with a caring service. We were very concerned about the wellbeing of three people who lived with dementia. We spent 30 minutes in their company in one of the lounges and noted that each of them spent nearly all the time on their own. Two of them were passive and showed no sign of being engaged in what was going on around them. Although we saw nurses and care staff coming and going in the lounge they were usually on their way to provide care elsewhere in the service. They either did not have time or did not recognise the need to provide the people in question with the individual assistance they needed to experience this period of time in a meaningful way. After the inspection visit the registered persons told us that the people concerned were resting after having undertaken social activities earlier that day. However, the registered persons did not send us any evidence to show us what these activities had been.

The third person spent most of the time expressing increasing distress. This escalated to the point where we became concerned about the person's wellbeing and so we asked a member of care staff to sit with the person. After the member of staff did this the person became more settled, stopped using repetitive speech and was more engaged with their setting. However, shortly afterwards the member of staff was called away by a colleague to assist elsewhere in the service. As soon as the member of staff in question left the person's presence they again became increasingly distressed. On this occasion no other nurses or care staff were present and so one of our inspectors spoke with the person until a member of care staff became available.

Failure to ensure sufficient provision to promote people's dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, there were other occasions when nurses and care staff did have the time and insight they needed to treat people with kindness and consideration. An example of this occurred when we saw a member of care staff responding to a person who had become anxious because they could not remember the date of a relative's birthday. The member of care staff chatted with the person and reassured them that they would ask another of their relatives for the information so that there would be plenty of time for them to send a card. This kindness reassured the person who then smiled and became relaxed. A relative commenting on the approach used by nurses and care staff said "The staff go above and beyond with their care. If my family member looks sad the staff sit with them to cheer them up."

People's privacy was respected and promoted. Nurses and care staff recognised the importance of not intruding into people's private space. Bathroom, toilet and bedroom doors could be secured when the rooms were in use. We saw nurses and care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms. They also covered up people as much as possible when providing personal care. Speaking about their experience of receiving care a person remarked, "I like my hair to be brushed at least twice a day and before I go to bed, and they are ever so gentle doing it for me." Another person said, "I can't move at all and they care for me as if I'm the queen."

Nurses and care staff were considerate and we saw that a special effort had been made to welcome people when they first moved into the service. This had been done so that the experience was positive and not too daunting. The arrangements included inviting people to personalise their bedrooms by displaying their own photographs and ornaments. Furthermore, records showed that nurses and care staff asked newly-arrived people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night and whether they wanted to have their bedroom door closed or left ajar.

People had been supported by relatives and friends to make decisions about things that were important to them. They could speak with relatives, friends and health and social care professionals in private if this was their wish. Nurses and care staff had also made arrangements for people to have access to lay advocates if necessary. Lay advocates are independent of the service and can support people to weigh up information, make decisions and communicate their wishes.

Suitable arrangements had been made to ensure that private information was kept confidential. Most of the records relating to the provision of care were electronic and so they could only be accessed by authorised members of staff. Written records that contained private information were stored securely when not in use.

Requires Improvement

Is the service responsive?

Our findings

In their Provider Information Return the registered persons said that people who lived in the service were enabled and actively encouraged to make and review decisions about the care they wanted to receive. The registered manager told us that this involved people being consulted about their care and were invited to review their care plan at least once a month. They said that this helped to ensure that each person received responsive care that reflected their changing needs, wishes and preferences.

However, we found that suitable steps had not been taken to ensure that people were fully supported to receive person-centred care. This was because suitable provision had not been made to engage people who had mental capacity in reviewing the care provided for them. We looked at the records that had been completed to review seven key elements of care provided for two people who had mental capacity. The records described a total of 26 reviews and of this total only three had involved the person to whose care they referred. Furthermore, one of the people had not been involved in any of the three reviews that had resulted in changes being made to the care they received.

In addition to this sufficient provision had not been made to fully meet the Accessible Information Standard that was introduced on 1 August 2016. This measure requires all providers of NHS care and publicly-funded adult social care to make suitable arrangements to support people have information or communication needs relating to physical and/or sensory adaptive needs. It also includes people who live with dementia and who need to have information presented to them in an accessible manner using techniques such as large print and graphics.

Some provision had been made to provide information to people who lived with dementia in an accessible way. This included picture based signage to help people find their way around their home. It also included the use of colour to help people to identify different areas of the service. However, people's care plans were stored electronically and so were only available for care staff to see. Also, they were written in a formal management style and often presented information using technical terms and abbreviations with which most people would not be familiar. We asked the four people about their experience of contributing to decisions about the care they received. Each of them told us that they did not know that a care plan had been prepared on their behalf and was supposed to reflect the assistance they had agreed to receive."

Some people had not been offered sufficient opportunities to pursue their hobbies and interests and to engage in social activities. There was a team of family and social activities coordinators. They offered people the opportunity to enjoy a range of activities including gentle exercises, arts and crafts, singing and creative writing. These events were well organised and innovative. However, we were also told that people received individual support, particularly if they declined or were not able to participate in the group activities. The registered manager said that this was "particularly important" given the service's commitment to promoting the wellbeing of people who lived with dementia. However, we did not see anyone receiving the individual attention they needed to pursue their hobbies and interests that the registered manager said was a daily occurrence in the service.

Failure to provide person-centred care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In their Provider Information Return the registered persons told us that they adopted a positive approach to the receipt of complaints regarding them to be opportunities to further improve the service. They also said there were robust arrangements in place to ensure that complaints were properly identified, recorded, investigated and resolved. The records shown to us during the inspection visit only showed that the registered manager had only received two complaints since our last inspection. However, our records showed that we had received six complaints from relatives and/or representatives about the care provided in the service. Although the complaints referred to different elements of care a common theme was the complainants not being satisfied with the way in which their concerns had been managed. In particular, they considered that their concerns had not been promptly investigated and addressed so that improvements could be introduced and sustained. Two of the complainants emphasised that they were very disappointed by what they considered to have been the dismissive manner with which the registered manager dealt with their concerns. As a result of their experiences none of the complainants in question indicated or directly told us they were reassured that the registered persons welcomed critical feedback as an opportunity to improve the service.

We examined documents and records relating to the management of complaints. We were very concerned to note that some of the issues raised by complainants had been negatively described as being, 'grumbles'. After the inspection visit the registered persons told us that they had substituted this term with the phrase 'verbal and informal complaints. In addition to this, we found that some of the administrative systems used to track the steps taken to investigate and resolve complaints were inconsistently applied, poorly managed and inadequately recorded. As a result, we were not confident that the registered persons had resolved some complaints in an effective and responsive way.

Failure to have suitable systems and processes to receive and act on complaints was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nurses and care staff understood the importance of promoting equality and diversity. People were offered the opportunity to meet their spiritual needs by attending a regular religious ceremony that was held in the service. Nurses and care staff also recognised the importance of appropriately supporting people if they followed gay, lesbian, bisexual, transgender or intersex life-courses. This included being aware of how to help people to access social media sites that reflected and promoted their choices.

The registered persons had made appropriate provision to support people at the end of their life to have a comfortable, dignified and pain-free death. This included consulting with people, their relatives and the community leader to establish how best to support a person when they approached the end of their life. A part of this involved clarifying each person's wishes about the medical care they wanted to receive and the religious observances in which they wished to participate. Speaking about this a relative said, "We have had a very discreet but frank discussion involving my family member regarding end of life care and the staff couldn't have been more caring."

Inadequate

Is the service well-led?

Our findings

At our inspection on 20 July 2017 we found that the registered persons had not established suitable arrangements to assess, monitor and improve the quality and safety of the service. This was because the quality checks that had been completed by the registered persons had not been robust. As a result, shortfalls in the running of the service not being identified and quickly resolved. These included the registered persons' failure to take effective steps to provide people with safe care and treatment. After the inspection the registered persons told us that new and improved quality checks had been introduced to address all our concerns.

However, we found that there were multiple and serious shortfalls in the arrangements that had been made to manage the service. In particular, the registered provider and the registered manager did not have sufficient oversight of the service to ensure that people received safe care that met their needs. We were very concerned to note that at the start of the first day of our inspection the registered manager did not know how many people were receiving care in the service. The registered manager then asked the service's two deputy managers who we were told had a detailed knowledge of the day to day operation of the service. However, neither of them was able to quickly provide us with the basic information for which we had asked.

The registered manager also told us that new 'robust and comprehensive' checks were completed on a weekly basis by the deputy managers of each person's care plan and related records. They said that these checks were key to ensuring that people consistently received the right care at the right time. Nevertheless, we found that in reality these checks were neither robust nor were they comprehensive. Records showed that in practice the checks were mainly confined to the deputy managers auditing the action that had been taken to respond to changes in people's body weight. We found that more detailed reviews of people's care plans and records were only undertaken on an exceptional basis when a significant new issue arose. This arrangement increased the risk that mistakes would not be quickly identified and put right.

In addition to shortfalls in the auditing of the planning and delivery of care, we found that a number of other quality checks were incomplete, poorly administered and ineffective. This had resulted in the other concerns we have described earlier in our inspection report. These issues included oversights in relation to the deployment of nurses and care staff, completion of recruitment checks, competency of nurses and care staff, provision of responsive and person-centred care and the management of complaints.

People had not been fully involved in making suggestions about how the service could be improved. The registered manager said that people who lived in the service were actively and meaningfully consulted about its development. This included inviting people to attend 'residents' and relatives' meetings' that were held at least once every three months. However, we noted that the most recent meetings were dated 13 March 2018 and 16 August 2018. We also noted that only a small minority of 10 people who lived in the service had attended one or both of the meetings. In addition to this, we were concerned to note that no other action having been taken to obtain feedback from the majority of people who had chosen to not attend the meetings. Although relatives had been invited to complete a questionnaire every six months to give their views about how well the service was doing, this was not a substitute for actively consulting with

people who lived in the service.

Failure to assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activity was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is necessary so that we can check that appropriate action has been taken. However, we noted that the registered persons had not always submitted notifications to us in appropriate and timely manner in line with our guidelines. This was because they had failed to tell us about the two occasions we have described in our domain 'Safe' on which people had been subject of abuse. In addition to this, they had failed to promptly tell us about the fatal incident we have also described in our domain, 'Safe'.

Failure to submit statutory notifications was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a registered manager and they had taken a number of steps to promote good team working so that nurses and care staff understood their responsibilities to meet regulatory requirements. There were 'handover meetings' held at the beginning and end of each shift so that nurses and care staff could pass on to their colleagues important information about each person's current needs for care. There were also regular staff meetings at which nurses and care staff were invited to discuss their work and to suggest improvements to how the service was run. In addition to this, members of staff knew what action to take if they had concerns and needed to whistle-blow.

The registered persons were working in partnership with other agencies to develop the local resources needed for people to receive joined up care. This included the chief executive officer liaising with local NHS providers about them using a new wing that had just been added to the service to deliver health care services to people in the area.

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