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Hankham Lodge Residential Care Home

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

About the service
Hankham Lodge Residential Care Home is registered to provide accommodation and personal care for up to 20 people who may have a disability or may be living with dementia. There were 19 people living at the service at the time of our inspection.

People's experience of using this service and what we found

There were not always enough staff deployed at the service which left people at risk particularly at night. This also meant that staff were not always able to spend meaningful time with people. Risks associated with people's care were not always being managed in a safe way including the management of medicines and aspects of infection control. Incidents and accidents were not always followed up on or analysed to avoid the risk of reoccurrence.

Staff had not always received training and supervision to ensure best practice within the service. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. There was a lack of meaningful activities for people and people fed back they would like to go out on trips. We saw from surveys from people and relatives that the provider had been aware of this.

Quality assurance was not always effective. Where shortfalls in care had been identified with staff this had not been addressed robustly.

Pre-assessments of care were detailed with information about people's care and staff understood people's needs. People and relatives knew how to complain and were comfortable doing so. People had access to health care professionals to support them with their care. People and relatives told us that staff were caring and respectful and we saw examples of this throughout the day. Relatives and visitors were welcomed as often as they wanted. People enjoyed the meals on offer at the service.

Previous Inspection
The last rating for this service was Good (Report published 6 May 2017.)

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvement. Please see the Safe, Effective, Caring, Responsive 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.

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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Hankham Lodge Residential Care Home

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.

Inspection team
Our inspection was completed by two inspectors.

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

The service had a registered manager, but they were not in day today charge of the home. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The provider had submitted an application to register as the manager with the CQC. The provider was present for part of the inspection.

Notice of inspection
This inspection was unannounced. We inspected the service on the 8 November 2019.

What we did before inspection
We reviewed information we had received about the service since the last inspection. The provider completed a Provider Information Return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections.

During the inspection-
We spoke with seven people who used the service and two relatives. We spoke with the provider and three members of staff. We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● There were mixed comments from people and relatives about staff levels. One person told us, "I press the bell. I never had to wait (for staff)." A relative told us, "We've never had to find staff when we come in." However other comments from people included, "There's not nearly enough staff. Mostly at night", "Staff get awfully busy, if the buzzer goes you could wait a while" and "Not enough staff at night. We only have one at night. Let's put it this way, its unsafe when you are lying in bed and there's only one staff here."

● There were not enough staff on shift to support people putting them at risk of harm. The provider told us staffing levels were determined by finances rather than what people needed. In the morning there were three staff on duty however this reduced to two staff at 12.00pm. During the afternoon we saw that the two remaining staff were required to provide care and support to people in their bedrooms. These people required two staff due to their mobility needs. This left around nine people alone in the lounge area for most of the afternoon. Many of these were at risk of falls if they tried to get up without staff being present. We saw occasions where people called for staff to try and get their attention when staff were busy elsewhere.

● The chef went home after lunch which meant that the two carers on duty also had to prepare supper for people. For the most part people were left alone in the lounge as staff were busy elsewhere. Staff only came to the lounge to support a person to get up or if they were being given a drink.

● At night the staff level reduced to one staff at 22.00 to support 19 people. This placed people at risk for example, in the event of a fire there were people that required two staff to assist them to evacuate. Although there were staff on call they told us that this was not ideal as there could be a delay to them arriving at the service which ordinarily they said would take 10-15 minutes. The provider told us, "I maintain that our staffing levels are reasonable, they're not the best, but they are reasonable." We asked the provider for a copy of the dependency tool they used to assess people's level of need so that we could ascertain how they determined the staff levels. They told us, "I don't have a dependency tool, I just use what other people use. If you're saying that not's safe, I am saying to you it's set at that level because of financial constraints."

● We noted from the accidents and incidents records that there had been a number of falls that were unwitnessed either in the lounge or in early hours of the morning. The provider had not considered or reviewed the staff levels in relation to this.

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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection

● Some chairs that people used were dirty and some areas of the home smelled of stale urine. For example, we found an armchair cushion had recently been cleaned by a member of staff. The cushion was wet and

smelled strongly of urine. We noted from relative feedback that they had raised the smell of urine in the reception area. The provider told us, "We have had good comments and bad comments about that. We are battling against that all the time. Sometimes I go down there in the morning and I smell it and I mention it to the cleaners. Whether they clean it efficiently or not I can't comment on."

● The laundry room where staff handled people's soiled washing had no hand washing facilities. This meant that staff had to leave the room before they were able to wash their hands.

● The sluice room smelled strongly of urine, the room had no lock on the door so was accessible by people. There were no handwashing facilities in there and no bin to place dirty gloves.

● In the communal bathroom there was a rusted apron holder and we could see that remnants of rust were smeared across a clean apron that was in the holder. In the laundry cupboard, clean bedding was on the floor of the cupboard. The rear part of a toilet basin was cracked and there was a risk that this could not be sufficiently cleaned. There were also tiles missing around the sink in the bathroom which made it difficult to clean.

● There were lounge chairs that were stained and in need of a deep clean. The provider told us that they did not undertake regular infection control audits. They said, "The last one was done (year) 17/18, I'm not sure that [member of staff] has done one this year yet. We have two excellent cleaners. All I have to say to them is hmm, these chairs are getting a bit iffy and she's on it straight away."

● Risk associated with people's care was not always managed in a safe way. Where people had fallen their falls risk assessment had not been updated to reflect this. In one person's care plan we noted that they were at risk of falls however there was very little information for staff on how to manage this risk.

● There was a person that smoked. Staff told us that they were not aware that the person smoked until after they had moved in. However, despite now being aware of this there was no smoking risk assessment in their care plan. The area where the person smoked did not have a fire extinguisher nearby and the person was not offered a smoking apron to protect them from the risk of fire. This was despite the known risk of clothes becoming flammable near a flame particularly as the person used emollient creams.

● People were restricted and at risk of falls as their walking aids were moved from them when they were sat in the lounge. The layout of the lounge was such that if people's frames were left in front of them people would be at risk of tripping over them. However, people were having to alert staff if they wanted their frame if they wanted to get up. One person said, "I would prefer my walker with me. Would help with my independence if I want to go to the toilet I wouldn't have to ask."

● There was a person that had a pet at the service that meant a lot to them. However, there was no risk assessment in their care plan to assess the risk of having a pet.

● Where people were losing weight their food and fluid was not being recorded. Although the GP had been consulted in relation to their weight loss, there was no record in place of what people were eating and drinking each day. This could help determine whether there was an underlying medical concern that needed to be addressed. According to their records, four people had been consistently losing weight since April 2019. After the inspection the provider told us, "We are monitoring this. It just so happens that the food and fluid charts are not in place yet."

● The first aid box at the service contained out of date dressings some of which had expired in 2001.

● Accidents and incidents, we reviewed had very little detail on what preventative measures had been taken to reduce further occurrence. For example, in relation to people having falls. The provider told us, "Accidents and incidents are stored in the HSE (Health and Safety Executive) book. We have very few here." We noted that there had been 22 recorded falls at the service in 2019. We asked the provider if the incidents and accidents were collated and reviewed to look for trends and themes. They told us that they were not and that, "I take your point and I've noted that." This was despite the provider stating in their PIR that they were going to, "Develop critical incident analysis systems to fully investigate all incidents where the safety of a service user was affected."

Using medicines safely

● The management of medicine was not undertaken in a safe way which put people at risk. There were gaps in people's MAR (Medicine Administration Record) and there was a risk that people had not received their medicine. People's medicines were kept in their room; however, temperatures were not being taken that ensured that the medicines were kept at a safe temperature.

● Where people required 'as and when' medicines there was not always guidance in place for staff on when this should be given. Where hand written prescriptions had been entered on the MAR these had not been signed by two members of staff despite the providers own policy stating, "Two trained staff have to sign the entry which should reflect the drug label." The photos of people on the MAR were out of date. For example, there were people's photos that had been taken in 2013 and their appearance may have changed since then.

● There were no detailed medicine audits taking place other than to record the stock of medicine. The provider told us after the inspection that the management of medicines, "On my inspection is up-to-date, audited and follows exactly the guidelines given to us by the pharmacist who regularly visits with advice." We asked the provider for evidence of audits from the pharmacy and to date we have not received this.

The failure to assess and mitigate the risk of infection, to ensure risks to people's safety were assessed and mitigated, accidents and incidents were monitored and that the management of medicines was undertaken in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were aspects of the management of risks that were adequately managed. For example, one person had a specialist bed in place. There was a risk assessment in the care plan advising staff to check that the bed was raised to the person's comfort level. Where bed rails were in place there was risk assessment in the care plans.

● The medicine room was securely locked, and the fridge temperature of medicine for people that required insulin was checked daily to ensure it was at a safe temperature.

● People told us that they felt the home was clean. One person said, "Its clean and quite comfortable." The overall cleanliness of the bathrooms and bedrooms was good.

● Staff were aware of some risks posed to people and how best to support them. One member of staff told us that one person had a pressure cushion attached to their chair to reduce the risk of getting pressure sores. We saw that this was in place for this person and others that were at risk.

● There were improvements required around the recruitment practices when employing new staff. One member of staff had recently started to work at the service. There had been no references secured or Disclosure and Barring Service (DBS) checks undertaken for them. The provider told us, "They (the references) haven't come back. I should chase those. I'll make a note." In relation to the DBS check they believed that because the member of staff did not perform care work with people it was not necessary to obtain one. We discussed the need with them to obtain a DBS for this member of staff.

● There were however DBS checks in place and evidence of the identity of other staff files we looked at. We also saw references and full employment histories for other staff.

Systems and processes to safeguard people from the risk of abuse

● People told us that they felt safe at the service. A relative told us, "She (relative) never liked being on her own and here she has lots of people around."

● Safeguarding incidents were being reported appropriately and investigated by the provider. Staff had received training in safeguarding and were able to tell us what they would do if they suspected abuse.

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.

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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Where decisions were being made for people there was no evidence that their capacity had been assessed. For example, one person had a bed rail and sensor mat in their room. Staff told us that this person lacked capacity to make decisions. There was no assessment of the person's capacity to agree to the bed rails and sensor mat or any evidence of the discussion to determine that this was in the person's best interest or whether less restrictive measures had been considered.
- Other people were being restricted from leaving the service. There had been no capacity assessment in relation to this or DoLS application to the Local Authority to determine that this was a legal deprivation of their liberty. There was a record of a DoLS application for one person from 2016 however this had not been reviewed. We asked the provider to send us a matrix of DoLS applications that had been made and to date these have not been received.
- Staff received training in the past around MCA and DoLS however there was a lack of understanding of the principals involved. Staff confirmed that the training had not been provided for some time. One member of staff, when asked if they knew what best interest decisions were they told us they did not.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

- Staff had not always received training specific to their role. We asked the provider for a matrix of the most

up to date training that staff had received. The list they provided us with did not include three of the most recent members of staff. There was training on the matrix that had not been provided for a number of years and there was a risk that staff did not have the most up to date guidance. For example, first aid training, infection control training, dementia awareness and health and safety training had not been provided to some staff since 2015. Medicine training and moving and handling training and MCA had not been provided to the majority of staff since 2016. The provider told us, "The regular training we won't necessarily refresh all the time."

● During our inspection we found shortfalls in the practices of staff. Up to date training would assist them in understanding what was required of them. For example, in relation to MCA, infection control and medicines training. One member of staff told us, "It would be nice to be offered training."

● The provider told us that new staff were required to undertake the equivalent of the care certificate. However, we were not provided with evidence that this had been done. One member of staff told us that apart from fire safety, medicines and moving and handling they had not been asked to complete any training since working at the service. They did however say that they had shadowed some shifts.

● There was no formal system of supervising staff in their role despite this being a requirement of the regulations and part of the provider's policy. The provider told us, "We dropped the formal supervisions because they take time. We see each other every day and staff know if they wish to discuss anything they can set up a meeting. We deal with things as and when they arise and supervise accordingly. We dropped appraisals too. They are too formal and take time. Staff know how they are doing when you only have a staff team of 20."

● Staff fed back that they wanted to take part in supervisions. One told us, "I feel they are important and useful for staff, especially new staff." Another told us, "It would be good to have them (supervisions) to talk through if you have any worries." Staff however did say that they felt supported by the staff team and that they all worked well together.

● The service supervision policy stated that supervisions are an opportunity for staff to, "Have "space" away from their work in a private one-to-one setting" and "The employer gives time and focus to the individual worker." In relation to appraisals it stated, "As a condition of your employment, if necessary, you will be required to take part in an appraisal, which is a confidential meeting between yourself and your employer." In their PIR they stated, "We back up all training with competence assessments and formal supervision sessions." We found that this was not happening.

As staff were not appropriately trained and supervised in their role this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Improvements were required to the environment to support people. When we arrived at the service we noted that the conservatory was being used to store furniture and filing cabinets. There were chairs in the conservatory that were worn and were in need of being replaced.

● The décor around the communal areas was tired. In the dining room the wall paper had been scraped away from the wall where a chair had been pulled in and out daily from a person sitting at the dining room table.

● Staff told us that the service environment needed improvement. One told us, "The carpets, furniture and the rooms needs sprucing up. A lick of paint on the walls would be nice." Another said, "The environment needs a lot of work doing. The paint work is shabby, the tables cloths and flowers on the table need changing."

● There were people walking around but there were no particular areas of interest or sensory items to keep them occupied or engaged.

● After the inspection the provider told us, "I totally take on board the comments you made about the

lounge and conservatory. I agree that the decor is just a little tired at the moment." They told us since the inspection they had made some changes to the conservatory and that they had already started planning for the service to be redecorated. We will check this at the next inspection.
● There were aspects to the service that were homely, and people liked this. One person said, "I think the environment is quite nice." Each person had their personal effects including furniture in their bedrooms.

We recommend that the provider checks the environment to ensure that it is properly maintained and decorated to a suitable standard.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us that they enjoyed the food at the service. Comments included, "It's plain, but nice", "The food is good", "It's very good. If I want, they do something a little different for me." ● During the inspection people called out to us for them to have a cup of tea. We noted that there was no space for people to have drinks placed next to them throughout the day. Instead staff would bring temporary tables to the lounge whilst people were drinking and would place them back once people had finished.
● The chef was provided the information about people's dietary needs including whether meals needed to be modified, for example pureed, and those that had allergies.
● During lunch people were offered a hot meals and alternatives offered if people wanted something different.

We recommend that people have access to drinks throughout the day.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Information about people's needs had been assessed before they moved in. This was to ensure that they knew the service could meet their needs. Assessments included information about communication, allergies, medical background, weight, dietary needs, mobility, memory and cognition.
● People had appropriate access to health care services in their ongoing care. One person told us that staff would get the doctor if they needed them but had not had the need to. There was evidence in care plans that a wide range of healthcare professionals were involved including the Tissue Viability Nurse, GP, district nurse, optician and dentist.
● Staff were aware of what they needed to do to monitor a person's health. One told us that a person had a small wound that needed to be dressed by the district nurse. We saw that this had taken place. Another person became unwell the day before the inspection and staff had requested that a professional from the GP surgery came to see them. We saw that the person was seen by a nurse practitioner on the day of the inspection.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported and did not always have choices around their care delivery.

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

- People and relatives told us that staff were caring. Comments included, "I think staff are caring. If I have a problem I can go to them", "Staff are friendly", "They (staff) are at your beck and call. I like it here; the staff are kind" and "I have full confidence in the staff and everybody is lovely."
- We saw that when staff interacted with people this was done a kind and caring way. However, staff were very busy which left little time for them to have a lot of meaningful interactions with people. One person told us, "I thought I would get more attention" whilst another said, "Staff are just so busy all the time."
- Due to the current staff levels and deployment people did not always have a say in when they were provided care. For example, we noted that people were only offered one bath or shower a week unless there was a specific need. This meant people were not being involved in decisions around their care, and their preferences were not always accommodated.
- We saw member of staff approach a person to wake them up. They gently rubbed the person's arm and stooped down to their level. On another occasion a member of staff laughed a joked with a person.
- There were religious services planned for people of various dominations. This included services at the home and people attending services outside. Relatives and friends were encouraged to visit and maintain relationships with people. One relative said, "They [staff] are very good to us. They offer you drinks when you come."
- We saw feedback from relatives to staff at the service. Comments included, "You have all been so kind to him [their loved on]", "I am so grateful to all your lovely staff for their hard work and love shown to mum" and "Your girls (staff) are just lovely beyond words."
- People told us they got up and went to bed when they wanted. One person said, "I usually go down about 10.00pm and get up about 07.00-07.15. That's what I prefer."
- There were people that chose to stay in their rooms and staff respected this decision.

We recommend that the provider ensures that staff have sufficient time to spend with people and that people have choices around their delivery of care.

Respecting and promoting people's privacy, dignity and independence:

- People and relatives told us that staff were respectful. A relative told us, "What I really like is she [their loved one] is dressed in a co-ordinated way."
- When staff provided personal to people this was provided behind closed doors to protect people's dignity. We observed staff to knock on people's doors before they entered. When staff spoke with people they did

this in a polite and respectful manner.

● Staff encouraged people to do things rather than assume they could not do them. People during lunch were encouraged to eat independently.

● We saw a member of talking to a relative when they were visiting their family member. The member of staff ensured that the person was included in the conversation.

● Staff told us that they liked working at the service. One said, "I love working here. I love the people."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. People's needs were not always met.

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

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Care plans contained some information on the likes and interests that people had but this was not detailed. There was information missing on people's preferred routines and their life histories. For example, one person gave us information on the past life before they moved in to the service and their family, however this was not included in the care plan. Relatives also made us aware of the background of their family member however none of this information was in their care plan.

● There was not always sufficient and up to date guidance in the care plans around the specific needs of people. This meant that there was a risk that staff would not deliver the most appropriate care. For example, in one care plan it stated that the person's weight was, "Fine" however the person had been losing weight since April 2019. There was no nutritional care plan to show how this was being managed. One member of staff told us, "The care plans should be updated monthly. I find them hard to read through as there is so much paperwork."

● End of life care was not being planned around people's wishes. There was no record that discussions took place with people about their spirituality, religion, what family they wanted around them and where they wanted to be at the end of their life.

● People and relatives fed back that there was not enough for them to do. Comments included, "We do get bored. We don't go out on trips. I would like to", "They do have singers coming in but I sometimes get bored", "I'm a little disappointed in activities. The external activities are very good" and "No activities, nothing. We are bored. We just sit here with nothing to do. Nothing to entertain us." There were people that chose to stay in their rooms and felt that they had enough to occupy themselves. One person said, "I stay in my room because I don't like the programmes they watch on the television downstairs."

● One person's care plan stated that staff should, "Encourage [person] to attend activities which include bingo, crafts, quizzes, reminiscence. Establish relationships by listening, refer to her life history to help start a conversation." We did not see that staff were able to do this with the person as they were busy elsewhere. There were no records in daily care notes to indicate this took place.

● During the inspection we found that people were sat in the lounge area and, apart from the television being on, there was very little for them to do. Most people in the lounge were not watching the programme as it did not interest them. One person told us they had not chosen what was on and did not know who actually wanted it on. Staff were busy and had little time to do any meaningful activities with people. One member of staff said, "I do feel there should be an activities person here. You don't get time to do activities

with them. They are not occupied enough."
● There were entertainers that came in to the service which people enjoyed. However, when we looked at the activities schedule it included a visit from the chiropodist and the hairdresser.
● People told us that they would like to go out on trips with the service. One person said, "You're in the home all the time. It would be nice to get out." The provider told us, "Hoping a member of staff could take a few people out every Thursday, but not quite materialised, I'll be honest. That has lapsed which I am disappointed about."

Failure to plan care and treatment around people's needs and preferences was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were elements to the planning of care that was informative for staff. For example, we saw the care plans included information on people's continence, mobility, religious needs and skin integrity.
● Where people had diabetes there was clear guidance on signs staff should look out for should the person become unwell and what they needed to do.

Improving care quality in response to complaints or concerns
● People and relatives told us that they would not hesitate to raise a complaint if they needed to. One person said, "I've not made a complaint, but I could speak to any of them (staff)." A relative said, "We wouldn't be slow in coming forward if needed."
● There had been no recorded complaints at the service. The provider told us, "No complaints. We do have grumbles, but we sort those out." There was no record of these 'grumbles' in the complaint folder. The complaints made about the smell of urine had not been recorded in the complaints folder and no evidence of what actions had been taken.
● Compliments were received into the service. Comments included, "I think the staff are very nice and caring and are happy to listen to what we say. No complaints at all, I don't feel lonely as I have lots of company and I am very happy here", "I am happy and satisfied with the care I receive" and "Management and staff very good at helping sort any problems I have."

We recommend that the provider records all complaints with evidence of how they have been investigated and resolved.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans contained how best to communicate with the person. There were care plans that stated how staff should maintain eye contact with the person and to speak clearly.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- At the previous inspection we made a recommendation around the lack of recorded audits, the lack of up to date records in the care plans and the lack of guidance on as and when required medicine. The provider had failed to address the issues we recommended to them at the last inspection and we found further issues across the service evidencing deterioration in the service people received and lack of good governance.
- People and relatives were positive about the provider. Comments included, "I don't have much to do with him, but he did fix my glasses." Another said, "I have met the manager. He has done a lot for me."
- However, there was a lack of robust oversight from the provider to ensure the quality of records and care being provided. The provider advised us that they would walk around the service and feed back to staff any areas they felt that needed to be addressed. We asked if they recorded this audit and they told us, "No, we don't record it, I'm sorry. You do this, the social team do the same, expecting us to record every single thing. What I can tell you, is it is done. If you want every bit of evidence written down, then it's not." Recording where areas for improvement had been identified is important, as it enables a person to record what has been done to address concerns, and to later check that these changes have been effective at making an improvement.
- Where shortfalls had been identified by the provider these had not always been addressed in a timely way. For example, we raised the concerns regarding the environment and the need to update the décor. The provider told us they were aware of this, but had not yet employed a handyman, this post was being advertised.
- The provider undertook an audit of the environment in November 2019 that looked at the electrical equipment, roof areas, outside area, the lift, and all rooms at the service. We saw this was completed twice a year and where the provider recorded shortfalls these were addressed including the repair of a toilet seat and the curtains being hung back up in the lounge. However, this audit had not identified or recorded the shortfalls in the environment that we had found including the décor and the conservatory being used as a storage room
- There were no formal systems in place to audit care plans, the medicine records, training and supervisions for staff. We found shortfalls in all of these areas.
- We reviewed the feedback comments from the surveys that had been completed by people and their families in 2018. A sample of these comments from people included, "I would like more choice with the activities", "Would like to go out a bit more", "More entertainers to come in. When I first came here we used to go out more." Comments from relatives included, "It would be nice if the residents that are fit enough be

taken out now and again" and "I think it would be a good idea to receive trips/outings." There were also comments raised regarding the smell of urine in the reception area and improvements needed to the environment. Sufficient action had not been taken by the provider to address this feedback.
● Although residents' meetings were taking place this was not being used as an opportunity for people to be involved in the running of the service and decision making. Discussions were limited to whether they liked the food and what the Christmas activities. There were no discussions about what felt about the schedule of activities on offer, whether people were happy with the laundry, the environment or reminded how they could make a complaint.

As quality checks and leadership was not always robust at driving improvement this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was no doubt that people, relatives and health care professionals were happy with the caring nature of staff and fed this back on surveys. Comments included, "I just wanted to say how amazing your staff at Hankham Lodge are. During our friend's stay over the last two years and particularly the last few weeks, the care and compassion shown has been amazing" , "Words can't express how grateful I am to all of you for giving my Nanny the love and respect that she deserves", "Lovely atmosphere and courteous and caring staff who are always a joy to liaise with", "The home is caring and vigilant about fire safety."
● Staff said that the provider was well meaning and they felt valued by them. One member of staff told us, "[The provider] is in all the time, from 06:30 in the morning. He's very generous. If the residents need anything he's perfect." Another told us, "He is good at sorting things out quickly." A third told us, "I do feel valued. We all work together so well." We saw staff had meetings and talked through safeguarding and any other matters they wanted to talk through.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Whilst on the inspection we identified incidents of safeguarding that had not been notified to the CQC.
● We noted in one person's notes that they had been observed hitting another person. An incident form had been completed but this had not been reported to the CQC. Another person had fallen and had an injury that required them to be taken to hospital and again this had not been reported to the CQC.

As notifiable incidents were not always sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

Working in partnership with others; 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
● Where incidents and accidents had occurred, we noted from the records that families were contacted.
● The provider and staff worked with external organisations that regularly supported the service. This included staff from the local health centre and the local authority. One health care professional fed back to the service, "Lovely atmosphere and courteous and caring staff who are always a joy to liaise with."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that the appropriate notifications were sent to the CQC where required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care was provided around the needs of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people's capacity had been assessed and consent was sought before care was provided

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitable qualified and supervised staff at the service

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that the risks around people's care was being managed in a safe way.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were robust systems in place to assess the quality of care

The enforcement action we took:

We issued a warning notice