Mr Peter Sims & Mrs Svetlana Sims

Hankham Lodge Residential Care Home

Inspection report

Hankham Hall Road
Westham
Pevensey
East Sussex
BN24 5AG

Tel: 01323766555
Website: www.hankhamlodge.com

Date of inspection visit:
23 May 2022

Date of publication:
28 June 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hankham Lodge Residential Care Home is a residential care home providing accommodation and personal care to up to 20 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
Risks to people's safety were not always assessed and managed. People's care plans and risk assessments were not up to date and did not always contain enough guidance for staff to keep people safe. The provider had begun working with an external consultant to make improvements to care plans and risk assessments.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People that may lack capacity did not have capacity assessments in place to see if the person was able to make their own decisions, and no best interest decisions had been recorded. DoLS (Deprivation of Liberty Safeguards) applications had not been made when required.

People did not always receive person-centred care. People's care plans did not contain information about people's individual wishes and interests. People did not always have enough meaningful activity to keep them occupied.

Governance and oversight of the service needed improvement. Audits to identify shortfalls at the service were not always in place, for example for medicines and care plans.

People were supported by staff that knew people well. Staff spoke about people warmly and enjoyed supporting people. People told us they were happy at the home. Staff were recruited safely and there were enough staff to support people. The home was clean and hygienic.

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

Rating at last inspection and update
The last overall rating for this service was requires improvement (published 1 August 2020). This was a focused inspection to review Safe and Well Led.
At the last comprehensive inspection (Published 25 January 2020) we identified breaches of regulations around the need for consent, staffing and person-centred care. The provider completed an action plan after this inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the provider check the environment was maintained and

decorated to a good standard. At this inspection we found that improvements had been made.

At our last inspection we recommended that people should have access to drinks throughout the day. At this inspection we found people were provided with drinks throughout the day.

At our last inspection we recommended that the provider ensure staff have sufficient time to spend with people and that people have choices around their delivery of care. At this inspection we found that improvements had been made.

At our last inspection we recommended that the provider make a record of complaints and evidence how complaints had been investigated and resolved. At this inspection we found that the provider kept a record of complaints and actions taken.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 7 November 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve person centred care and need for consent.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. During the inspection, we found evidence to suggest we needed to look at the safe key question. This meant we opened up the inspection to a five key question inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk management, person-centred care, need for consent and governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Hankham Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hankham Lodge Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post. The registered manager was also the

provider.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 23 May 2022 and ended on 26 May 2022. We visited the location's service on 23 May 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service. We spoke with six members of staff including the provider. We observed interactions between staff and people. We spoke with nine people's relatives by telephone. We reviewed a range of records. This included four people's care records and multiple medicine records. We looked at two staff files in relation to recruitment and further records relating to the quality assurance of the service, including feedback surveys and accident and incident records.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- Risks to people's safety were not always assessed and managed. We found one person with bed rails did not have risk assessments in place to assess the safe use of these. Another person had a risk assessment for the use of bed rails, but this was not dated and had not been reviewed to ensure the bed rails remained appropriate and safe for the person. People had bumpers on their bed rails to prevent the risk of entrapment in the bed rails. However, for one person this was not a full-length bumper and did not cover the full length of the bed rails. This meant the person was at risk of entrapment and injury. The provider told us during the inspection they would contact the company that supplied the bumpers to discuss alternatives.
- People's mental health needs had not always been assessed and people's care plans did not always contain enough information to support people safely. For one person who regularly experienced episodes of mental ill health and was at risk of self-harm, there was no information in this person's care plan about how to support the person and no risk assessments to assess the person's safety. Although staff we spoke to knew this person well and were able to tell us the support in place for this person, new staff and agency staff were at risk of not having this information.
- One person was living with diabetes. Staff supported the person to manage this through regular blood sugar tests and insulin injections. However, there were no care plans or risk assessments to guide staff or inform them when to measure blood sugar levels or what this person's blood sugar range should be. There was generic information about what actions to take if the person should experience low or high blood sugars. This was not specific to this person. A small number of staff supported this person with their injections. They were able to tell us about the support they provided and how risks were managed. However, further staff were now receiving training and would soon be administering this medicine, so there was a risk of staff not having enough information to support the person safely with their medicine.
- Environmental risks were not always safely managed. We found that one window on the top floor opened wide and did not have a window restrictor on it. There was a fold out stool attached to the wall below this window so people could get out of this top floor window. We raised this with the provider who told us they would re-attach a window restrictor immediately. We received evidence after the inspection that this had been done.
- We saw that a fire exit in someone's bedroom which was in use had an armchair restricting access to the door in the event of a fire. We raised this with the provider who agreed the chair shouldn't be there and told us they would move the chair out of the way.
- Improvements were needed to some aspects of medicine management. There had not been any regular counts of medicines. Monitoring stock levels for individual boxed medicines is important to minimise the chance of error and ensure people received the prescribed amount of medication. There were no medication audits to check for errors and we found there were gaps on people's medication administration

records (MARs). We have detailed this further in the well led key question.
● A risk assessment for one person who managed their own medicines had been completed. However, it had not been identified that the medicines had not been stored securely. This was raised with staff who said they would ensure this person's medicines would be stored securely.

The provider had not assessed the risks to the health and safety of service users. Medicines were not managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our concerns throughout the inspection. Staff responsible for updating people's care plans and risk assessments acknowledged that these were not up to date and were working with an external consultant to improve things.

● Staff had begun to put falls audits into place to identify trends and themes of people falling. We saw that where people had fallen and this had been unusual for the person, staff had contacted the person's GP to discuss if their health may be impacting on the person's mobility.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding incidents had not always been appropriately investigated and reported. We saw one incident where a person had caused a bruise to another person in the home. This had been recorded in the person's daily notes but there was no incident or accident form to show that an investigation had taken place. This incident had also not been reported to the local authority safeguarding team. We raised this with the provider who told us they were not aware it needed to be reported to the local authority safeguarding team. The provider told us they would submit the safeguarding referral retrospectively.
● Staff received safeguarding training and were able to tell us different types of abuse, this included physical and mental abuse and not giving choices. They told us and actions they would take if they were concerned someone was at risk of harm, abuse or discrimination. Not all staff were able to say which external organisation they could report safeguarding concerns to.
● People's relatives felt that staff kept people safe. One person's relative told us, "Having the support of the staff here is an incredible weight off our shoulders, we know [person] is safe and if anything happened to them there's always someone around."

Staffing and recruitment, Learning lessons when things go wrong
● There were enough staff to support people safely. Staff told us that when they had raised concerns about people falling due to staff supporting people in their bedrooms, the provider had instated another member of staff to support people in communal areas during busy times. Staff told us this had reduced the number of falls people were having.
● Staff were recruited safely. The provider carried out appropriate checks before people started working at the service. This included references from previous employers and DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
People were supported to receive visitors without any restrictions in place. Visits were booked in advance to ensure a member of staff would be available to support safe visiting.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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

At our last inspection the provider had not ensured that people's capacity had been assessed and consent was sought before care was provided. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People who staff had made decisions for had not had their capacity assessed to see whether they could make those decisions for themselves. This included decisions around restrictions.
- For example, one person had bed rails to keep them safe. Staff told us this person did not have the capacity to agree to this decision. There was no mental capacity assessment for this person to assess whether they could make this decision for themselves, and no best interest discussions recorded to determine whether the person's representatives had been involved in the decision-making. There was also no evidence that the least restrictive option had been considered.
- There were CCTV cameras in operation in communal areas of the service, these were only looked at where there had been an incident such as a fall. Although the provider told us that people or their relatives had consented to this, there were no mental capacity assessments or best interest decisions to assess whether

this was the least restrictive option.
● DoLS applications had not been made for people that lacked capacity and had restrictions in place as required.
● Staff had received training in Mental capacity act, best interest decisions and DoLS, however staff were not able to tell us the principles of this and what should be in place for people who may lack capacity.

The provider had not ensured that people's capacity had been assessed and consent was sought before care was provided. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection the provider had not ensured staff were appropriately trained and supervised in their role. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had been made and the provider was no longer in breach of regulation 18.

● Staff received an induction into the service and spent time shadowing other members of staff.
● Staff received training in areas that were relevant to the people they supported. This included training in dementia, oral health, infection control and safeguarding. Staff told us they found the training useful to undertaking their job role.
● Staff told us they received regular supervisions and were comfortable to go to the provider if they had any concerns. One staff member told us, "We go straight to [provider] if we or the residents ever need anything."

Supporting people to eat and drink enough to maintain a balanced diet

At the last inspection, we recommend that people have access to drinks throughout the day. At this inspection we found that improvements had been made. People had access to drinks throughout the day.

● People's relatives were confident that staff were supporting people appropriately with their meals. One person's relative told us, "One thing I would say, is that they help [person] to eat and drink, [they] have put on weight which is a miracle for [them]."
● People were provided with food and drink which suited their individual preferences and dietary needs. Most people were able to tell staff what they would like to eat and where people could not, staff told us they knew what people liked.
● People who were at risk of losing weight were provided with fortified meals. However, for one person, although staff knew about one person's fortified diet, this information was not in the person's care plan. We have detailed this further in the responsive key question.

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

At the last inspection, we recommend that the provider checks the environment to ensure that it is properly maintained and decorated to a suitable standard. At this inspection we found that the provider had made some improvements.

● The provider undertook a walk around of the service to assess for environment issues that needed to be

addressed. We saw that where issues were identified, they had been actioned.
● Staff showed us a book where they logged any concerns they had with the environment as they arose. The provider and maintenance staff looked at this weekly and we saw that issues raised were addressed.
● The home was decorated in a homely and traditional way. Due to the building being older, routine maintenance was ongoing.

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
● People had their needs assessed by staff before moving into the home. This included people's references for aspects of daily living such as what they would like for breakfast and how often they would like a bath or shower.
● People's care plans had their oral health needs documented and showed staff how people needed to be supported to maintain good oral hygiene.
● Staff contacted health professionals when people needed them. We saw that staff worked in partnership with psychologists, district nurses and GP to meet people's needs. Interactions with professionals were recorded in people's care plans and records of hospital appointments and outcomes from hospital appointments.

Good

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

At the last inspection we recommend that the provider ensured staff had sufficient time to spend with people and that people have choices around their delivery of care. At this inspection we found that improvements had been made.

- People were supported by staff who enjoyed their job and cared about people. One staff member told us, "I actually really love my job because I can give back, I have a caring nature and I know I can make a difference here."
- People told us they were well treated by staff. One person told us, "The staff are a nice friendly bunch, they couldn't do more for us." Through conversations with staff, we found that staff knew people and their preferences very well. Staff were able to tell us what was important to people.
- People's relatives told us that staff were kind and caring. One person's relative told us, "The carers are very affectionate to their residents, they look after them like they are their own family."
- We saw that staff spent time speaking to people kindly and respectfully. People seemed comfortable around staff and enjoyed their company. We saw that staff spent time talking to people who chose to spend time in their bedrooms.
- People told us that they were offered choices, one person told us, "I have a lot of choice to be honest." We saw that where people chose to spend time in their room, this was respected by staff.

Respecting and promoting people's privacy, dignity and independence
- Staff told us the different ways they supported people to be as independent as possible. One staff member told us, "We try to give people as many choices as possible and when we help with personal care, we try and encourage people to do things for themselves. For example, giving someone their hairbrush instead of just doing it for them. Always trying to get people to participate as much as possible."
- People told us that staff respected them. One person told us, "The staff are absolutely wonderful." We saw that staff spoke to people in a respectful way and addressed people in the way that they had chosen to be addressed.
- Another person told us that staff were very respectful when supporting them to wash and dress and ensured the curtains were closed and the door was shut.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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

At the last inspection the provider had failed to plan care and treatment around people's needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● At the last inspection we identified that people's care plans contained little information about their likes, dislikes, hobbies, interests and previous life history. At this inspection, we found improvements had not been made. We discussed this with staff responsible for writing people's care plans. Staff were aware people's care plans did not contain enough person-centred information. They were taking advice from an external consultant about the information contained in people's care plans and plans were in place to improve this.
● At the last inspection, we found there was a lack of up to date guidance in the care plans around the specific needs of people. This meant there was a risk staff would not deliver the most appropriate care. At this inspection we found improvements had not been made. People with diabetes did not have individual care plans in place to guide staff on how to support the person safely. The lack of detail in care plans and risk assessments around diabetes, meant the provider could not be assured people were receiving consistent and safe support to manage their diabetes.
● We also found that one person was consistently losing weight and was only drinking small amounts. There was no weight loss care plan or up to date risk assessment in place for this person. Staff had contacted the person's GP for professional advice. However, staff had not updated the person's care plan regarding their weight loss, or taken action to monitor this. Staff were not recording how much this person was having to eat or drink.
● Information about risks to people who experienced episodes of frustration, anger or distress were not always detailed. There was limited information about what may cause these episodes, how to support people during these times and reduce the impact on themselves and others. Staff were able to tell us how they would support people when they became upset, but this knowledge was passed to staff through word of mouth and was not recorded in the person's care plan. This meant that staff that were new to the service and agency staff may not be able to support people appropriately when they experienced episodes of anger

or distress.
● People's end of life needs had not always been discussed or assessed with the person or their relatives. For one person who was receiving support with end of life care, their care plan did not contain information about their end of life wishes. When staff were asked about this person's wishes, staff were unable to tell us what they were and said, "We don't know, we would call the person's relative when the person had passed away and they would deal with it, but I agree, that information should be in the care plan."
● People, their relatives and staff told us that people did not have regular access to meaningful activities. Our own observations supported this. One staff member told us, "I don't think there's enough here for people to do, not enough activities. Staff are supposed to spend an hour with people in the afternoon doing activities, but it often doesn't happen." A person's relative told us, "They used to do activities, but they are all pretty sedentary now since Covid-19, they watch TV all the time, there is no stimulation." We saw that some people were involved in arts and crafts during our inspection. However, for the majority of the day people watched TV and were not offered the opportunity to get involved in any other activities.

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

The provider and staff acknowledged that people's care plans did not contain up to date personalised information. They were working with an external consultant to improve people's care plans. The provider was currently recruiting further members of staff to enable staff responsible for writing care plans to have the time to focus on keeping people's care plans up to date.

Improving care quality in response to complaints or concerns
At the last inspection we recommend that the provider records all complaints with evidence of how they have been investigated and resolved. We saw that improvements had been made.
● Complaints and suggestions for improvement had been recorded by staff and action documented to show that these had been actioned.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● Staff were aware of the Accessible Information Standard and told us that they would provide materials in different formats if people needed them.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- After the last inspection, the provider completed an action plan to show how they planned to address the concerns raised. At this inspection, we found whilst actions had been completed at the time, this had not been maintained or embedded.
- The provider was also the registered manager and had overall responsibility for the home. The provider had delegated the responsibility of care plans and medicines management to senior members of staff. Staff responsible for keeping care plans up to date were not allocated enough time to do this effectively. The provider was recruiting staff to allow this staff member to focus on care plans.
- Medicine audits had not been completed. This meant there was limited oversight to help ensure medicines were managed safely. We found one person's medicine administration record (MAR) had not been fully completed. We discussed this with staff, they were able to identify that the medicine had been given but the MAR had not been signed. However, this shortfall had not been recorded as part of any audit. This meant the information could not be monitored and analysed to identify any trends or patterns which may show further actions were needed to prevent any reoccurrences.
- Care plan audits were not completed. Staff were aware that care plans and risk assessments were not up to date and told us they were working with a consultant to change the format of care plans to improve information provided for staff. However, people's care plans did not contain enough information at the time of our inspection to ensure people were kept safe and they received care which met their needs and preferences.
- The provider was not aware of some of their regulatory requirements. We found gaps in the provider's knowledge of DoLS and safeguarding and when appropriate stakeholders needed to be contacted.

The provider had failed to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider was aware of their responsibilities under duty of candour.
- Statutory notifications had been submitted by the provider. We saw that one incident between two people at the service had not been reported. The provider told us they would submit this notification immediately.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● Relatives told us they felt communication could be improved at the home. One relative told us, "Bills come through promptly but that's the limit of the communication from the home." Another said, "They need to improve their communication." We saw staff contacted people's relatives if there had been falls or incidents but some relatives felt communication about issues involving medication and health needs could be improved.

● The provider had set up a text message group for staff in order to pass on key information such as training dates and changes to government guidance relating to the COVID-19 pandemic.

● We saw that staff had recently raised concerns through a staff survey. The provider told us they had responded to these concerns and told staff how they were addressing these issues. Staff did not have regular meetings as the provider felt that these were not a productive use of time as staff did not often speak up in these meetings. However, staff told us they felt listened to.

● People had regular 'resident meetings' in which staff discussed with people what was going on in the home and upcoming activities and events.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● Staff created a family feel to the home. One person told us that they were lonely during the pandemic which was frightening. They told us staff had kept them going through this time and when the registered manager told them we're all one big family and we're in this together, it reassured the person and made them feel better about the situation. Another person told us, "They (staff) are all very kind, I am very happy."

● Relatives were positive about the atmosphere of the home. One person's relative told us, "[Person's] happier than they've been in years, and I think that's down to having company." Another told us, ""[Person] is very happy and relaxed with the carers."

● Staff worked in partnership with district nurses, GP's and psychologists where needed.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to plan care and treatment around people's needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 assessed the risks to the health and safety of service users of receiving the care or treatment. Medicines were not managed safely . This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had failed to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.