Care Quality Commission

SHC Clemsford Group Limited

Horncastle House

Inspection report

Plawhatch Lane
Sharpthorne
East Grinstead
West Sussex
RH19 4JH

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Tel: 01342810219
Website: www.sussexhealthcare.co.uk

Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

This inspection took place on 13 September 2018, was unannounced and in response to concerns raised with us from a relative and by the local authority.

Horncastle House 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. Horncastle House accommodates up to 43 people in one adapted building. There were 23 people using the service during our inspection. Horncastle House provides nursing care to older people; most of whom live with dementia or memory loss.

Services operated by the provider had continued to be subject to a period of increased monitoring and support by commissioners. As a result of concerns raised about other locations operated by the provider, the provider is currently subject to a police investigation.The police investigation is ongoing and no conclusions have yet been drawn. There have been no specific criminal allegations made about Horncastle House at the time of our inspection. Since May 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find. Our findings from inspections of other locations operated by the provider also informed the planning of the inspection of Horncastle House.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. The former registered manager had left in September 2017 and their deputy had taken over the management of the service. They had applied to the CQC to become registered but had then left the service in April 2018. A peripatetic manager had been in place for 11 weeks prior to our inspection. A new manager was started work at Horncastle House on 13 August 2018 but had yet to apply to become registered with the CQC.

Horncastle House was last inspected in August 2018. At that inspection it was rated as 'Inadequate' overall and 'Requires Improvement' for Caring and Responsive domains. These were the same ratings as had been applied following an inspection in March 2018. There had been little improvement between the inspections of March and August and we had continued to find that risks to people's safety and well-being had not been adequately monitored or reduced. We had been sufficiently concerned during the August inspection, to request immediate action was taken by the provider and that confirmation of these actions was confirmed in writing.

Despite the CQC being given these assurances, at this inspection we found that known risks to people had increased rather than reduced. This had left people exposed to immediate risk of serious harm or death.

The service was unsafe for the people living there, because risks from choking, lack of access to their call

bell, from falls, poor hydration management, improper use of pressure-relieving equipment and the environment had not been remedied since our last inspection. We found a level of risk to people that was extreme and required urgent action.

There were not enough experienced and competent staff deployed to meet people's needs, and a heavy reliance on agency staff remained. Staff practice was observed to be poor but had been unchallenged by managers or the provider.

Information and records about people's care needs were dangerously inaccurate and conflicting; making them unworkable as guidance to staff, many of whom were from agencies and did not know people well.

There was evidence of a lack of learning from previous CQC inspection findings, feedback and reports to improve the safety of the service.
The service was not well-led. Auditing and oversight by the management team and provider had been ineffective and had not checked that staff practice was keeping people safe.

Assurances had been given to the CQC about improvements which had not been made. Staff culture had deteriorated and inappropriate and unsafe actions were going unchecked and unchallenged.

The provider continued to display the incorrect rating for the service on their website and the CQC had not been notified of the death of a person using the service; which is a statutory requirement.

We found continued breaches of three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We will publish information about our actions when we are able to do so.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

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.

The risk of people choking had increased since our last inspection, despite assurances that had been given to CQC by the provider about this.

Other risks to people from lack of access to their call bell, falls, hydration, pressure wounds and the environment had not been remedied since our last inspection.

There were not enough staff deployed to meet people's needs, and a heavy reliance on agency staff remained.

Is the service well-led?

Inadequate

The service was not well led.

Known, serious risks to people had not been reduced across a range of areas.

Auditing and oversight had been ineffective and had not checked that staff practice was keeping people safe.

Staff culture had deteriorated and inappropriate and unsafe actions were going unchecked and unchallenged.

There had been no registered manager in post since September 2017.

The provider was displaying the incorrect rating for the service on their website.

The CQC had not been notified of the death of a person using the service; which is a statutory requirement.

Care Quality Commission

Horncastle 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 September 2018 and was unannounced. The inspection was an urgent, focussed inspection looking at specific areas of the Safe and Well-led domains only. It was carried out in response to information of concern received from a relative and the local authority, and which indicated that people living at Horncastle House may not be safe. The inspection was carried out by two inspectors. Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We observed their care of people using the service, including breakfast and some activities. We inspected the environment, including communal areas, bathrooms and some people's bedrooms. We spoke with two registered nurses, three care staff, the manager, the peripatetic manager, the service review and transformation lead, a quality manager supporting the service and the provider's registered person.

We 'pathway tracked' 12 of the people living at the service. This means we looked at people's care documentation in depth and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care and whether care is delivered in line with people's needs.

During the inspection we reviewed other records. These included staff rotas, risk assessments, accidents and incident records, quality audits and handover information.

Inadequate

Is the service safe?

Our findings

At our last inspection of Horncastle House in August 2018 we found serious concerns relating to the risks people faced from choking. These risks and the need to address them had also been raised at our inspection of the service in March 2018 and in detailed follow-up correspondence with the provider. During the August inspection our significant concerns about choking risks to people were such that we requested the management team to carry out an urgent and immediate review of people who may choke to ensure the risks had been thoroughly and properly assessed; and were reduced in practice. We received assurances during the August inspection about this, and written confirmation from the registered person that the urgent review of people at risk of choking had been carried out.

On 11 September 2018 we received extremely concerning information from the relative of a person living at Horncastle House, to say that the person was not being supervised as they should be when they ate and drank. As a result, the relative said, "I know my father could choke. They are meant to be risk feeding from a distance but they don't. I know he is choking on things, I walked in twice last week and Dad was going purple and frothing at the mouth. They leave him unattended, nobody stays with him in his room when they bring him food." We raised an immediate alert to the local safeguarding authority about this.

This person had been observed by inspectors during the August inspection and had not been supervised while they ate their lunch; and had been seated out of staff's line of sight. We brought this to the immediate attention of the management team who assured us both verbally and in writing following the last inspection that the choking risks to this person had been reduced. We were sent a copy of updated information about the specific support this person needed two days after the inspection. This stated that the person was at risk of choking and 'Must be supervised when eating and drinking at all times'.

At this inspection we observed that the same person, about whom we had received these assurances, was left alone and unattended in their bedroom with a tray of breakfast. The tray was within easy reach of the person and contained cornflakes and milk, half a slice of toast, a cup of tea and two bottled milkshakes. The person was finishing a mouthful of food when we asked if we could enter their bedroom, and they told us they had eaten toast. There were no care staff visible in the corridor outside this person's room to hear if they coughed or choked. The person was lying in bed at approximately a 40-degree angle and was slumped to one side. The layout of the person's bedroom meant they were not visible from the corridor from the waist upwards. A care file kept in the person's room had a front sheet which stated '[Person's name] must be supervised when eating and drinking at all times- this includes in the morning when having breakfast. If [Person's name] has decided to have breakfast in bed, they must be assisted to be sat up in the bed and staff must be observing them. Try to encourage them to sit out in the chair preferably. [Person's name] may tell you to go away. If this is the case please respect their wishes but keep them in sight.' 'Please be aware… [Person's name] is at HIGH risk of choking'.

We made the peripatetic manager aware of this situation straight away and they removed the breakfast tray. However, this person had been exposed to immediate risk of choking because care file instructions had not been followed in any way by staff. If Inspectors had not intervened, there was a very real possibility that this

person could have choked, and potentially died.

Kitchen staff confirmed that they always left a tray of breakfast with this person, regardless of whether any care staff were with the person. They did not know of any particular risks to the person but did say that bacon was cut up for them in Wednesday and Sunday's cooked breakfasts. The person's recent nutrition care plan documented that 'High risk of choking foods should be avoided where possible, e.g.; dry, chewy fibrous foods'. Bacon would be described as both chewy and fibrous and the toast the person was eating during the inspection was buttered but chewy. This was further evidence that care file directions were not being followed in practice; and that known risks had not been minimised.

Another person who had been assessed as at risk of choking was observed being fed porridge and tea by a nurse, while the person was in an unsafe position and lying flat on their back in bed. This placed the person at significant risk of choking. The person had a current chest infection and was coughing while being fed. An Inspector intervened and requested that the nurse reposition the person so they were safe to be eating and drinking. Instructions given by a health professional in their care file said that the person should be sitting upright for meals, but this had not happened. The person had been assessed by a speech and language therapist (SaLT) who had recommended that they be referred to them at any sign of increased aspiration. Aspiration is breathing food or other matter into the airway and can happen if people cough while eating. The nurse confirmed that no re-referral had been made. This person had been exposed to serious risk of harm because staff were not delivering care in line with their care plan and professional directions.

A further four people were found to be at increased risk of choking because care file directions about eating and drinking safely were unclear, confusing and contradictory. One person's care file said they should receive a 'soft diet' but kitchen records showed they had pureed meals. The file also said that 'Staff need to sit with [Person] during eating and drinking'. Another document in the same file recorded that they could drink independently but needed assistance to hold the cup. It went on to say that the person needed supervision with hot drinks. There was no mention that staff should sit with them while they ate and drank all fluids whether hot or cold as per the first document. A care plan about maintaining healthy skin stated that this person should be encouraged to drink to keep their skin hydrated, and that staff should ensure drinks were in their reach. There was no mention again that staff should sit with them while they drank or that they needed support to hold a beaker. This mixed information created the opportunity for this person to receive unsafe care or treatment and be exposed to risk of harm.

Another person was at risk of choking because staff did not have accurate information in care plans about the action to take if the person displayed signs of aspiration. Guidance in a report from a health care professional instructed that the consistency of fluids must be changed, to be made thicker, if this person began coughing whilst drinking. This instruction had not been included in the care plan or risk assessment about choking and the person had a current chest infection. This created the risk that staff would not be aware of the instructions from the health care professional; and that the person would continue to have thinner fluids than deemed safe when at heightened risk of choking. Permanent staff did not know about the guidance to increase the thickness of drinks.

A further person had been assessed as needing supervision to eat and drink at all times and a soft and moist diet. This person should avoid high risk choking foods such as anything dry, crispy or fibrous according to the assessment. However, a different document in the person's room file stated they should have, 'Normal diet and fluids. Able to eat and drink independently.' This conflicting information placed the person at risk of choking because staff may not realise that they needed soft foods and supervision to eat them. We spoke with nursing and care staff on duty who held differing views about this person's dietary needs. A nurse said that the person required 'a soft diet' but no support to eat and two care staff said the person had chopped

meals but no assistance or supervision to eat them. Kitchen records showed that this person needed a 'Chopped diet' but no information was recorded to show that they should not receive dry, crispy or fibrous foods. Again, the person had been exposed to unacceptable risk because care file guidance was confused and contradictory. The impact of this was evidenced by the fact that staff gave us varying responses when asked about the person's current needs.

At the March 2018 inspection we found tubs of thickening granules left in people's bedrooms. These granules are extremely dangerous if swallowed dry and there have been national safety alerts about their storage because people have choked and died after swallowing them. By the August inspection we found that thickeners had been locked away but at this inspection they were again found in a person's bedroom. The granules are prescribed by a health professional but these had no dispensing label on them to confirm to whom they had been prescribed and the ratio of granules to fluid that was necessary for the individual's needs. The person was not in their bedroom but the door was open and the thickening granules accessible there. We gave these to a manager to be locked away. This person's care plan about nutrition said that they had been seen by SaLT who had recommended a fork -mashed diet and thickened fluids. However, records held in the kitchen showed the person received 'Super puree' meals. This was not in line with the SaLT directions or care plan.

Despite the detailed assurances given to CQC by the provider, the risks to people from choking had in fact increased from our previous inspection in August 2018. People had been exposed to significant and extreme levels of harm, and their care and treatment had been unsafe.

At our last inspection, a person told us that their call bell was not working and that they had to shout out for staff to come to them. They felt unsafe because of this as they were reliant on staff hearing and responding to them. We discovered that the call bell had been disconnected from the wall. At this inspection, the call bell for another person who was cared for in bed was found behind the headboard in the morning when we visited them. This person's bedroom was on the first floor and at the end of a corridor, so it would be difficult for staff to hear them; even if they had been able to call out. Staff notes made the night before stated that the call bell had been placed in reach and a chart showed the person had been checked by staff every hour until 7am (but had not been checked at 8am as per staff instructions to keep them safe). However, the chart did not include any information to show that the position of the call bell had been checked on each occasion, so it was not possible to know how long it had been inaccessible to the person. Following the inspection, a visiting professional told us that they had found the same person's call bell behind the headboard when they had seen them in the afternoon of the day after our inspection. This was despite the fact we had made the peripatetic manager immediately aware during the inspection of our concerns about this person's safety. They had placed the call bell onto the person's bed next to their hand at that time, but the care provided to this person was neither consistent nor safe.

At our last inspection, falls were not being managed in a way which kept people safe. At this inspection there was evidence that the situation had not improved. One person had a laminated notice above their bed, which said that they should have an alarm mat by the side of their bed at all times while they were in or on their bed. The person was in bed when we visited them and there was no alarm mat in place. The side rails on the bed were also down, so there was nothing to prevent them getting out of bed and falling. There were no staff around in the corridor outside this person's room when we visited them and they were not visible from outside the bedroom, due to its layout. This person therefore remained at risk of harm, because actions to reduce the risk of falling had not been taken.

At our last inspection, concerns were raised around people's hydration and the recording of it. We were sufficiently concerned to request immediate actions in this area and confirmation of them following the

inspection. The provider had assured us that processes and management checks had been put in place. However, at this inspection we found that a person's restricted fluid intake due to a health condition had not been properly monitored. Again, differences in care file information had presented opportunities for the person to receive inappropriate care and treatment. A document in their room file said, 'On normal diet and fluids, able to eat and drink' but another information sheet documented in capitals 'I am on a fluid restriction of 1500mls per day'. The nutrition care plan recorded slightly different guidance in that it stated between 1200 and 1500mls as the restricted fluid level. For this person to receive safe care, it relied upon staff knowing which was correct. But not all staff had understood that fluids were to be limited because fluid charts showed the person had received more than 1500mls on seven days since 15 August 2018; with the maximum amount recorded as 2100mls on one day. One nurse told us the wrong medical reason why fluids were being restricted and two nurses were unable to say whether liquid foods such as gravy or soup should be included in daily totals. During the inspection, this person's fluid charts were in their bedroom while they were downstairs. They had a cup of tea on their lap when we observed them in the lounge, but this was not included on the fluid chart until we made managers aware of our concerns. There was a risk that this person would have drinks which were not recorded onto charts and which could lead to them receiving excess fluid. There was a hospital passport for this person which is used to pass important information about their care needs to hospital staff if they needed to be admitted to hospital. However, this did not include information about the need to restrict fluids, further placing them at risk if they had been transferred to hospital for treatment. Neither had this person's fluid restriction been recorded in staff handover sheets. At our last inspection we highlighted that important information about another person's hydration needs was not included in handover information. This demonstrated again that lessons had not been learned from previous inspections and that communication about people's needs was seriously flawed.

At our last inspection, some people were at risk of developing pressure wounds and had special air-inflated mattresses on their beds. The pump for these mattresses was supposed to be set according to people's current weight so they received the therapeutic effect of them. We highlighted that not all air pumps had been correctly set or reviewed. At this inspection there had been no improvement and some people were on mattresses that had not been properly adjusted to reflect their weight. One person was 77.8kgs at the most recently recorded weighing in July 2018, but their air pump was set at 90kgs. Another person's pump was at 80kgs when they weighed 54.7kgs. A third person had a repositioning chart which had been completed to show the mattress pump had been set at 3.5, 40 and 60 on different days. This showed a very large difference between the level of settings in a short space of time; which was unlikely to be explained by changes in the person's weight. However, the pump only had available settings of 1-10 and was set at 5 when we visited the person's room. We asked care staff what setting the mattress should be on and they changed it to 3.5. However, they were unable to explain how this setting had been determined from the person's weight or why entries of 40 and 60 had been regularly made on the charts. Air mattresses are designed to reduce the risk of pressure wounds developing but these are only effective when operated correctly. The fact that these differing settings had been documented meant that the equipment was not being used properly to protect people's skin. People had daily checklists in their rooms which staff had ticked to show that the air pump levels were correct, when they were not always.

At our last inspection, the door to the kitchen was found to be left open on a number of occasions. We highlighted that there was a risk of injury to any person going into the kitchen. At this inspection we continued to find that the kitchen door (which had a combi-lock on it) was routinely left open and ajar.

The failure to assess, monitor and mitigate a range of risks to people is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the communal areas of the service appeared clean, one person's mattress was found to be stained

and unhygienic. At our inspection in March a person had injured themselves on an armchair which had sharp parts exposed on it. At the August inspection the armchair had been replaced but at this inspection some people's special, padded wheelchairs had the vinyl covering falling off the footplates. These were made of a hardboard material and were rough in places. There was a risk that people could damage frail skin on these chairs.

At our last inspection, records of people's weights had been grossly miscalculated on tables held in individual care files. Gains were sometimes recorded as losses and vice versa. The tables reviewed sometimes showed people had lost 19 or 20kgs. This was not correct and our calculations showed weight losses were far lower. However, the incorrect adding up on these tables had not been picked up until inspectors highlighted it during the last inspection. At this inspection, the incorrectly added up records about people's weights remained in their care files and gave a skewed picture of their actual bodyweight. We asked to see updated records about people's weights but the manager was unable to locate them during the inspection. There was a risk that staff would not pick up on any losses which needed attention because the information held was confusing and incorrect.

At our last inspection, records of people's prescribed cream applications had not had not been properly completed. At this inspection, this continued to be a problem. For example, one person had been prescribed cream for a very sore area, which was meant to be applied three times a day. The medicines charts showed that this had only ever been applied twice daily. Another person had medicines charts for a cream that was prescribed twice a day but records only showed one application. A third person had a cream prescribed for three times daily application but their medicines chart only showed it being applied twice a day. It was unclear from the records whether people were receiving the correct amounts of these medicines as prescribed by their doctors.

At our last inspection we had raised concerns that a person was not being supported to reposition in bed in line with care plan instructions. The management team had explained this at the time by telling us that the person was able to reposition themselves. We highlighted that this had not been reflected in their care plan. At this inspection, the care plan about maintaining healthy skin had been updated, but there remained no information in it about repositioning.

The failure to maintain accurate, complete and contemporaneous records is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, there had not been enough competent, skilled and experienced staff deployed to meet people's needs. At this inspection we continued to have significant concerns about how the service was staffed. There were not enough staff on the day of our inspection and there were not enough staff directly employed by the provider to meet the requirements of the service. There continued to be a high reliance on agency staff. The peripatetic manager told us at the start of the inspection that two nurses and five care staff had been as assessed as necessary to meet people's needs during the day.

On the day of our inspection there were two nurses, one of whom was agency staff and three care staff, one of whom was also agency staff. Two new agency care staff who had never worked at Horncastle House before were also on shift being inducted into the service. At our last inspection the management team had given us assurances that the same agency staff would be regularly used so that people received continuity in their care and staff got to know people's needs better, but this had not happened when we inspected. A member of permanent care staff told us that their instructions for inducting the new agency staff was to, "Show them around the home and the fire exits". They said that the inductee would 'shadow' them thereafter. One of the new agency staff told us that they had not read care plans or other information about

people's needs and an agency nurse gave us incorrect information about a person's medical condition.

We were very concerned that staff who were being inducted to work in the service were included in the assessed staff numbers needed to meet needs, and were not supernumerary. We asked how this would be immediately resolved and were told that attempts would be made to obtain more staff from another of the provider's services to help that day. The new manager said that another of the provider's services was also short-staffed so could not assist and that it was proving impossible to source agency staff with prior knowledge of working at Horncastle House. The provider brought in two managers later in the day and told us they would be working 'on the floor' to support staff. However, these managers were mainly in offices reviewing care files. One of them told us that the intention had been for them to work on the floor but instead they had needed to work on care records urgently, because of the multiple, serious concerns we had highlighted.

The impact of the lack of experienced staffing was seen in corridors and on the first floor where there were no care staff visible for long periods of time. There had been no care staff around to supervise one person with their breakfast, as deemed essential for their safety, no hourly check for another person whose call bell had been beyond their reach, many people were left in wheelchairs all day rather than being transferred to comfy chairs and a person repeatedly called out, "Help, help, 999" when there were no staff nearby to hear them. Staff appeared hurried when they supported people to eat and were observed standing over them and spooning porridge into their mouths at a pace, with the people seated in wheelchairs.

Rotas for the month preceding this inspection were reviewed alongside information about permanent staff's contracted hours. This showed that night nurse shifts had been exclusively staffed by agency nurses. One of these agency night nurses had worked six, 12-hour shifts (72 hours total) in a row each week. They had also worked nine consecutive nights at one point, totalling 108 hours. This was concerning as these were excessive working hours and the nurse was the only qualified staff on duty to make all clinical decisions relating to people's care and treatment at night; and without clinical support or leadership from the provider. Further analysis showed that in the same four weeks the provider was reliant on agencies for more than 60% of its staffing. Following our inspection, a permanent nurse also needed to be temporarily replaced. The manager confirmed that no replacement had yet been sourced for this nurse, so the agency usage was likely to increase further.

On one day the rotas also showed that there was only one agency nurse on shift during the day and three agency care staff were on shift. This meant that there were only two care staff directly employed by the provider who were on the rota to give care to people. The staffing numbers for that day were lower than assessed as necessary overall and a higher percentage of staff were from an agency.

In response to the staffing issues we highlighted, the registered person said they would bring permanent staff from others of the provider's services to Horncastle House, and send agency staff to replace the permanent ones at those services who donated staff. This was not a robust solution because the care planning and other records at Horncastle House were confusing and misleading and the staff brought in from other services would have no knowledge about people's care needs. Staff would be reliant on the information in records to know what service users needed, how and when, and those records were so muddled that there were significant risks involved in this approach.

The failure to ensure that enough suitably skilled, competent and experienced staff are deployed is a continued breach of Regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. The registered person said they were "Mortified and angry" about the multiple and continuing failings we found during this inspection. They also told us, "The staff are letting us down", but this explanation did not take account of the provider's overarching responsibility to ensure that people received safe and appropriate care. Despite detailed and specific assurances given to the CQC both verbally and in writing, the risk to people from choking had increased rather than been reduced. For example, at the August inspection we observed a person eating their lunch in the dining room seated behind a pillar and without the staff supervision they needed. However, at least if they had choked there was a chance that another person may hear them and raise the alarm. At this inspection the risk to that person was far greater because they had been left completely alone with food and drink in a room where they could not be observed or heard by staff, even from a distance. As a result, this person had been exposed to immediate and avoidable risk of harm.

A combination of issues in the service had significantly increased the risk of harm to people in a range of areas, but the provider had consistently failed to effectively address the problems. There had been no registered manager in the service for almost a year, and temporary management arrangements had been in place until around a month before this inspection. The lack of robust leadership, and minimal clinical oversight, had seriously impacted on the safety and quality of care provided to people. The reliance on high levels of agency staffing meant that people did not always receive continuity in their care; and our inspections highlighted that agency staff often did not know people's needs well. The failure to ensure that information about people's care and treatment was consistent, accurate and correct further increased risks that staff would not have the right guidance about individual needs. The lack of meaningful auditing and supervision of staff practice by the provider and management team was also a contributory factor in allowing poor care to continue unchecked.

Aside from choking, we continued to find concerns about staffing, call bells, falls and hydration management, pressure-relieving equipment, environmental risks and care records which created risks to people that the provider and management team had not sufficiently mitigated.
The provider's response to previous CQC inspection findings had been wholly inadequate, had not addressed our concerns, and demonstrated that learning from them had not been used to improve the service. Managers told us about signs they had put up to remind staff about important aspects of people's care. However, these had failed to result in people receiving the right care and, in any event, were no substitute for proactive checking processes to ensure that staff were following accurate guidance.

The failure to assess, monitor and mitigate risks relating to the health. Safety and welfare of service users is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Managers told us that auditing had increased in the service but this had failed to identify the many areas of concern and continuing breaches of regulations we found during this inspection. Managers' daily walkaround checks had been recorded. At our last inspection we fed back that these were limited to mainly

environmental checks, and at this inspection some new areas to audit had been added. However, the audits remained ineffective because those we reviewed had not been fully completed, with many questions left unanswered by the manager carrying them out. Despite our clear and detailed feedback and reporting about choking and hydration risks specifically, at the last inspection, the walk around checks did not include any observation of staff practice or of fluid charts (other than to see that the use of thickener had been transposed to them).The lack of any effective audit of choking and hydration risks resulted in people being placed at an extreme level of potential harm as care plans were not clear, staff were not following guidance from healthcare professionals, and poor practice was not identified and put right.

The failure to assess, monitor and improve the quality and safety of the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given and on every website operated by or on behalf of them. This is so that people, visitors and those seeking information about the service can be informed of our judgments. At our last inspection, the provider's website gave the rating assigned to Horncastle Care Centre and not Horncastle House. This could cause confusion to those seeking information about the service as the provider was displaying a better rating than the one they were had been awarded for Horncastle House. At this inspection, the situation had not changed and the incorrect rating continued to be displayed.

This is a continued breach of Regulation 20A of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

It is a statutory requirement that CQC is notified without delay of certain events which may happen in registered services. The provider had failed to notify us of a death which had occurred more than two weeks before our inspection.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection, a poor culture had been developing amongst the staff team. At this inspection we continued to be concerned about poor staff practice, such as a nurse giving a person food while they were lying flat and care staff standing up while spooning porridge into people's mouths. People were also left sitting in wheelchairs for large parts of the day rather than being transferred to comfortable seating, and some people were seen calling out for help whilst staff walked past them. All these situations happened when staff were aware that they were being observed by inspectors. They did not appear to see anything wrong in their actions and did not challenge or question each other's practice. This was evidence that the culture in the service was deteriorating and had not been effectively picked up or addressed by the provider or management team.