

Bexhill Care Centre Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on the 3 December 2018 and was unannounced.

We inspected this service in July 2017 and found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Registration Regulations 2009. The provider had not ensured people received safe care and treatment; records were not up to date and people had not received personalised care and support and the quality assurance system had not been effective as it had not identified areas where improvements were needed. The overall rating was inadequate and the service was put in 'special measures'.

At the last inspection in February 2018 we found improvements had been made and the provider had met the legal requirements. However, some areas needed further improvement and time to ensure they were part of everyday practice at the home. The overall rating for the service was Requires Improvement.

At this inspection we found the improvements had not been sustained and there were breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The quality assurance system had not been effective as it has not identified areas where improvements were needed. For example, medicines were not managed safely and people had not consistently received their medicines as prescribed by medical practitioners. Care plans had not reflected people's individual assessed needs and there was no clear guidance for staff to follow to provide personalised care and support.

Risk had been identified and systems were in place to reduce these, but the provider had not ensured these were followed and risk was reduced as much as possible. Accident and incidents had been recorded. However, the provider had not investigated the causes or implemented changes, which meant lessons had not been learnt and plans had not been put in place to prevent a re-occurrence.

This is the fourth comprehensive inspection where improvements were needed under the key questions safe, responsive and well led and the overall rating remains Requires Improvement.

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

The home is registered to provide nursing and personal care and accommodation for up to 41 older people. At the time of the inspection there were 24 people living in the home. 22 people in Poppy unit and two people in Lavender unit. Some people were living with dementia and needed support with personal care and others had more complex needs, which required nursing care.

The service did not have a registered manager. A manager had been appointed six weeks prior to this inspection and they said they were completing their application to register with CQC as the registered

manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we rated the service 'Requires Improvement'. We found improvements were needed to ensure there was an adequate process for assessing and monitoring the quality of the services provided and to ensure that records were accurate and complete. The provider has been rated 'Requires Improvement' four times and we have determined they are not meeting the regulation in relation to Governance because of this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff knew people well and were kind and caring as they assisted people to move around the home safely. They respected people's preferences and encouraged them to make decisions about their day to day lives and be as independent as possible.

Staff had completed training, including safeguarding and moving and handling, and were supported to develop their practise through regular supervision. People and relatives said staff provided the support and care they needed and comfortable in their care.

People said the food was very good; they were offered choices for each meal and staff provided assistance when required. Relatives and visitors were made to feel very welcome and people were supported to keep in touch with them.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Previous improvements in the management of medicines had not been sustained and people had not always received their medicines safely.

Risk had been assessed but staff had not followed current guidelines and were unable to ensure risk was reduced as much as possible.

There were enough staff working in the home and robust recruitment procedures meant only suitable staff were employed.

The home was clean and well maintained and staff followed infection control guidance to reduce risk.

Is the service effective?

Good ●

The service was effective.

Staff understood the Mental Capacity Act and enabled people to make choices about the care they received.

Staff were supported to develop their practice through ongoing training and supervision.

People were encouraged to maintain good health, through nutritious meals and sufficient fluids and access to health professionals when needed.

Is the service caring?

Good ●

The service was caring.

People were supported to make decisions about the support and care provided and staff had a good understanding of their individual needs and preferences.

Staff treated people with respect and offered support in a kind and caring way.

Relatives were encouraged to visit people as often as they wished and were involved in discussions about people's support needs and how these would be met.

Is the service responsive?

The service was not consistently responsive.

Care plans had been written with people and their relatives, but they did not consistently reflect people's individual needs and there was no clear guidance for staff to provide personalised care.

A range of group and one to one activities were available for people to participate in if they wished and people enjoyed doing these.

People and relatives knew there was a complaints procedure and had been encouraged by the manager to raise any concerns.

Requires Improvement 

Is the service well-led?

The service was not consistently well led.

The quality assurance systems was not effective and additional work was needed to ensure all aspects of the services provided were monitored to identify areas for improvement.

The manager was working with the provider and local authority to identify and prioritise improvements.

Feedback was sought from people, relatives and staff and meetings had been set up to encourage them to put forward suggestions and work together to develop the service.

Requires Improvement 

Bexhill Care Centre Limited

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 checked 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 3 December 2018 and was unannounced. The inspection team consisted of 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.

Before the inspection we looked at the information we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager, about events that occurred at the service. We also reviewed the information sent in by the provider and registered manager in the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service; such as what they do well and any improvements they plan to make. This had been completed by the previous registered manager and only included limited information.

We spoke with 10 people, four relatives and 12 staff; including the manager, nurse, care staff, chef, activity staff, maintenance staff and housekeeping staff.

We reviewed records, including four care plans, three staff files, medicine records and accidents and incidents, policies and procedures and audits.

We asked the registered manager to send us the training plan, supervision programme, staff rota, the activity programme, the safeguarding referral and the action plan when it had been completed. These were sent following the inspection.

Is the service safe?

Our findings

At our previous inspections in December 2015, February 2016, December 2016 and July 2017 we found the provider had not ensured safe care and treatment for people and, there was a breach of Regulation 12, Safe care and treatment in July 2017.

In February 2018 we found the breach had been met and there was some evidence that some improvements had been made. Nurses had taken responsibility for the management of medicines and risk had been identified and action taken to reduce risk as much as possible. However, additional work was needed to ensure people received their as required medicines when they needed them and the improvements were embedded into practice. This key question was rated Requires Improvement.

At this inspection we found that the improvements in the management of medicines had not been sustained; the provider had not ensured people were protected from risk, which was a breach of Regulation 12, Safe care and treatment. The rating remains Requires Improvement.

Nurses had not followed current good practice guidelines regarding medicines and people had not always received their medicines as prescribed. We looked at the insulin prescribed for three people. Following discussions with the GP there had been a change to the amount of insulin prescribed for one person. This had been recorded in the care plan but had not been added to the MAR. The care plan stated insulin should not be given if the person's blood sugar level was below 10mmol. We saw from the MAR insulin had been given three times over a six-day period when the blood sugar level was below 10mmol. The nurse on duty at the time of the inspection knew about the change, however, this information had not been passed on to other staff responsible for giving out insulin. The MAR had not been updated to reflect this information. This meant the person received insulin when they had not needed it, which put them at risk of harm.

The guidance for staff to follow when giving 'as required' (PRN) medicines was not clear. PRN medicines were given when people needed them, such as paracetamol for pain. Medicines were prescribed as PRN, but staff had not included in the guidance exactly when and why they should be given. For example, one person had Lorazepam, for anxiety; paracetamol for pain relief and Senna for constipation prescribed on a PRN basis. However, there was no guidance about when the medicines should be given or what staff should look for before giving them; particularly as some people were living with dementia and may be unable to express their needs verbally. There was no indication on the guidance for changes in body language or expressions that might give staff some indication that the person needed the medicines. The provider had not ensured people received their medicines consistently or when they needed them, which may have had a negative impact on their health and well-being.

The manager told us there had been audits of the MAR and an overview of the management of medicines to ensure they were appropriate. We looked at the recent audit carried out the week before they inspection and found the issues we identified had not been picked up. We asked the manager to refer the concerns we found with medication to the local authority in line with safeguarding procedures.

Risk assessments had been completed depending on each person's needs. This included assessing risk of pressure sores and the use of pressure relieving mattresses to reduce this as much as possible. The setting for some mattresses was based on people's weight, we found these were not all at the correct level and therefore the mattresses did not offer appropriate protection. Staff said they were required to check the level daily, but there were no records to show this was consistently done.

Staff said they completed accident/incident records when these occurred and assessed what had happened to try and prevent it happening again. Records showed staff had recorded the accident/incident but there was no information for staff to follow to prevent or reduce the risk of a re-occurrence. There was no overall analysis of accidents/incidents, staff were unable to show they had identified trends, that lessons had been learnt and improvements had been made to reduce risk.

The provider had not ensured safe care and treatment for people. Medicines were not administered in accordance with the prescriber's instructions and in line with people's care plans. Where risk had been identified staff had not followed current guidance to reduce the risk as much as possible and there was no clear system to identify trends or reduce accidents and incidents to protect people. This is a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The corridor in Poppy unit was being redecorated at the time of the inspection. Tape had been used to secure part of the flooring. The tape had peeled back in some areas and the floor was uneven, which put people and staff at risk of tripping or falling. Maintenance staff replaced the tape during the inspection and staff said the flooring was being replaced when the re-decoration had been completed. The home was clean and staff followed appropriate infection control procedures, including using gloves and aprons when needed to reduce the risk of infection. The fire alarm system was checked weekly, staff attended regular fire safety training and personal emergency evacuations plans (PEEPs) enabled staff to support people to leave the building safely if there was an emergency. The home was well maintained and checks had been completed to ensure facilities were safe to use. Such as the lift, hoists, water temperatures and electrical equipment, including TVs and radios people used in their rooms.

People told us they were comfortable and staff provided the care they needed. One person told us, "I love it here, I could not be happier." Relatives were equally positive and said, "There is so much kindness and nothing is too much trouble" and "We know he's in good hands, we've never had any concerns over safety." Staff had completed safeguarding training and explained what they would do if they had any concerns. One member of staff pointed out the contact details for the safeguarding team was displayed in the office and said, "I don't have a problem reporting anything I don't like. It is our job to look after residents although I haven't had to." Another member of staff told us they had read the whistleblowing policy as part of their induction training and were sure the senior staff would want to know about poor practice, "If it happened." Safeguarding referrals had been made to the local authority and records showed the staff worked with the safeguarding team to ensure issues were identified and appropriate action taken to protect people if needed.

We started this inspection at 6.20am to assess the staffing levels for nights and days. There was one nurse and two care staff on the night shift, with 22 people in Poppy unit and two people in Lavender. One of the people in Lavender was independent and preferred not to be checked during the night. Staff said they checked hourly on the person who needed support in Lavender unit. Staff signed the form in the person's room to evidence this had been completed. Staff said there were enough of them on nights to provide the care people needed and most people were asleep when we arrived. The home was quiet and staff offered assistance only if people needed it or were awake.

People and relatives spoke positively about the staff. People said, "They look out for us", "They wait on me hand and foot, I love it" and "Yes there are enough staff." A relative told us, "He receives phenomenal care, some of the staff have known him for three years now." People and relatives raised concerns about the staffing levels and the high turnover of staff while their family member had lived in the home. Two senior care staff said they were leaving before Christmas and people had some concerns about this. From discussions with staff, the manager and our observations it was clear senior care staff organised the allocation of care staff and the provision of support provided on a day to day basis. The manager said during and after the inspection that staff had been employed to cover for the care staff who were leaving and nurses had also been recruited, to ensure there were enough staff with the skills and knowledge to provide the care people needed.

Robust recruitment procedures ensured only suitable staff were employed. Relevant checks had been completed and staff files included application forms, two references, interview records and evidence of their residence in the UK. A Disclosure and Barring System (Police) check, which identify if prospective staff can work in the care sector, had been completed for all staff. Confirmation had also been sought from the Nursing and Midwifery Council (NMC) that nurses employed at the home were registered with the NMC to provide nursing care.

Is the service effective?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and had completed the training. The 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Staff knew how to make referrals to the local authority if required and referrals had been made, or advice had been sought, and related assessments and decisions had been properly taken. Staff explained how people were assisted to make decisions about all aspects of their lives and we observed staff asked people if they wanted to sit in the lounge, where they wanted to sit, if they were comfortable and if they had everything they needed. One member of staff told us, "All the residents can make choices, some more than others because they do not have dementia, but everyone decides when to get up, what they want to eat and if they want to do activities." One visitor said staff understood their friends needs and, "Allow him to do what he wants."

Regular training and updates had been arranged, this included, dementia awareness, safeguarding, infection control, food hygiene and health and safety. Staff said they were required to complete the training provided, they were aware of their roles and responsibilities and were supported to develop their practice through regular one to one supervision. People's needs had been assessed; support was based on each person's individual preferences and was provided in line with current guidance. Staff demonstrated a clear understanding of people's right to appropriate care, irrespective of their age, sex or disability and had completed relevant training, to ensure they were up to date with their practice. Relatives said they knew staff had attended training and one relative told us the staff were, "Skilled and adequately trained."

Staff completed induction when they first started work at the home. One member of staff said they had started with an introduction to the home, people and staff, with details of fire safety and what they should do if the fire alarm went off during their first day. One new member of staff had been given the induction workbook and would be working through this over the next few weeks. They had completed the first day of induction and were working with senior staff during the inspection. They had experience of working in the care sector and spent their second day learning more about people's specific needs, assisting people to get washed and dressed with senior care staff and supporting people with meals. They told us, "It is a nice home to work in and I am looking forward to getting to know the residents and their families." The manager said new staff would be expected to do the care certificate if they had no previous experience and had not completed national vocational qualifications. The care certificate is a set of standards that health and social care workers adhere to in their daily working life and they had assessed them for each module to ensure they had the knowledge and competency to meet people's needs.

The chef was very aware of people's food and drink preferences; meals were provided based on each person's likes and dislikes and specific dietary needs were met. For example, for people with diabetes. There were at least two choices for each meal and people could have something else if they changed their minds. People and relatives said the food was good. One person told us, "The food is very good yes I have no complaints." Another person said, "They come with drinks on a regular basis, tea, coffee and juice." Relatives told us, "It is well balanced to meet their needs", "The cook is fabulous, I've eaten here before and he makes cakes for our resident's meetings, they are very good" and "The food is great."

People chose where they wanted to sit for their meals, some remained in their bedroom while other sat in the lounge. Condiments, napkins and drinks were provided and staff prompted or assisted people to eat them meals as required. People were encouraged to have enough to eat and drink. People were weighed monthly, or more often if there were any concerns and staff recorded how much people ate and drank to assess if they needed additional support or a referral to the dietician. The chef said fortified meals were made when needed and these included additional cream and cheese for extra calories. The atmosphere in the lounge during meals was relaxed and sociable, staff chatted to people as they assisted them, asked if they had enough and if they were enjoying the meal.

People were supported to be as healthy as possible and received healthcare assistance from professionals when they needed it. One person said, "Yes the doctor comes and they look after my feet." A visitor told us their friend and said they had seen their GP and a relative told us, "All medical professionals have been welcomed, they really are great and supportive with that sort of thing." Records showed that visits to the home had been arranged for GPs, chiropodist, dietician, speech and language therapist (SaLT) and mental health team as needed. The visits were included in the care plans and guidance had been added to ensure staff were aware of any changes. For example, when a person's ability to swallow had been assessed by SaLT and advice included changes to their diet, such as mashable or pureed, depending on their needs.

People's individual needs had been met by adaptations to the home and equipment was provided to ensure they were as independent as possible. People's rooms had been personalised, with photographs, furniture and pictures. One person who enjoyed playing the piano had a keyboard in his room and another resident enjoyed knitting. Bexhill Care Centre is two buildings connected through a short link corridor on the ground floor. People accessed their rooms and communal areas using the lifts when needed and, there were slopes and ramps which enabled people to use the gardens when weather permitted. The manager said changes were planned to improve the environment in Poppy unit and the walls were being painted during the inspection.

Is the service caring?

Our findings

At our last inspection this key question was rated Good and this inspection found it remained Good.

Conversations between people, relatives, visitors and staff were relaxed and comfortable. There was friendly banter when appropriate and staff supported people in a kind and caring way. People said, "The carers are wonderful, they are just wonderful", "I only need a bit of help now and then, but it's nice to know they are here" and "They always greet me with a smile, they're lovely." Relatives were equally positive and one told us staff had responded to their family members changing needs, "And are still treating her with the respect they did before."

People were supported to make decisions and be in control of their day to day lives as much as possible. If necessary assistance was sought from relatives or health and social care professionals so that the support and care provided was what people wanted. One member of staff said, "Residents who have dementia may not be able to tell us what they want so relatives can be involved in planning care. It helps us build up a picture of people's lives, what they did and what hobbies they have, so we can plan activities as well." A relative said they were involved in decisions about the care their family member received; they could visit at any time and staff always asked for their opinion about the person's needs. Relatives told us, "They are all very friendly, when I come in, all very welcoming and have got to know me as well" and "I would not have her anywhere else, the carers are wonderful." Relatives knew there was a 'resident of the day'; which meant each person's care and support, including records were reviewed regularly with relatives, if they wanted to be involved.

Staff had a good understanding of equality and diversity and provided personalised support in line with people's preferences, rights and beliefs. Staff spoke knowledgeably about people's life stories, their families, interests, hobbies and their work. We saw staff treated people with respect and were kind and caring as they assisted them with personal care and to move around the home safely. Staff asked people where they wanted to sit, if they chose to use the lounge; they checked people were comfortable, offered a drink and assisted them if necessary. Staff said people decided where they spent their time, some preferred to remain in their rooms. Staff respected this and told us, "We drop in to see them regularly throughout the day, to check they are ok and ask if they need anything" and "We offer residents choices. Like where they want to sit, depends on how they are feeling and if they want to join in activities. It is up to them and we support them to do what they want." Staff said they filled in the daily sheets to show they had checked on people who chose to remain in their room. We observed staff chatting to people who remained in the rooms and the records had been completed to evidence this.

Records were kept secure and staff were aware of the General Data Protection Regulation (GDPR) which came into effect in May 2018. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy. Care plans and other records were stored in the office in the lounge.

Is the service responsive?

Our findings

At our inspection in February 2018 this key question was rated Requires Improvement. This was because improvements were needed to ensure care plans reflected people's individual needs and there was clear guidance for staff to follow to provide personalised care. At this inspection we found some improvements had been made, but additional work was needed so that people received care that was specific to their needs and there was clear guidance for staff to follow when providing support. The rating remains Requires Improvement.

This is the fourth comprehensive inspection where we have found that improvements were needed, so that records were correct and personalised care was provided.

Staff said the care plans had been reviewed and updated when people's needs changed and there was guidance for staff to follow when providing support. However, the care plans had not consistently been reviewed and updated and the guidance for staff had not included clear information about how staff should provide the support people wanted and needed. For example, one person's care plan stated they had 'no emotional needs' and were 'stable' and 'no challenging behaviour or risk to others'. Although the health professional's mental capacity assessment stated, 'recurrent depression' and the DoLS referral had been made because the person had tried to leave the building and their behaviour had challenged their own and staff safety. There was no guidance in the care plan for staff to support this person if their behaviour changed, such as distracting them by offering a drink or talking to them about an interest of theirs. Staff told us the person's behaviour had settled and they were more comfortable living in the home, the care plan had not been updated to reflect this. From our observations staff had not responded promptly to requests for assistance from the person and were not clear about how they would reduce the person's distress about living in a care home.

Care staff recorded the support provided in the daily records, which were checked by the nurse to ensure they reflected the care accurately. We looked at the daily records linked to the care plans we reviewed. We found the daily record for one person stated they had eaten their supper and returned to bed. We observed the person remained in the armchair in their room and supper had not been provided. When asked staff said they did not know why they had completed the daily records before care was provided.

People's different communication needs were recorded in the care plans; however, records were contradictory and did not show exactly how people should be supported to communicate their needs. For example, in one care plan it stated the person was 'able to communicate their needs' and 'has a good understanding'. However, the records also stated the person did not have the mental capacity to make decisions and ensure their own needs were met. The manager said additional work was needed on the care plans and record keeping and agreed it was an area that required improvement. The manager said they would review the training for Accessible Information Standard and arrange updates as required so all staff had a clear understanding of how to enable people to communicate their needs, with staff and health and social care professionals.

Senior staff visited people to talk about their needs, with their relatives if appropriate, before they were offered a place at Bexhill Care Centre. One member of staff told us, "So we know what support they need and we can be sure we can look after them properly." Records showed the assessments included information about people's medical history, communication, mobility and social needs and were used as the basis of the care plans. Staff said care plans were written with people and their relatives, "We can discuss what their needs are, what they want and how we can look after them. It is their home." One person told us they were very involved in their care plan, they were aware of their individual needs and told staff if they want something changed. Relatives said they knew their family member had a care plan; they had been involved in discussing the person's needs and how best to meet them. One relative told us, "We all work together for the best for him."

A range of activities were available for people to take part in if they wished. Activity staff said they provided group and individual activities and had arranged for external entertainers, including musicians, to entertain people. A relative told us, "She used to love activities, the karaoke especially we've been to the garden party once, that was excellent." Staff asked people how they wanted to spend their time and those in the lounge joined in a number of activities. They chose the TV programmes they wanted to watch and a film was played during the afternoon. One person played the piano for people in the lounge, they enjoyed playing the songs requested and people joined in when they knew the words. People also helped the activity staff to decorate the Christmas tree in the lounge, they chose the colour of the decorations and pointed out where they should be displayed and clearly enjoyed themselves. People were supported to remain in their rooms if they wished. One person told us, "I don't have any hobbies. I just watch TV and stay in my room." Another person liked to paint, they could do this in their room and it was their choice not to join in with activities. Broadband was available for people to use to email friends and relatives or order things they wanted on line, this enabled one person to continue to enjoy their hobby and be independent. Activity staff said they respected people's choices, whilst also telling them what activities had been arranged and asking them if they wanted to join in.

People and relatives said they would talk to staff if they had any concerns. One relative said they did not have any complaints, but had pointed things out to staff, they had changed their practice and their family member was very well looked after. The manager said their door was always open and they were available to talk to people, relatives and visitors at any time. They told us, "I encourage residents and their relatives to talk to me, if they have a complaint I urge them to talk to me so that I can sort out any problems." Staff said people and relatives were asked for feedback about the care and support provided daily. One member of staff told us, "We always ask residents if they are comfortable, if they need anything else and we know some residents cannot tell us so we ask their relatives. We hope they will tell us if they are not happy, we are here to look after the residents and their families."

Staff said they had completed training to support people when their health needs changed and they needed end of life care. One member of staff told us, "Residents and their relatives decide what is best for them, we know some want to stay here rather than go to hospital and we have discussed this with their GP and this has been agreed." People's preferences were recorded in their care plan, these included do not resuscitate forms that they or their relatives had signed. One relative told us, "We have agreed that she stays here and just go peaceful in her room with people she knows, even if I am not here, I know a familiar face will be."

Is the service well-led?

Our findings

At our previous inspections in December 2015, February 2016, December 2016 and July 2017 we found the provider had not ensured the quality assurance was effective. It had not identified areas where improvements were needed and, there was a repeated breach of Regulation 17, Good governance in July 2017. In February 2018 we found the breach had been met and there was some evidence that some improvements had been made. The quality assurance system had been reviewed and where areas for improvement had been identified action had been taken to address them. Although additional work was needed to ensure these changes were embedded into day to day practice. This key question was rated Requires Improvement.

At this inspection we found the improvements had not been sustained, the quality assurance system was not effective as it had not identified the areas of concern we found and there was a repeated breach of Regulation 17 Good governance. The rating remains Requires Improvement.

This is the fourth comprehensive inspection where we have found the quality assurance system was not effective; areas where improvements were needed had not been identified and the service had not improved. Issues identified at this inspection had been identified at previous inspections. Although these had been addressed at the time these had not been embedded into everyday practice. The provider had not ensured the governance system enabled improvements to be sustained, embedded and developed. There was limited evidence of learning from previous issues.

The manager had been employed at Bexhill Care Centre for six weeks at the time of the inspection. He had worked with the previous registered manager for two weeks and had been responsible for the day to day management of the home for four weeks. He said he would be registering with CQC as the registered manager and was very clear that he was looking forward to improving people's lives at the home. The application had been received by CQC and was being processed.

A quality assurance system had been in place and was used by previous managers. However, audits to identify areas where improvements were needed had not been carried out since October 2018. We found there was not an adequate process for assessing and monitoring the quality of the services provided; to ensure that records were accurate, complete and included clear guidance for staff to follow to meet people's needs, which may put people at risk of harm. The management of medicines was not safe and had not ensured people had their prescribed medicines when they needed them. For example, there was no guidance for staff to follow when assessing if people living with dementia were uncomfortable and needed pain relief. In addition, the medicine audit that had been carried out just prior to the inspection had not identified the areas of concern we found.

Care plans had not clearly reflected people's individual needs and care was not personalised and planned effectively to meet these. For example, one person was confused about why they were living at Bexhill Care Centre and they became distressed as we talked to them during the inspection. Their care plan had not identified they may be confused at times and there was no guidance for staff to follow to alleviate their

distress and, staff were unable to explain how they supported the person to be comfortable at the home.

We found one person's bedroom was bare, with only the basic furniture, an armchair and a TV. There were no familiar objects, books or magazines; when asked staff were unable to explain why the room had no personal items and there was no information in their records to support this. This was discussed with the manager who said they would talk to the staff and the family, to clarify why the room was bare.

This is the fourth time the 'well-led' question has been rated requires improvement. The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support and to ensure changes made were embedded and sustained. This is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager said he had been working through the available quality assurance records and said they had not covered all the areas he felt were essential. He said new audits would be introduced and the first would look at care plans and supporting documentation, the management of medicines and accidents and incidents and nurses would be involved in developing these.

An action plan was being developed to prioritise the areas where improvements were needed and some changes had been made. For example, the use of agency staff had been reviewed; they were no longer employed on a regular basis and new staff had been recruited. The number of hours staff worked had been reduced from 48 to 42 and the manager said there had been some changes in the shift pattern to ensure there were enough staff with the right skills working in the home at all times. The feedback from staff was that it was better if permanent staff were working at the home, because they understood people's needs and knew their relatives as well.

The manager had started 'heads of' meetings to discuss all aspects of the services provided each morning. We joined the home's manager, housekeeping manager, chef and maintenance person as they talked about their area of responsibility and any concerns or suggestions they had as to how the service could improve. They all thought the meetings were a good idea and kept each department head up to date with any planned changes and how these could be arranged so they had limited impact on people and staff. For example, the re-decoration of the corridors in Poppy unit. The manager had also appointed a 'clinical lead' to review the management of medicines and support nurses to develop the care planning process, to ensure records were correct and reflected people's needs accurately. The manager explained the clinical lead had only just started work at the home and was still going through their induction.

These changes had been discussed and agreed with the nominated individual. A nominated individual (NI) is the responsible person within the organisation. In addition, the manager had contacted the market support team from the local authority to discuss his plans and seek advice about how they felt the service should improve. The manager clearly understood there was a lot of work to do to bring about the improvements needed to change the rating for this home.

Feedback from people, relatives, visitors and staff about the care and support provided was positive. Although relatives had some concerns about the change of management. They told us, "My concern is the staffing issue, so I hope the new manager is able to keep the good staff", "The ones I like the most have got to know Dad, I just hope they stay" and "I must say the new managers door is always open." The manager said he had set dates aside for residents/relatives and staff meetings and planned to ask them about improvements they wanted at the home and to explain his philosophy of care and how he saw the service

developing. One relative told us the residents/relatives meeting had been arranged for the day after the inspection and they were looking forward to meeting the manager.

A relative's support group had been set up at the home. They met monthly to have a chat, 'share stories, advice and have a good cry', if needed. One of the founder members said they had invited the new manager and the administrator to the first 10 minutes of the next meeting so they could introduce themselves. The group had started with three family members and currently had 11 members, which they felt was a very positive development.

Staff also said the manager was available at any time to talk to and worked with them if needed. One member of staff told us, "He starts work early and stays late if needed and seems really interested in how we feel and that we are able to look after residents." Another member of staff said, "He always asks the residents how they are and asks us if we have everything we need. Which is quite nice."

The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to, it requires providers to be open and transparent and sets out specific guidelines providers must follow if things go wrong. Notifications had been submitted to CQC about events or incidents they are required by law to tell us about.

There were two websites for Bexhill Care Centre on the internet. Both included information about the services provided and have a link to a facebook page where picture of activities were available to view. However, only one had the current CQC rating for this service, which is required by law. Staff said they manager was aware of this and they were combining both to ensure appropriate information was clear to see.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured safe care and treatment for people. Medicines were not administered in accordance with the prescriber's instructions and in line with people's care plans. Where risk had been identified staff had not followed current guidance to reduce the risk as much as possible and there was no clear system to identify trends or reduce accidents and incidents to protect people.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support.</p>