Reed Care Homes Limited

Nayland Lodge

Inspection report

44 - 46 Nayland Road
Mile End
Colchester
Essex
CO4 5EN

Tel: 01206853070

Date of inspection visit:
27 June 2023
06 July 2023

Date of publication:
12 October 2023

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Nayland Lodge is a residential care home providing accommodation for up to 8 persons who require nursing or personal care. The service does not provide nursing care. The service provides care and support to people who may have a learning disability or mental health condition. At the time of our inspection there were 8 people using the service.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

This was a targeted inspection that considered the areas of safe, risk, management, and governance. Based on our inspection of these areas we found the provider did not have effective oversight and governance to drive improvement in a timely way and breaches of regulation continued.

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

We found the provider had failed to respond effectively and promptly to our concerns; very little pro-active action had been taken to drive, embed and sustain improvement for people and stop previous breaches from continuing or re-occurring.

The service was not well-led. The provider failed to carry out their regulatory responsibilities and did not have adequate oversight of the service. They lacked recognition and understanding of risk and subsequently lacked robust assessments and controls to protect people and keep them safe. There was a high number of incidents requiring police intervention and a failure to identify and act on where things were going wrong.

There were no clear management systems followed in practice to ensure safe staffing levels. New and inexperienced staff members were not sufficiently supported to deliver safe and appropriate care. Learning and development was not managed and planned in a way that ensured staff had the opportunity to build on their knowledge base and develop their skills to carry out their roles and meet people's specific needs.

The service was not meeting the underpinning principles of Right support, right care, right culture.

Right Support: People did not receive the right support to maximise their choice, control, and independence. There were not enough staff to meet people's assessed needs and commissioned support arrangements. This meant people did not lead fulfilling and meaningful everyday lives that promoted their wellbeing. The model of care did not focus on people's strengths or promote what they could do. Limited information was available about people's aspirations and goals and how staff could support them to

achieve these. People did not receive a safe, interactive and stimulating service.

Right Care: Gaps in staff training, supervision and competency checks did not ensure people were cared for by staff with the necessary skills, knowledge, and expertise to deliver the right care and support. Care delivered was not person centred and did not promote people's dignity, independence and safety.

Right Culture: The culture of the service did not empower people to lead their best life. Leaders and care staff did not demonstrate values, attitudes and behaviours that ensured people at Nayland Lodge led confident, inclusive, and empowered lives. Staff were unable to demonstrate their understanding of 'Right support, right care, right culture' guidance and how this should influence the support people received.

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 rating for this service was inadequate (published 1 February 2023) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had not made enough improvement and remained in breach of regulations.

This service has been in Special Measures since December 2022.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. We also checked compliance with Regulation 13 and 18. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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

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.

Enforcement
We have identified continued breaches in relation to safeguarding, staffing, staff training, risk management and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will

re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

Inspected but not rated.
At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

Inspected but not rated.
At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Nayland Lodge

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.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 Safe care and treatment and Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 team consisted of 2 inspectors.

Service and service type
Nayland Lodge 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. Nayland Lodge 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post

for a year and had applied to the CQC to register. We are currently assessing the application.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 13 June 2023 and ended on 12 July 2023. We visited the service on 27 June 2023 and 6 July 2023.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority safeguarding and quality team, and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service. We looked at records in relation to 4 people's care.
We also spoke with the director of the company, the manager and 4 staff members. We looked at records relating to staffing, recruitment, training and development of staff, management of the service and systems for checking the quality and safety of the service.

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

Inspected but not rated

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 inadequate. This meant people were not safe and were at risk of avoidable harm. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to provide care and support to people in a safe way. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of Regulation 12.

● Risks associated with people's support needs were not adequately identified in their severity or managed safely. There was a failure to recognise and understand the root cause of people's heightened behaviours and deterioration of their mental wellbeing. In some cases, actions taken by the provider and manager impacted on people's mental health. For example, serving warning notices of eviction instead of providing the right level of support.
●People's risk assessments and risk management plans did not specify how staff were to support people safely and effectively to meet their needs and mitigate risk in a planned, agreed, and consistent way.
● Fire safety arrangements were not robust. The provider was unable to demonstrate a suitable and sufficient fire safety risk assessment had been carried out by a person qualified and competent to do so. The fire safety risk assessment in place failed to consider safety risks relating to the occupants, the potential for a fire to occur and the harm it could cause to people. It also failed to review and consider existing fire safety measures to establish whether they were still adequate or if more was required to be done.
● Personal emergency evacuation plans (PEEPS) were limited in detail and did not consider essential information for a safe evacuation such as the person's level of awareness and co-operation, or any prescribed medicines that may cause drowsiness or emollient creams that can be a fuel source.

Preventing and controlling infection

Our last inspection identified poor infection prevention and control (IPC) measures and practices.

● This inspection found the communal areas of the home to be cleaner. Care and support staff were having to include additional enhanced and more frequent cleaning schedules as well as regular daily cleaning in a

shift. Records showed there were days when cleaning was missed which meant this level of cleaning could not be sustained.
● Some people's bedrooms did not support good infection control due to their complex needs and the inability of staff to support them.

Using medicines safely
● Senior staff were given the responsibility to improve medicine management. However, people's medication administration records (MARs) and associated documentation were torn, had come loose from the folder and were in a disorganised state, which made management unsafe.
● People prescribed as and when required (PRN) medicines for the short-term relief of severe anxiety did not have informative plans in place. There were no detailed positive strategies to be used first and identify at what point staff should resort to PRN medicine, amount and how often, to ensure they received it appropriately.
● Weekly medication audits continued to identify errors in stock count and record keeping but failed to show what action had been taken with those staff responsible to identify root cause and/or prevent them re-occurring.
● We were told all staff who administered medicines had completed training and had their competency assessed. The manager was unable to evidence this.

The providers failure to provide care and treatment in a safe way including recognising and mitigating risk, medicine management and infection control and prevention, placed people at risk of receiving unsafe care and support. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we had not served a warning notice in relation to Regulation 13 and 18 we also reviewed these regulations because the provider was in breach at our last inspection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider lacked effective systems and processes to keep people safe from harm and risk of abuse. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) 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 13.

● Safeguarding incidents were not well managed or appropriately reported. There was a culture in the service of not recognising incidents as safeguarding concerns and alerts to the local authority and statutory notifications to the Care Quality Commission were not appropriately made. No pro-active actions or lessons learned arose from incidents which meant there was always a risk of them reoccurring.
● People and others were not always kept safe from the risk of harm because staff were not being given the training that enabled them to meet the needs of, and/or effectively safeguard people. Staff continued to tell us they were not equipped to manage people's distressed behaviours that posed a risk to themselves and others.
● Since our last inspection the manager had completed training to become a trainer to deliver de-escalation training and physical intervention training to staff. Staff confirmed the manager had not delivered this training to them. The manager told us they had not had time to deliver the training, nor did they feel sufficiently competent to do so.

● The provider did not have an effective and robust system in place to ensure there was oversight and analysis of incidents, accidents, and people's behaviours. We identified incidents where people expressed heightened anxiety and distress which were avoidable.
● People were not effectively supported, and positive actions were not put into practice when staff faced difficult situations that could potentially cause harm or compromise people's safety. The service experienced a high level of incidents which were referred to the police.
● We were told a director of the company regularly took people out, but the provider was unable to evidence a recent Disclosure and Barring (DBS) check had been carried out for this purpose. DBS checks provide information including details about convictions and cautions held on the Police National Computer. There was no evidence to demonstrate the director had received appropriate training for this role, including safeguarding.

The provider failed to ensure people were protected from harm. This was a continued breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we found there were insufficient numbers of skilled and competent staff to meet people's needs. This was a breach of Regulation 18 (Staffing) 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 18.

● The provider had not ensured safe staffing levels. There were not enough staff with the right skills and competencies to provide the right level of person-centred care to people. This affected the safety and quality of care and support people received.
● The level of staffing and shift patterns were not linked and determined by people's support needs and funding arrangements. People were not receiving their additional funded support hours to ensure they led fulfilled and meaningful life. This impacted on their mental health and heightened their stress and anxiety which placed them at risk of harm.
● The provider had insufficient resources dedicated to keeping the environment clean and fit for purpose. Care staff carried out all the cleaning as well as cooking which took them away from supporting people.
● Not all staff had completed or refreshed e-Learning in core subjects needed to do their job.
● Training for staff remained outstanding in subjects relevant to people's specific needs such as mental health and associated conditions, Oliver McGowan mandatory training in learning disability and autism, positive behaviour support, person centred care, communication, de-escalation, break away techniques and physical intervention.
● The provider was unable to demonstrate how new and inexperienced staff were being supported to create a positive workplace and skilled work force. There was no evidence to show a structured support and supervision system was in place or that robust probationary reviews were consistently carried out during an induction and probationary period.

The providers failure to fully support and develop staff, placed people at risk of receiving unsafe and inappropriate care and support. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The provider had failed for the last 4 consecutive inspections to establish and effectively operate systems and processes to assess, monitor and improve the safety and quality of the service provided to people. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17. The rating remains the same inadequate.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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

- Despite attempts to encourage improvement through enforcement action and assurances given by the provider they failed to respond promptly or effectively to our concerns. The overall quality and safety of the service was not addressed, and breaches of regulations continued. This included staffing, staff training, risk management and governance which all link directly to poor and ineffective leadership.
- The provider continued to not recognise the need for effective and robust governance systems to proactively recognise and act on failings that impact on the safety and quality of service provision. Nor did they have a robust, workable, and sustainable plan to drive improvement.
- The provider had not ensured legal requirements were met. We identified notifiable incidents that had not been reported to CQC in line with the provider's legal responsibilities; we were not assured they had all been referred to the local authority safeguarding team.
- The service has not had a manager registered with the Care Quality Commission for nearly 6 years. Whilst there was a manager in post, they also managed the provider's other care home. This meant Nayland Lodge lacked the consistent, visible management it needed to drive, embed, and sustain improvement.
- The provider was not robustly checking staffing levels were appropriate, to assure themselves and other agencies they had enough staff with the right skill mix to meet people's assessed needs and keep them safe. In addition, ensure there were enough staff to carry out additional tasks such as cleaning, laundry, and cooking.

● The complexity of people's needs was not considered, and people were not receiving the care and support the provider was contracted and funded to deliver. This meant people's recovery, well-being and optimal independence was not effectively promoted and sustained, and situations were not prevented from reaching crisis point.
● A more comprehensive learning and development plan was needed to enable staff to develop the skills and expertise they needed to carry out their roles effectively.
● The provider had failed to ensure staff had the knowledge they needed to support people safely in line with best practice, nor did staff have the information they needed to ensure the care and support they delivered was safe, responsive, and consistent. Staff told us they had requested training, but this was not facilitated by the provider.
● Staff were not effectively supported. There was a failure to provide regular, good quality staff supervision and time for debriefs and reflective practice. The manager confirmed supervisions for staff was not fully established and therefore staff did not receive the right level of on-going and effective support they needed to create a positive workplace.
● For new staff recruited, particularly those who had no previous health and social care background and/or were recruited from overseas, induction and support systems were poor.
● De-brief meetings had been introduced and were attended by senior staff. Minutes of meetings showed incidents were briefly discussed but there was no review of what preceded the incident, how they were managed, what could have been done better or any lessons learned.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider did not promote a positive person-centred culture and the service provided failed to achieve good outcomes for people.
● There was no clear set of values, aims and aspirations for the service which staff could follow or be a part of. Staff told us they wanted the service to improve but they were unaware of any improvement plan or what their role was within any improvement strategy.
● The provider was not assessing people's experience of care and support to see if they could be improved upon in any way.
● Staff were unable to provide tailored and consistent support because there was not enough guidance in people's plans on how this was to be done.
● People's support plans did not include clear strategies to enhance their independence and did not evidence any future planning or consideration of the longer-term aspirations of each person. Goals and interests were not explored or developed.
● Records of staff and resident meetings were poorly completed with no record of follow up actions and outcomes from one meeting to the next.
● There was a lack of openness and transparency by the provider, they did not lead by example and lacked a commitment to provide high-quality person-centred care.
● Professionals told us they did not always receive accurate information from the service which did not enable effective working in people's best interests.
● There was no evidence to demonstrate the service had engaged in local and national forums or development groups which would assist in gathering best practice knowledge to support improvements in the service in relation to mental health, learning disability, autism and hoarding.
● The provider could not assure us they were meeting CQC's Right Support, right care, right culture (RSRCRC) guidance.

Working in partnership with others

● The provider and manager were unable to show us relevant paperwork and documents upon request. The same information was not forthcoming within a given timescale following our inspection despite repeated requests. The provider did not demonstrate commitment to the inspection and regulatory process.

● The local authority had placed a suspension on commissioning new placements with the service, to enable them to address improvement. There was a reluctance to take up offers of support from the local authority quality improvement team and very little improvement was seen.

● Professionals told us they did not always receive accurate information from the service which did not enable effective working in people's best interests.

● There was no evidence to demonstrate the service had engaged in local and national forums or development groups which would assist in gathering best practice knowledge to support improvements in the service in relation to mental health, learning disability, autism and hoarding.