Care Sussex Ltd

Margaret House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Margaret House on the 31 July and 2 August 2017 and the inspection was unannounced. The inspection of Margaret House had been brought forward due to a number of safeguarding concerns around the management of medicines.

Care Sussex Ltd provides personal care services to older people in their own homes (flats) who live in Margaret House. People live in an assisted living development within privately owned, self-contained one or two bedroom flats. The building is owned by Saxon Weald and a restaurant is on site along with communal areas for people to participate in a range of activities. The Care Quality Commission was only inspecting the care provided by Care Sussex Ltd and not the accommodation or building maintained by Saxon Weald. On the days of our inspection, 33 people were receiving a package of care from Care Sussex Ltd.

At the time of our inspection, a registered manager was not in post. 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. The previous registered manager had left the service in April 2017 and a replacement manager had recently been recruited. On the days of the inspection, they had only been in post four weeks.

The overall rating for Margaret House is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the providers' registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Care Sussex Ltd had been subject to a period of instability. The management team had changed considerably and staff told us they had experienced a turbulent year. The service was experiencing difficulties with recruitment and consequently there was a high use of agency staff. Within recent months, a number of medication errors and missed calls were identified which had led to a number of safeguarding

concerns being raised. These safeguarding concerns were subject to on-going reviews at the time of our inspection. Staff were found to not be following procedures and there was a lack of accountability within the staff team. Staff morale was low which heightened a negative and blame culture. The provider was working in partnership with the local safeguarding team to address these concerns and expressed clear commitment to driving improvement. A new manager had been appointed and staff told us that things were beginning to improve. People also felt that the provider was now taking steps to ease their anxiety and distress. One person told us, "I have met the new manager, it has been pretty good since she has been here, and she deals with things pretty quickly." However, on the days of these inspections, these improvements were not yet embedded or sustained.

Quality assurance processes were not consistently robust in identifying shortfalls with documentation and the provision of care. An overarching action plan was not in place and therefore the provider was unable to monitor any progress being made or have strategic oversight of the actions required to drive improvement. The action plan for the management of medicines had not been reviewed since April 2017 and it was not clear what actions had been completed or were in progress.

Robust risk assessments were not in place and failed to provide sufficient guidance for staff to follow in order for them to provide safe care. The management of diabetes and catheter care was ineffective and placed people at risk of harm. The provider had failed to follow the principles of the Mental Capacity Act 2005 (MCA) and there was a risk that people's legal rights were not being upheld.

The oversight of 'Do Not Attempt Resuscitation' was ineffective and placed people at significant risk of being resuscitated when they were not for resuscitation. The management of medicines was not safe. Allergies were not recorded on people's medicine administration records (MAR charts), medicine risk assessments had not been reviewed or updated following a medicine error and subsequent safeguarding concern. Risk assessments were not personalised and failed to include information on where medicines were stored in people's individual flats. Staff had not consistently been signed off as competent to administer medicines.

Care plans were in place and included an overview of the care calls and the tasks required at each care call. However, care plans had not been reviewed in over a year. Internal reviews of people's package of care had not taken place.

The oversight of people's nutrition and hydration needs was unclear and contradictory which had the potential to place people at risk. Communication between Care Sussex Ltd and the restaurant on site was not effective in ensuring people's dietary needs were met. We have identified this as an improvement that needs improvement.

People felt confident in the abilities of permanent staff. One person told us, "I think they are well qualified and trained." However, people lacked confidence in the skills and abilities of agency staff. Before agency staff worked for Care Sussex Ltd, the provider received a profile of their training. On the first day of the inspection, we identified one agency staff member whereby the provider had not received confirmation of the training they had undertaken. The manager confirmed that moving forward full profiles will be requested and reviewed before agency staff worked for Care Sussex Ltd.

Staffing levels were being maintained with the use of agency staff. Steps were being taken to recruit permanent staff and people confirmed that staff arrived on time to their care call. Staff identified that improvements had been made to the way care calls were allocated which had significantly helped with promoting staff morale. One staff member told us, "We use to have back to back care calls which didn't help, we were always rushing. But now there are gaps between each care call which means if we run overtime, we

don't have to worry." Formal complaints were logged and responded to.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered providers to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Margaret House was not safe.

Medicines were not managed safely and put people at risk. Risks associated with people's care had not always been mitigated and robust risk assessments were not in place.

Staffing levels were being maintained with high use of agency staff whilst vacant posts were recruited to.

Recruitment practice was safe and safeguarding procedures were in place.

Is the service effective?

Inadequate

Margaret House was not effective.

People's legal and human rights were not consistently upheld. The status of 'DNARs' (do not attempt resuscitation) was unclear and placed people at risk. The management of diabetes and catheter care was not always effective.

The oversight of people's nutritional needs was not consistently clear.

Staff felt supported and supervisions were in the process of taking place.

Is the service caring?

Requires Improvement

Margaret House was not consistently caring.

People had experienced an unsettled time due to high use of agency staff, missed calls and medication errors which had caused anxiety and uncertainty.

People's confidentiality was respected and maintained.

People's regular care workers knew their preferences about their care and support

Is the service responsive?

Requires Improvement

Margaret House was not consistently responsive.

Care plans had not been reviewed in over a year and internal reviews of packages of care had not taken place.

There was a sense of community for people living at Margaret House. A complaints policy was made available to people

Is the service well-led?

Inadequate

Margaret House was not well-led.

The service had been subject to a period of instability and steps were being taken to improve staff morale, accountability and the culture of the service.

The provider had failed to establish quality assurance systems which were used to drive improvement. Shortfalls in documentation had not been identified and the provider's internal quality assurance framework was not robust.

Margaret 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.

The inspection took place on the 31 July and 2 August 2017 and was unannounced. The inspection team consisted of three inspectors, one of whom was a pharmacy inspector 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 service.

On this occasion, we did not ask the provider to complete a Provider Information Return (PIR), this was because the inspection of Margaret House had been brought forward due to a number of safeguarding concerns the local authority had received. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 12 people, two visiting relatives, six care staff, the manager, the nominated individual (provider), a member of the management team from Saxon Weald and a manager from the provider's sister's service. We reviewed a range of records about people's care and how the service was managed. These included the care records for 10 people, medicine administration records (MAR), training records, staff files, agency profiles, quality assurance reports, policies and procedures and other records relating to the management of the service.

We also 'pathway tracked' people who received a package of care from Care Sussex Ltd. This is when we followed the care and support a person's received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

This was the first inspection of the service under the new provider with the CQC.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living within their individual flats. One person told us, "I'm here and I'm safe." However, high use of agency staff made some people feel uncomfortable and unsafe management of medicines placed people at risk.

Care and treatment was not provided in a safe way for people and risk assessments lacked sufficient guidance for staff to follow. Guidance produced by the Health and Safety Executive advises that 'the provision of care and support should be tailored to meet the needs of the individual and should encourage them to do what they can for themselves. This is particularly important in the provision of social care but also applies to people receiving longer-term healthcare. Often when assessing the care and support needs of an individual, everyday activities are identified that will benefit their lives, but also put them at some level of risk. This requires a balanced decision to be made between the needs, freedom and dignity of the individual and their safety.' Most people had a risk assessment in place which considered a range of areas, including environment; moving and handling, mobility, personal care, skin care, meals, laundry and a significant risk summary. Despite having risk assessments in place, these failed to provide guidance on how safe care and treatment should be provided. One person's care notes didn't include a copy of their risk assessment. We asked to see a copy of their risk assessment online and the acting manager identified that the risk assessment online made reference to another person. The manager told us, "In my mind, they don't have a risk assessment. It refers to another person and has therefore been copied and pasted."

A number of people were living with complex care needs including diabetes, catheters, mental health, dementia and substance misuse problems. Staff told us that they felt confident in meeting people's needs, however, due to the high use of agency staff, the lack of guidance and risk assessments had the potential to place people at risk. For example, staff and the manager told us about one person who still drove, yet experienced problems with substance misuse and was known to decline care at times. Their risk assessment identified alcohol abuse yet failed to provide guidance and information on the controls required to manage the risk. Their significant risk summary included the following factors to consider; personal hygiene, maintaining a clean and safe environment and deterioration in health and well-being. The risk summary failed to include reference to alcohol abuse, concerns about driving whilst under the influence or their history of declining care calls.

Care and support was provided to a number of people living at high risk of falls. Guidance produced by the National Institute for Health and Care Excellence (NICE) advises that falls and falls related injuries can be a common and serious problem for older people. They can be a major cause of disability. Incidents and accidents that had occurred since January 2017 showed that one person had experienced 12 falls within their flat. Staff told us that they regularly checked on the person, encouraged them to walk with a zimmer frame and promoted them to wear shoes and not slippers. One staff member told us, "We are finding recently they are walking without their zimmer frame and their slippers are a slip risk which add to their risk of falls." However, this information was not reflected in the person's risk assessment. Their risk assessment identified they were at risk of falls, however, there was no guidance available for agency staff or new members of staff to follow. They would therefore be dependent on other staff to share this information in

order for them to provide safe care.

The above examples demonstrate that systems and processes were not established and operated effectively to assess, monitor and mitigate risks relating to the health, safety and welfare of people use the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Arrangements for managing medicines did not always keep people safe. High use of agency staff at the service had led to a number of medication errors over recent months and consequently the local safeguarding team had become involved. Despite input from the local safeguarding team, the management of medicines remained unsafe. The providers' medicines policy had not been reviewed or updated in over a year and current practice followed by staff did not reflect procedures set out in the providers' internal medicine policy. Additional medication guidelines had also been implemented following a number of medication errors; however, some parts of these guidelines were not safe and placed people at risk of receiving their medicines inappropriately. For example, the guideline dictated that staff members could transcribe antibiotics onto a person's medicines administration record (MAR) without the need for a second staff member to witness that the transcription was correct. This guidance was also reflected within the medicine guidelines under the section titled 'as required' medicines. This meant that there was a risk that antibiotics could be transcribed on to the PRN section of the MAR, when they had not been prescribed as PRN medicines. Guidance produced by the National Institute for Health and Care Excellence (NICE) advised that 'antibiotics are never prescribed to be given when required, they must be given regularly and the course should be completed to ensure the person receives the best outcome from their medicine.'

The recording of the administration of medicines was not always clear and clear guidance was not always in place for the use of 'as required' medicines (PRN). PRN medicines can include pain relief such as paracetamol. Protocols were not in place which included information on the frequency of dosage, whether the person could tell staff if they were in pain and any possible side effects. Some people had been prescribed topical creams which were to be applied to affected areas. However, MAR charts and care plans did not always include information about where on the body the cream was to be applied to. This meant that creams were at risk of being applied to body areas for which they were not intended, or not used appropriately.

Medicine administration records failed to include people's allergies and information about people's allergies was not always easy to find within people's individual care plans. One person's care plan included a hospital discharge summary which stated they were allergic to a certain medicine. However, their MAR chart reflected this medicine had been administered to this person on a number of occasions. We asked the manager to investigate this and they subsequently informed us that the person was not allergic to the medicine as identified on the discharge summary. However, internal medicine procedures had failed to identify this shortfall. Another person was allergic to three medicines including penicillin, yet this was not reflected on their MAR chart. We brought these concerns to the attention of the manager to take action immediately.

Best practice guidelines advise that 'it is essential that any member of staff administering medication is competent to do so. Medicines must only be administered by designated and appropriately trained staff who have had their competency assessed.' The provider used the 'Opus competency assessment' which requires staff to be observed administering medicines on three separate occasions before they can be signed off as competent. During the inspection, we were unable to locate any completed medicine competency assessments for staff. Competency assessments reflected that some staff had been observed on one occasion, but not on a further two and the competency assessments had not been signed off by a senior member of staff. We also identified that one staff member did not have a competency assessment in

place. Another staff member had recently been involved in a medication error. The acting manager was able to demonstrate that they had completed refresher training in the administration of medicines after the error and they were observed administering medicines on the 17 July 2017. However, this observation had not been signed off by a senior member of staff to confirm they were competent. Subsequent to the inspection, the provider informed us that they would be reviewing their competency assessments. In the interim, the provider was unable to consistently demonstrate that staff were competent in the administration of medicines.

Medicine risk assessments were in place, however, these were not personalised and failed to include information on where medicines were stored, how to encourage independence with the administration of medicines or how to safely support a person. For example, one person was registered blind and self-administered their medicines. Their medicine risk assessment identified they were unable to read the labels on their medicine boxes and bottles. However, the risk assessment failed to include guidance or the action required to support the person to self-administer their medicines safely. A number of medicine risk assessments had not been reviewed or updated in over a year and failed to include the name of the staff member who completed the assessment. When people had been involved in a medication error, due to being administered the wrong person's medicine, their risk assessment had not been reviewed in light of the error and subsequent safeguarding concern. The manager told us, "I would have expected all medicine risk assessments following a medicine error and safeguarding to have been reviewed and updated."

Systems were in place for people to have their medicines delivered by the pharmacy to their individual flats within Margaret House. Staff recorded the delivery of medicines in a book and medicines were stored in a locked medicines trolley before being delivered to people's individual flats for storage. However, best practice guidelines by the 'National Institute for Health and Care Excellence' advise that locked medicines trolley must be secured to the wall. The medicines trolley in the office of Care Sussex Ltd in Margaret House was not secured to the wall. Best practice guidelines had not been followed.

People had mixed opinions about staff's competency to administer medicines. Some people raised no concerns, however had experienced difficulties. One person told us, "I have a carer twice a day to do my eye drops and three times a day to do my blood sugars because I can't read the monitor. With all the small cock ups I couldn't trust the carers to order and give me my other medicines so I do it myself." Another person told us, "The carer I had this morning was very inexperienced she had no idea how to put my creams on."

The management of 'Do not attempt resuscitate (DNAR)' was unsafe and placed people at significant risk of being resuscitated when they had made the decision not to be resuscitated. For example, the management team told us that people with a red coloured care plan meant they were not for resuscitation and people with a black coloured care plan were for resuscitation However, we found this system was ineffective and not accurate. One person's care plan was in a red folder and documentation stated they were not for resuscitation. However, staff later informed us they were for resuscitation. In the event of an emergency, there was a risk that this person would not be resuscitated. Another person's care plan was in a black folder meaning they were for resuscitation. However, we were later informed that a DNAR was agreed in 2014, however, a hard copy was not on file. A consistent theme was that hard copies of people's 'DNARs' were not kept in people's care plans, which added to the risk of people receiving inappropriate care and treatment. We brought these concerns to the attention of the manager who took immediate action. However, inspectors had to identify this shortfall before action was taken.

Failure to provide safe medicines management and not do everything that is reasonably practicable to mitigate all risks relating to DNARs is a breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) 2014.

Despite the above concerns, the manager and provider were working hard to try and make improvements to the management of medicines. Systems had been introduced to check people's MAR charts three times a day to monitor for any missed medication or gaps in MAR charts. Incidents and accidents reflected that in July 2017, there had been three incidences of medicines errors which primarily involved morning medication being administered instead of lunch medicines or teatime medicines. Face to face medication training had been provided and the pharmacy had also provided recent training. Documentation confirmed that daily checks were having an impact and fewer medicines errors were occurring. With people's consent, we joined staff whilst they supported people to take their medicines in their individual flats. Observations demonstrated that staff were kind and caring and supported people to take their medicines by encouraging them and providing prompts. Unwanted and expired medicines were removed from people's flats and returned to the pharmacy and appropriate records were made.

Systems were in place to determine staffing numbers and ensure all care calls were covered. The manager told us, "We are currently providing 423.5 hours of care a week. We have four vacancies and are continually recruiting, but in the meantime we are using agency staff." Rota's confirmed that on most shifts, agency staff were present. One staff member told us, "We are short of permanent staff and we always use agency staff. I know they try and send the same agency but when it's a new agency staff member, we have to explain to them what to do and it can take just as long." Another staff member told us, "Staffing is improving. At one point we were very low but they have recently recruited." A third staff member told us, "It's been stressful here. At one point we had back to back calls which had an impact and staffing was poor. However, things are slowly starting to improve. We do use a lot of agency. Nearly every shift there is an agency staff member." People confirmed that normally staff arrived on time for their care call and they received a rota each week informing them who would be coming and at what time. One person told us, "It would be nice to get more regular staff, I have a rota over the weekend Monday to Sunday and if it says A that means I'm having an agency carer." Rotas' demonstrated that staff had time in between care calls and staff told us how this allowed them to spend time with people in-between care calls. One staff member told us, "One person recently returned back from hospital and I hadn't been allocated any of their care calls. During a gap, I went and had a cup of tea with them which I think they appreciated."

A number of concerns had been raised regarding missed calls and in response to these concerns, the provider had implemented a daily checking tool to ensure that all calls were covered. During the month of July 2017, we could see that no calls had been missed. Although no calls had been missed, we identified concerns with the overarching governance of care calls which we have discussed under the 'Well-led' section.

Staff had an understanding of safeguarding adults and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. One staff member told us, "I had concerns with one agency staff members conduct towards a 'resident'. I raised my concerns immediately and they haven't been sent back." The provider was working in partnership with the local safeguarding team to address the concerns regarding medication errors and missed calls.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with adults at risk. Where people received support from agency staff, the provider requested a profile from the agency which included information on their DBS,

record of their training and C.V (curriculum vitae). Profiles had been provided for nearly all agency staff working at the service, however, we identified one agency worker whereby the provider had not been provided with information on their DBS and training. This posed the risk that they had not received the appropriate training to safely meet people's needs and that they did not have an up to date DBS check. The manager advised that in future, full profiles would be requested for all agency staff.

Staff members recognised the importance of a leaving a person's flat safe and secure at the end of a care call. One staff member told us, "I make sure everything is neat and tidy, any hazards are removed. They have their call bell to hand, phone to reach and a drink to hand." Another staff member told us, "I always make sure they are safe and secure by ensuring they have their lifeline to hand and check that they are ok."

Inadequate

Is the service effective?

Our findings

People told us that they mostly felt confident in the skills and abilities of permanent staff working at Margaret House but felt agency staff were not always qualified and competent to meet their needs. One person told us, "Most of the carers employed by 'Care Sussex' are trained but not sure about the agency staff." Another person told us, "The agency staff are not trained to use my electric hoist also I had my sling washed and the agency staff did not know how to put the straps back on."

The application of the Mental Capacity Act 2005 (MCA) was inconsistent and placed people at risk of their legal and human rights not being upheld. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Mental capacity assessments were in place but these did not follow the principles of the Act. For example, they failed to record the decision that was being made and reflected that people either had capacity to make specific decisions or not. A number of consent forms were in place and some people's relatives had signed the consent form. Some care plans advised that people's relatives had appropriate authority to sign on their behalf (lasting power of attorney for health and welfare was in place). However, other care plans advised that appropriate authority was not in place, yet people's relatives had still signed the consent form.

A number of people living in their own flats within Margaret House had restrictive practice in place. This included the use of bed rails, medicines locked away in people's flats and sensor's on people's doors. Documentation failed to reflect whether people had consented to the use of this restrictive practice within their flat or whether it had been implemented in their best interest. A member of the management team told us, "Where people had sensor alarms on their flat door, I imagine that was a decision made by the social worker and family members." Although the decision was not made by staff, staff were engaging with the restrictive practice by responding to the sensor alarm. However, the provider was unable to demonstrate that the restrictive practice was lawful. For example, there were no copies of the mental capacity assessment or best interest meeting held by the social worker.

The care and treatment of people must only be provided with the consent of the relevant person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of diabetes was not consistently effective and clear guidelines were not in place for staff to follow. People living with diabetes can have an increased risk of disability, pressure ulcer development and hospital re-admission. A number of packages of care were provided to people living with diabetes. Care plans included information about peoples' medical history and indicated if there was a diagnosis of type one or two type diabetes. Risk assessments also advised whether people were living with diabetes, however, there was no guidance on the signs of high or low blood sugar and the action to take in either event. One person required staff to record their blood sugars three times a day. Documentation reflected on a couple of

occasions that there blood sugars were extremely high. However, documentation failed to reflect what should happen in the event of a person having high blood sugar levels. Entries made in the person's daily notes on some occasions noted that they took action themselves to lower their blood sugars. Another person required staff to check their blood sugars six times a day. This action was the outcome of recent concerns raised. However, documentation failed to reflect that staff were consistently checking their blood sugars at every care call. Incidents and accidents also reflected incidences where this person's blood sugars were found to be high. In June 2017, their blood sugars were found to be 21.6 one day (placing them at risk of a hyperglycemia attack). The GP was contacted who advised to check the person's blood sugars after food. However, this guidance was not transferred to the person's risk assessment. This posed a risk as staff were unaware of this guidance. A third person was also diagnosed with diabetes and experiencing a high number of falls. Their care plan noted 'for staff to prompt me to take my blood sugars before I eat my breakfast.' Their risk assessment also identified the risk of falling and high blood sugar levels as known risks. However, daily notes for this individual made no reference to prompting this person to check their blood sugars. For example, whether they did or not. Following a recent fall which resulted in a hospital admission, their blood sugars were found to be high.

Training records also demonstrated that staff hadn't received training on the management of diabetes. One staff member told us, "I was with (person) the other day recording their blood sugar and they told me it was high, but I didn't know what to do with that information. Additional training would be beneficial." The manager confirmed that all staff had been enrolled on diabetes training following our feedback.

The failure to assess, record and mitigate the risks for people who have diabetes is a breach of Regulation 12 if the Health and Social Care Act 2008 (Regulated Activities) 2014.

Care and support was provided to a number of people living with a catheter. Guidelines produced by the National Institute for Health and Care Excellence advises that effective catheter care requires good management of infection control, hydration and monitoring for signs of catheter acquired infections.' People's individual care plans included reference to the use of a catheter and some care plans included guidance on the signs of blockage and bypassing. However, this was not consistent in all the care plans we reviewed. Some people required their day and night catheter bag to be changed weekly. The manager told us that all catheter bags were changed every Monday. Documentation failed to reflect this. For example, between the period 30 June and 31 July 2017, documentation reflected on only two occasions, that a person's catheter bag was changed. In a four week period, there should have been four references. For another person within the same time period, we only found one reference to their catheter bag being changed. Lack of recording meant the provider could not demonstrate whether people had not received the necessary care or if staff had simply failed to record their actions.

The oversight of people's nutritional needs was contradictory, unclear and placed people at risk of not receiving the appropriate support they required with nutrition and hydration. A restaurant was on site at Margaret House. The restaurant was run and overseen by Saxon Weald who owned the building. The kitchen was contracted out and Care Sussex Ltd had no direct input with the management of the restaurant. As part of people's care package and tenancy agreement, some people attended the restaurant for their lunchtime meal whereas others had the meal brought up to their flat. On the first day of the inspection, a stand in chef was working in the kitchen who advised that they had list of 'resident's' dietary requirements. This list included whether people were vegetarian, diabetic or if they required a soft or pureed diet. According to the list provided to the stand in chef, one person required a pureed diet. However, their care plan failed to reference that. A member of staff who had oversight of the kitchen and worked for Saxon Weald confirmed they required a pureed diet, yet when we spoke to the person they advised they did not require a pureed diet and never had. We were later informed that the list in the kitchen was three years out of date. Staff

subsequently told us, that there were only two people who required a pureed diet. However, their care plans and risk assessments failed to reference this. It was not clear if this was a personal preference, medical need or whether it was just for certain foods such as meat. We joined people for their lunchtime meal which was sociable with people eating and chatting together. We observed that the two people, who, according to staff, required a pureed diet, were eating a meal which had not been pureed and they told us that they had happily chosen their meal.

During the inspection, we were informed by staff that nobody required staff to complete a food and fluid chart. However, on the front of one person's care plan was a note which stated, 'please complete fluid and food chart.' This chart had been completed sporadically since December 2016. There were only 24 entries on the chart with the last entry made on the 24 July 2017 which reflected that the person had a cup of tea. We brought this to the attention of the manager who was also unsure as to whether the person required their food and fluid intake to be monitored. They advised that it could be due to a recent urinary tract infection. The person's care plan failed to make any reference to the need for their food and fluid intake to be monitored. Therefore it was unclear whether staff should be monitoring and recording food and fluid intake. If so, the need for that oversight was unclear.

Poor communication and lack of documentation all added to the poor oversight of people's nutritional needs and it was unclear what dietary requirements people required and whether they were receiving that. We brought this to the attention of the manager. Systems and processes were not established or operated effectively to ensure that accurate records were maintained. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Despite the above concerns, people spoke highly of the food provided at the restaurant and confirmed that staff members supported them to prepare light snacks and other meals within their individual flats. One person told us, "The morning carers get my breakfast, I have lunch in the restaurant then the carers come in the afternoon and prepare tea."

Staff members undertook an induction upon commencing employment with Care Sussex Ltd. As part of their induction, staff shadowed other senior members of staff and completed mandatory training which included safeguarding, moving and handling and fire safety. If staff members were new to care, they completed the care certificate. The care certificate sets the standard for new health care support workers. People told us that they felt confident in the skills and abilities of permanent members of staff. One person told us, "I think they are well qualified and trained." Another person told us, "They usually do it right everything is checked and they have to sign for everything."

Mechanisms were in the process of being implemented to ensure staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us that supervisions were becoming more regular and they felt able to approach the new acting manager with any concerns or worries. One staff member told us, "I feel listened to now."

A range of health care professionals were involved in people's care. District nurses visited people on a regular basis along with the GP and other healthcare professionals. The provider operated a Tunstall system (emergency call system). In the event of an emergency, people could press the Tunstall and staff would visit their flat to provide support. Documentation reflected that staff attended to Tunstall calls. For example, responding to falls and calling 999 for people.

Requires Improvement

Is the service caring?

Our findings

People told us that permanent members of staff demonstrated kindness and empathy when delivering care and support to them. One person told us, "The carers are very friendly, dignified and respectful we chat and pass the time of day during my personal care." However, a number of concerns regarding medication, missed calls and high use of agency staff had made people feel uncertain, anxiety and stress in relation to their care and support. A recent letter sent to all 'residents' on the 31 July 2017 from management identified steps that the provider was taking to address the concerns. However, people continued to express concerns about the care provided, especially care provided by agency staff. One person told us, "I had an agency care worker this morning. They didn't make my bed as they didn't have enough time; they kept looking at their watch as if they needed to rush off."

Steps were in the process of being made by the provider to ease people's anxiety and distress, however, these required time to be embedded and sustained. We have identified this as an area of practice that needs improvement.

Staff who worked permanently for the provider had built positive rapports with people and provided care in a kind and sensitive manner. One staff member told us, "It is because of the residents that I enjoy working here." Another staff member told us, "I love working with the residents, they are the best." A third staff member told us, "I really enjoy getting to know the residents and their likes and dislikes." Staff described to us what people were independent with as well as how to provide their care and how they promoted people's independence. One staff member told us, "I always encourage people to do as much for themselves as possible. For example, when assisting with a morning wash, prompting people to wash their face themselves."

Staff were aware of the need to preserve people's dignity when providing care to people in their own flat. Staff told us they took care to give privacy to people when needed. They also said they drew curtains and closed doors to ensure people's privacy was respected. One member of staff told us. "I always ensure people are covered up when assisting with washing. For example, covering their top half whilst I support them with their bottom half." One person told us, "The carer always shows dignity and respect." Another person told us, "The carers are very friendly, dignified and respectful we chat and pass the time of day during my personal care." People confirmed that staff always rang the doorbell or entered their flat in the way they had requested. One person told us, "At 05.45am I have a five minute check call, they use the master key to get in and when they go they leave the door on the latch for the carers at 07.00am. When they come in the ring the bell and shout good morning as they come in the door. I am happy with this arrangement."

People's confidentiality was respected. Staff understood not to talk about people outside of the service or to discuss other people whilst providing care for others. The providers' policy on confidentiality was covered during staff induction and training. One person told us, "The regular staff are very sociable but also confidential."

Staff gave us examples of how they engaged with each person and explained how they promoted respectful

and compassionate care. It was clear that staff had spent time getting to know people, what was important to them and their life history. One staff member told us, "I've been supporting one person for the past six years. They love to gossip and know everything that is going on at Margaret House. They use to own their own taxi firm."

People either owned their flat or had shared ownership of the property with Saxon Weald. It was clear that people's flats were highly personalised to reflect their likes and life history. Some people had also decorated the outside of their flat with pot plants and decorations. A range of communal space was available for people to access which included a lounge and activity room. Throughout the inspection, we observed people spending time in the communal lounge, chatting to others and enjoying a cup of tea from the restaurant on site. Some people lived at Margaret House with their pets and support was in place to enable people to continue having their pets at home with them.

People told us they were given choice in their day to day care. One person told us, "I like living at Margaret House because it gives me freedom with help when I need it, yesterday I wanted to go to bed at 4.00pm so my package was varied to accommodate me." Another person told us, "I'm happy here, I'm self-sufficient, I can do what I like when I like." Staff members recognised the importance of giving people day to day choice within their live and recognised that they were entering the person's own home.

Requires Improvement

Is the service responsive?

Our findings

People told us that despite recent concerns, they enjoyed living at Margaret House. One person told us, "It's very nice and pleasant here, I feel safe." A third person told us, "It's ideal, it's the best of both worlds." However, despite people's positive comments, we identified areas of practice which were not consistently responsive.

As part of the process of moving into Margaret House and receiving care from the provider, a pre-admission assessment took place which was normally attended by a member of the management team from Saxon Weald and the provider. The purpose of this pre-admission assessment was to determine if Margaret House was the right environment for people and the level of care and support that people required. People were also offered the opportunity of having another care agency provide their package of care. However, the provider and the manager advised that on occasions, the management team from Saxon Weald had only attended the pre-admission and therefore there was no input from the provider to ensure that they could meet the person's needs and provide a package of care that was personalised to them. The manager told us, "Since being in post, I've identified a couple of people where they have extremely high care needs and I'm concerned that as a care provider, we cannot meet their needs." The provider confirmed that a meeting had been organised with the local authority to review people's care plans and package of care. Moving forward, the manager also confirmed that they would be attending all pre-admission assessments to determine whether people wanted to receive care from the provider and what package of care they required.

Care plans were not consistently person centred and the users' voice was not always included. Some care plans we viewed contained good personal information. For example, one person's care plan included information on their background and history and noted that they used to be part of the women's institute. Information was available on what was working well, what was important to them and their concerns for the future. One person's concerns for the future included their financial situation.

However, care plans we reviewed had not been reviewed in over a year and it was not clear whether they remained fit for purpose and if the personalised information remained correct and up to date. A member of the management team told us that most people had signed a consent form in February 2017 which indicated they were happy with their care plan. Although signed consent forms were in place, care plans had not been updated or reviewed to reflect any changes. For example, one person's care plan dated March 2016 identified they were not happy with management and they didn't like the slings they were using. A consent form had been signed in February 2017, yet the care plan had not been updated to reflect what action had been taken regarding their worries about management and the sling or whether they were still unhappy. We found this was a consistent theme across the care plans we reviewed. Care plans had not been updated or reviewed to ensure they remained person-centred.

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

People told us that staff normally arrived on time for their care call. One person told us, "Care staff always arrive usually on time very rarely late, the longest I've had to wait is 25 minutes." Although people were primarily happy with the timings of their care calls, documentation failed to reflect whether people had internal reviews with management to discuss how the package of care was going, if they were happy with the call times or if they wanted to make any changes to their package of care. The acting manager told us, "People usually come down to the office and ask for a different call time which we happily arrange; however, this isn't always documented." The provider had identified the need for all packages of care to be reviewed by the local authority; however internal reviews had not taken place in over a year. We have identified this as an area for improvement.

Care plans included a pen picture which provided an overview of the times of the care call and what was required at each call. For example, one person required the assistance of two staff members for their morning call at 07.00am. The care plan noted, 'please administer my medication, support me to have a shower and dress. Hoist me onto my bed, adjust the sling and then hoist me into my chair.' This provided staff with a clear overview of the level of support and tasks required at each care call.

People and their relatives confirmed they felt able to express their views, opinions or raise any concerns. One person told us, "If something was wrong I would complain." Another person told us, "I very rarely complain but I would have no hesitation in complaining if I needed to." A complaints policy was made available to people when they started receiving care from Care Sussex Ltd. Since January 2017, documentation reflected that the provider had received one formal complaint. Informal complaints were also logged and the provider had received two informal complaints since January 2017. However, on the first day of the inspection, one person told us they were unhappy with the care provided by an agency staff member and they subsequently informed a permanent member of staff. However, this had not been logged as an informal complaint. We brought this to the attention of the provider and manager to take action.

Inadequate

Is the service well-led?

Our findings

People and staff spoke highly of the new manager. One person told us, "The new care manager is excellent, she know everything and is very easy to talk to. She's firm but fair." Another person told us, "I have met the new manager; it has been pretty good since she has been here, and she deals with things pretty quickly." However, despite these positive comments, we found areas of practice that required improvement.

Care Sussex Ltd had been subject to a period of instability. A stable management team had not consistently been in place and staff spoke about the impact of having different managers and deputy managers within the space of a year. One staff member told us, "It has been a turbulent year. It takes a while to get used to the leadership style of a manager and having three different managers in a year, it has been hard." Another staff member told us, "It has been tough and stressful. People's needs have been increasing, there is a high use of agency and we used to only get paid per call and I was consistently worrying that I wouldn't get paid enough or my payment wasn't correct." A lack of stable management had led to a lack of accountability within the staff team. Policies and procedures were not routinely being followed which led to a number of medication errors and missed calls. Staff felt morale was low and a number of safeguarding concerns had been raised. However, steps were now in the process of being taken to improve morale, promote staff's accountability and ensure a stable management team was in post. A manager had been recruited who on the days of the inspection had been in post for four weeks. Staff member's terms and conditions had been reviewed and staff were now being paid per shift rather than per call. A resident meeting had been held on the 10 July 2017 to gain their views and advise on actions that were being taken to ensure that everyone received a safe service. One person told us, "We received a letter on 10th July explaining the improvements 'Care Sussex' are making regarding employing staff." The provider was committed to making the desired improvements. However, these required time to be embedded and sustained.

A governance framework was in place; however, this had not been effective in identifying a number of shortfalls. The service produced a three monthly report for East Sussex County Council which considered incidents and accidents, safeguarding, complaints, training and staffing issues. Following the production of that report, the provider met with East Sussex County Council to review the report and ascertain if any actions were required. The provider told us, "We attend along with one 'resident' who is our resident representation. They feedback on what life is like receiving a package of care from the provider. The latest three monthly reports from April to June 2017 had been submitted but they had not yet met with East Sussex County Council to discuss the report and therefore an action plan was not yet in situ. Despite, this governance framework in place, the provider's overarching governance framework was not effective and shortfalls in the provision of care which placed people at risk had not been identified internally. Alongside the three monthly reports submitted to East Sussex County Council, the provider also conducted internal audits which were based on CQC's key lines of enquiry and asked key questions. One audit completed in October 2016 considered the key question of 'safe.' However, despite the audit asking key questions, this audit failed to identify a number of shortfalls Inspectors found on the inspection and it had not been reviewed in light of the number of medication errors. For example, the audit recorded, 'new MAR sheets are brilliant, all information contained.' The shortfall of allergies not being recorded on the MAR sheet had not been identified. The internal audit also questioned, 'check documentation pertaining to mental capacity

assessments and best interest meetings /best interest decisions. Have the correct forms been completed?' However, this section of the audit had been recorded as non-applicable. Shortfalls with regards to the adherence of the Mental Capacity Act 2005 (MCA) had not been identified.

A subsequent internal audit in February 2017 considered the key question of 'effective'. However, this failed to identify a number of shortfalls. For example, the audit asked the question, 'review risk assessments, assessments of behaviour, and the management of 'Do not Attempt Resuscitation' Orders. Are these reviewed? Dated? Observe frequency? After reading the risk assessment, are you aware of all relevant risks?' The significant shortfall around the status of people's DNARs had not been identified as part of this internal audit. Where shortfalls had been identified, these were not transferred onto an overarching action plan. The provider confirmed that a service development plan was in place following the quarterly monitoring report submitted to East Sussex County Council. However, the any shortfalls identified from internal audits were not transferred onto an overarching action plan and therefore the provider could not demonstrate what action had been taken to address the shortfall. The provider told us, "The manager has only been in post a month and we haven't had a chance to go through all systems and processes and ascertain what is working and what isn't working." An action plan had been implemented in April 2017 following the increased concerns with medication errors. The actions included, 'rotas are being compiled in advance so that when agency has to be used, regular agency can be booked as they will be familiar with Care Sussex Ltd. Medication checks to be analysed and the Registered Manager will be recruited for and inducted so that they are able to focus specifically on Margaret House and the quality of the service that is provided. The ad was placed on the 5th April 2017.' However, the action plan was not subject to regular review to demonstrate what actions had been completed and what actions were in progress.

The absence of a robust quality assurance framework meant that a number of shortfalls had been omitted or not identified internally and there was a lack of oversight by the provider. For example, the provider's medication policy stated that medication audits should be undertaken every six months. Despite, the number of medication concerns, no formally medication audit had taken place. MAR charts were subject to daily checks. However, a medication audit considers the overall process from ordering people's medicines, to having them delivered to people's individual flats. What is working well and where areas could be improved. Shortfalls with the governance of care calls had also not been identified internally and no action plan was in place to address such concerns. Following concerns over missed calls, the provider had implemented a daily check sheet which staff signed to confirm they had undertaken the care call. At the end of each day, these daily check sheets would be reviewed by senior staff members to ensure that everyone had received their care calls. We reviewed these daily check sheets dating back to June 2017 and found that improvements in recording were evident. However, where there were gaps on the sheet (the care call had not been ticked to reflect a staff member had attended), documentation failed to reflect what action was taken. The manager told us, "I would expect staff to record on the back that they spoke with the person and checked their daily notes to ensure they received a care call." On the 31st July 2017, the daily check list reflected that someone did not have a morning call. We checked their daily notes which evidenced that they did receive that call. However, the daily check sheet failed to evidence what action had been taken by staff to ensure that person received that care call.

The systems in place to monitor care calls required strengthening. Daily notes were utilised as a forum for staff to record the time they arrived at the care call and the time they left. We looked at a sample of daily notes and found a consistent theme that care workers were not consistently
recording the time they left the care call. This meant the provider was unable to demonstrate and evidence that care workers were staying the allocated time. The manager told us, "We have identified this and if people felt that staff were not staying the allocated time, they would come and tell me." Although this shortfall had been identified, the lack of an overarching action plan meant the provider could not

demonstrate the steps they intended to take to drive improvement and evidence that staff were staying the allocated time.

Daily notes and care plans were not subject to regular auditing which meant a range of shortfalls with documentation had not been identified. For example, one person's care plan noted, 'please monitor my skin integrity and report any concerns.' We reviewed a sample of their daily notes which made no reference to their skin integrity. Whether it was intact or red. Another person's care plan identified seizures as a risk. There was no reference to the type of seizure, if they were prescribed anti-epileptics and there was no guidance on the risk of choking during a seizure and ensuring their airways were not obstructed. Staff told us that the person had not experienced any recent seizures and were prescribed anti-epileptics. However, this information was not reflected in the care plan. The lack of regular auditing meant shortfalls within documentation had not been identified and there were no actions on how care plans could be improved.

A quality assurance policy was in situ, but was not specific or personalised to Care Sussex Ltd and care provided at Margaret House. The provider told us, "All policies and procedures will be subject to review." However, in the interim there was no governing policy to determine what quality assurance framework was required.

Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of the service. There was a failure to maintain accurate, complete and contemporaneous records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, staff and management felt that things were in the process of improving. Staff felt morale was getting better, they were now being listened to and the recruitment of a new manager was having a positive impact.

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
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005 and had provided care and treatment of service users without the consent of the relevant person. Regulation 11 (1) (2)