Coast Care Homes Ltd

Bexhill Care Centre

Inspection report

154 Barnhorn Road
Bexhill-on-sea
TN39 4QL

Date of inspection visit:
11 August 2020
12 August 2020

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15 September 2020

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

Bexhill Care Centre is a care home with nursing and accommodates up to 43 people in a purpose-built building. The service provides step down nursing and is commissioned by East Sussex County Council to assist social services and the National Health Service during the COVID-19 pandemic. The service supports adults whose primary needs are nursing care although some may also be living with dementia. At the time of our inspection there were 17 people living at the service.

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The concerns were about people's safety, risk management, medicines, infection control and the governance framework of the service. We inspected using our targeted methodology developed during the Covid-19 pandemic to examine those specific risks and to ensure people were safe.

People's experience of using the service and what we found
Not all safeguarding issues had been investigated or recorded. There was a lack of investigation by managers into the cause of accidents and incidents and few plans had been put in place to mitigate further accidents from occurring. We spoke to staff who were aware of the process of reporting safeguarding but managers had failed to act on reports received.

The recording of wound management was poor with not all wounds being documented. NICE guidelines had not been followed with regard to measuring and recording wounds. Body maps provided insufficient information about the status of wounds, whether they were healing or not. A skin tear had been recorded on an accident form but there was no further documentation or photograph. Documentation relating to turning people who had pressure sores was poor with one showing only three turns in an eight-day period. No investigation had taken place into falls, no advice sought from other professionals and no assessments were in place to minimise further falls.

Medicines were not always managed safely. Medicine administration records (MAR) were hard to read and codes were inconsistently used. Counting medicines and recording refusals was inconsistent and it was not clear whether people had received their medicines or not. No clear protocol was in place for 'as required', (PRN) medicines. The management of pain relief medication was inconsistent and staff were not monitoring the effectiveness of different forms of pain relief. Some prescribed medication was missing. Clinical equipment in place for use in the event of a person choking, had not been checked to ensure it was fit for use.

There was a lack of managerial oversight with auditing processes. Issues had been identified relating to recording key information on support plans which had not been addressed. Some support plans relating to specific areas of support were missing and others lacked information and had missing entries. Daily notes contained entries that were written in an undignified way. This was brought to the attention of the registered manager who took immediate steps to address the situation. There was lack of oversight relating to accident reports and no changes made to risk assessments following accidents.

Systems were in place to effectively manage infection, prevention and control. Personal protective equipment (PPE) was available and used by staff and all visitors and regular staff completed a health questionnaire and had their temperature taken when entering the building. Since lock down visits from relatives were only made if their loved ones were in receipt of end of life care and the same infection control precautions were taken.

Rating at last inspection:
This service was registered on the 1 May 2020 and this was the first inspection. This was a targeted inspection.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific 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.

Enforcement:
We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

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

Is the service safe?
We have not rated this key question as we have only looked at the areas we had specific concerns about.

Details are in our safe findings below

Is the service well-led?

Inspected but not rated

Is the service well-led?
We have not rated this key question as we have only looked at the areas we had specific concerns about.

Details are in our well-led findings below

Bexhill Care Centre

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. This was a targeted inspection due to concerns we had about people's safety and care needs being met and the governance framework to support people and staff safely.

Inspection team
The inspection was carried out by two inspectors on-site and a third inspector available to take telephone calls if required.

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

Notice of inspection
We gave a short period notice of the inspection. This was because of the COVID-19 pandemic. We wanted to be sure that no-one at the home was displaying any symptoms of the virus.

What we did before the inspection
Before the inspection we reviewed the information, we held about the service and the service provider. We sought feedback from the local authority and healthcare professionals that are involved with the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Due to the COVID-19 pandemic we needed to limit the time we spent at the home. This was to reduce the

risk of transmitting any infection. Therefore, we had two calls with the registered manager. We discussed how we would safely manage the inspection. We also wanted to clarify the providers infection control procedures to make sure we worked in line with their guidance.

To minimise the time in the service, we asked the provider to send some records for us to review prior to the inspection. This included records relating to the management of the service, audits, training and supervision records and staffing rotas.

During the inspection
We observed people who used the service. We spoke with six members of staff including the provider and registered manager. We spent a short time in the home. This allowed us to safely look at areas of the home and to meet people and staff whilst observing social distancing guidelines. It also gave us an opportunity to observe staff interactions with people.

We reviewed a range of records. This included people's care records, medicine records, three staff files in relation to recruitment, training and supervision and further records relating to the auditing of the service, including accident, incident and safeguarding records.

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 avoidable harm.

We have not rated this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check on specific concerns about people's safety and care needs being met. We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from harm as incidents had not always been investigated thoroughly. We were shown a log of five safeguarding issues raised by staff and only one had documents that showed an investigation had taken place. The registered manager was aware of the lack of documentation to demonstrate issues had been investigated thoroughly. Opportunities had been missed to report and investigate concerns relating to pressure sores, wound care and falls.
- We noted on three care plans that people had pressure sores and a safeguarding had been raised by another service about a person discharged to them from Bexhill Care Centre who arrived with pressure sores. Bexhill Care Centre had not alerted CQC or the local authority regarding any discovery of pressure sores.
- Falls had been recorded as accidents but no link had been made between multiple falls and no notification about injuries had been raised with CQC. No advice had been sought from the local authority falls team to help prevent further falls occurring.
- We spoke to staff about safety and they were able to tell us what they would do if they had concerns. They told us that they would escalate issues to line managers and contact the local authority if they needed to. A member of staff said, 'I'd report to my line manager but ask for consent first.' Safeguarding training formed part of staff induction but no ongoing or refresher training had been scheduled. This was raised with the registered manager during the inspection and they undertook to arrange refresher training.
- Staff were aware of the service whistleblowing policy and told us they were confident to use it if required. Whistleblowing enables staff to raise issues whilst protecting their anonymity.

Systems were not in place to demonstrate effective recording and investigation of safeguarding incidents. This placed people at risk of harm. This was a breach of regulation 13 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Wound documentation for some people was poor. The care plans for wound care were not clear and not all wounds had been documented. The wound documentation was minimal and contained very little information about the wound, the treatment needed or the healing process.
- The NICE guidelines, relating to wound care state 'document the surface area of all pressure ulcers in adults. Use a validated measurement technique, for example, transparency tracing or a photograph.' Staff had not always followed this guidance. We found photographs that were not labelled or measured

appropriately so staff could not monitor the wound effectively.
● One person had several wounds that were identified on a body map. However, we could not tell from the documentation the status of the wounds and if they had healed or if treatment was on-going. Some wound charts whilst completed did not identify which wound was being dressed. One skin tear had been identified and treated according to the accident book and listed on the body map but there was no further documentation or photograph.
●The person had two new wounds noted on the room care plan but there was no further documentation or accident report completed and senior staff were not aware of them. Another person who was spending all their time in bed and who had pressure sores had not had their air mattress pressure checked for two days. Another person, who had pressure sores required regular turning to relieve pressure. The chart showed that they had only been turned three times in eight days.
● The management of the risk of falls was poor. We reviewed support plans relating to a person who had multiple falls during their short stay at the service. Each had been recorded as an accident but there had been no investigation into possible causes or links between the falls. No evidence was seen of any follow up action or steps taken to minimise the risk of further falls occurring.

Systems were not in place to demonstrate safe care and treatment was always provided. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely.
● We looked at medicine administration records (MAR). There was inconsistent recording in the use of codes for non-administration of medicines, some staff used the same code for 'asleep' whilst it was also used for out of stock. It was not clear therefore the reason for it not being given.
● Some people had refused their medicine. We were informed that the organisational policy for the refusal of medicines stated it should be offered three times if safe to do so. However, we could not evidence if the person received their medicine as there was no tablet count or evidence that it had been re-offered.
● Some people had been prescribed additional medicines on an 'as required' (PRN) basis. Not everyone had protocols in place to inform staff when these medicines were required and information about the safe administration of these medicines for the person concerned.
● There was also no consistent approach to monitoring the effectiveness of the pain relief such as a pain chart. One person was on a number of different medicines for pain relief which were prescribed and was also requesting various PRN pain relief. Staff were not monitoring the effectiveness of the pain relief and therefore could not use that important information to manage pain control safely and effectively.
● One person medicine of folic acid had been out of stock for eight days. There was no evidence that this medicine had been followed up with the GP to check if it was still required.
● Clinical equipment used for an emergency reason, such as suction machine was not set up and ready for use despite there being people who were at risk of choking. There was no evidence that any medical equipment was checked to ensure it was fit for use.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

● There was good practice regarding the application of creams. Body maps were in place and staff signed to say these had been applied. Medicines were stored safely. Medicines were disposed of safely.

Preventing and controlling infection
● We saw one member of staff collected soiled laundry from a person's room, they collected it in their arms

without wearing gloves or an apron. This was brought to the attention of the registered manager who dealt with the situation immediately to ensure correct protocols were followed. We spoke to the registered manager about kitchen staff wearing face masks when preparing food. We observed that this was not happening. The registered manager agreed that wearing face masks when preparing food was good practice and implemented this straight away.

● The building was clean throughout and we observed cleaning staff in each of the four parts of the building.

● All staff had completed IPC training as part of their induction. Staff told us there was always enough PPE available. A staff member told us, 'We had specific COVID-19 training about PPE. We always follow the guidance.'

● Staff entered and left the building through one door which went straight to a room where they washed and dressed before and after each shift. PPE was donned and doffed in this area and all uniforms were left on site and laundered at the service to minimise infection. Before the start of each shift staff completed a health questionnaire and had their temperatures taken. Any professionals or relatives visiting the service went through the same process.

● Before moving to the home people had COVID-19 tests and were only accepted if the test was negative. On arrival residents were placed in a 14-day isolation period to minimise the risk of infection. In the event of a COVID-19 outbreak at the service there were clear plans in place to look after those affected by a dedicated staff team in a specific, isolated part of the building.

● People who were in receipt of end of life care were able to receive visits from relatives and loved ones with strict rules being applied and visitors going through the same procedures when entering the building. Social distancing was observed as far as was possible in the communal areas of the home, including the garden.

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.

We have not rated this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check on specific concerns we had about people's safety and care needs being met and the governance framework of the service to support people and staff.

We will assess all of the key question at the next comprehensive inspection of the service.

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

- Auditing processes were being completed by staff not in managerial roles and there was a lack of oversight by the registered manager. An audit of one person's support plan highlighted a number of issues, this included no food or fluid charts completed, no record of the person being washed and gaps in the daily notes, periods of time where nothing had been recorded. The registered manager had not overseen this audit and was not aware of these issues.
- There were no support plans in place providing detail of these issues and the care and support needs required for people. Other support plans lacked detail. For example, a person was recorded as regularly refusing to drink. A fluid chart was in place but no daily amounts were shown and no information about the amount the person should drink each day.
- Another person had specific care needs such as an indwelling catheter to drain urine, but there was no clear records that staff were providing essential catheter care. As this person was also not drinking there was no oversight of the amount of urine draining to monitor the possibility of dehydration.
- In a person's daily notes, we saw entries that provided no detail or information about the person. It was written in an undignified way and we highlighted this to the registered manager. Steps were taken to identify the member of staff involved. The entries had been made two months before the inspection but had not been reviewed or audited by managers.
- We looked at accident reports. Several reports had been completed by staff relating to falls. A person who had experienced two falls within a week had recorded on the accident form that the care plan had been updated. When we looked at the care plan, a copy of the accident form had been attached but no review or update had been completed. No action plan had been put in place to identify the cause of the falls and to put systems in place to minimise the chance of recurrence.

The absence of support plans covering specific areas of care, incomplete records and the lack of effective management oversight of auditing processes is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The pandemic had meant that initial assessments of people prior to their arrival at the service had been

conducted over the telephone. The registered manager was now able to carry out face to face assessments and had reviewed and updated the assessment paperwork.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to demonstrate safe care and treatment was always provided. The provider had failed to ensure that there were systems and processes established to effectively manage medication and equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that there were systems and processes established and operated effectively to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of detail and inconsistency in support plans, a lack of effective auditing and a lack of oversight of accidents and incidents.