Sovereign Care Limited

Filsham Lodge

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

Filsham Lodge is situated on the outskirts of Hailsham. The care home provides nursing care and support for up to 53 older people, some of whom are living with dementia. The registered manager told us that the service accommodated a maximum of 51 people as double bedrooms were no longer used. There were 49 people using the service at the time of our inspection and the registered manager told us that most people were living with dementia and 48 people were receiving nursing care.

We last inspected Filsham Lodge in May 2015 when the service was rated 'Good'. After that inspection we received concerns in relation to the safeguarding of people's belongings in the service. This was a focussed inspection in response to these concerns. The inspection was carried out on 2 December 2016 and was unannounced. We looked at the three key questions 'Is the service safe', 'Is the service caring' and 'Is the service well led'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Filsham Lodge on our website at www.cqc.org.uk.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

Staff understood how to recognise the signs of abuse, but appropriate action had not always been taken by the registered manager to assess whether alleged abuse required reporting to the local authority safeguarding team under the multi agency safeguarding policy.

People's medicines were not always stored in a safe way. There were not effective systems in place for ensuring that opened medicines were disposed of within an appropriate timeframe.

The registered provider had not ensured that the premises were clean and hygienic to ensure the risk of the spread of infection was reduced.

People's right to privacy was not consistently maintained as some bathroom doors did not close properly and did not have a lock. Staff generally sought and obtained people's consent before they provided care. However we found that people's mental capacity had not always been assessed before a decision was made in their best interests, following the requirements of the Mental Capacity Act 2005.

There was not an effective system in operation for monitoring the quality and safety of the service to make improvements to the care provided. Where shortfalls in the service were identified appropriate action had not always been taken to make improvements.

There were sufficient numbers of care staff to meet people's care needs, but the registered provider had not demonstrated that sufficient numbers of nursing staff were deployed in the service to meet people's nursing

needs. We have made a recommendation about this.

The registered provider had not ensured that the service was organised in a way that provided personalised care. Some people had to wait a long time for their meals to be served and staff did not always meet the people's social needs. We have made a recommendation about this.

Risks to people's wellbeing were assessed and staff knew what action they needed to take to keep people safe. People had individual evacuation plans outlining the support and equipment they would need to safely evacuate the building.

Staff treated people with kindness and respect. People told us they liked the staff and that they were caring. Staff knew people well, understood what care they needed and responded to their physical needs. The staff promoted people's independence and encouraged people to do as much as possible for themselves. People were involved in making decisions about their care.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff knew how to recognise the signs of abuse, but appropriate action had not always been taken to report safeguarding concerns. The registered provider had not ensured that people had safe storage for their personal belongings.

People's medicines were not always stored and managed in a safe way.

The registered provider was not able to demonstrate that the number of nurses deployed to work in the service met the nursing needs of people living in the home.

Safe recruitment procedures were followed in practice.

The registered provider had not ensured the premises were clean and hygienic to reduce the risk of the spread of infection in the service.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always take the opportunity to engage in a social way with people outside of providing for their physical needs.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not consistently been met.

People's privacy was not promoted when using bathroom facilities due to poor fitting doors and a lack of locks.

Staff treated people kindly and respected their wishes. People were involved in making decisions about their care.

Staff promoted people's independence and encouraged them to

do as much for themselves as they were able to.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager had not ensured that the service consistently provided a personalised service to people. Staff did not always engage with people outside of meeting their physical needs.

The registered provider did not have in place effective systems for assessing and improving the quality of care provided. Where shortfalls in the service delivery were identified action had not always been taken to make improvements in a timely way.

Filsham Lodge

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 carried out to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This was a focussed inspection in response to concerns we received about the safeguarding of people's belongings in the service. The inspection was carried out on 2 December 2016 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. We looked at the three key questions 'Is the service safe', 'Is the service caring' and 'Is the service well led.'

Before the inspection we looked at records that were sent to us by the registered provider and the local authority to inform us of significant changes and events. We spoke with the local safeguarding team and commissioning team to obtain their feedback about the service.

We looked at three people's electronic care plans, risk assessments and associated records. We reviewed documentation that related to safeguarding and the systems used to monitor the safety and quality of the service. We spoke with seven people who lived in the service and two people's relatives to gather their feedback. We spoke with the registered manager, one nurse, two senior care staff and two care staff as part of our inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the service. One person told us, "Everything's lovely. The carers are good and I feel safe." Another person said, "They treat me well here." People told us that they felt there were sufficient numbers of staff to meet their needs.

Prior to our inspection we received notification that a recent safeguarding investigation had found that there had been a theft of three people's personal belongings whilst they were using the service. The registered manager described the action they had taken in response to the matter and to prevent any further abuse of people's property. The registered manager told us they had installed security cameras in parts of the service. They told us they had also spoken with the relatives of the people involved and apologised for the loss of property. The registered manager told us that it had always been the policy of the service to advise people not to bring valuables into the service and the contract advised people of this. This policy was shared with people using the service and their relatives again following the safeguarding incidents. The service did not routinely provide lockable space for people to keep their personal belongings in their bedrooms or locks on people's bedrooms doors, however people were advised, within the statement of purpose, that they could request this.

Staff meeting minutes showed that it had been identified by the registered manager that a person had been subject to poor practice that did not ensure their dignity. The same meeting minutes also highlighted neglect to meet the person's needs as they had not been repositioned for eight hours. This was not in line with the person's care plan and risk assessments and had resulted in sore skin. The registered manager had not taken appropriate action to investigate the matter and make an assessment about whether a referral to the local authority safeguarding team was required. The registered manager contacted the safeguarding team during our inspection.

We recommend that appropriate action is taken to assess allegations of abuse and report matters in line with the multi-agency safeguarding policy as required.

Staff we spoke with were aware of the need to report concerns about abuse to the registered manager and guidance was displayed for staff to follow. This included information about how to report concerns outside the home if appropriate. One staff member told us that the team "Know about whistleblowing and they will report concerns".

People's medicines were not consistently managed in a safe way. The home's medicines policy stipulated that the stock of controlled drugs held in the service should be checked at least every 24 hours. However, we found that checks on controlled drugs were inconsistent and had been completed only 14 times during November 2016. Audits of medicines management had been completed and it was evident that some issues had been identified within the audits, but steps had not been taken to rectify the problems. For example, it was noted in an audit dated 31 October 2016 that medicines in original packaging were not dated when they had been opened. An email had been sent by the registered manager to senior staff to address this issue, however, during our inspection we found that the issue remained unresolved. There were medicines seen

during the inspection that were in original packaging that had not been labelled with the start date in accordance with the home's policy. Liquid medicines were not always dated when they were opened and staff had continued to use the medicines despite this omission. One bottle of a liquid medicine seen during the inspection was half empty, however staff who had administered the medicine were not able to make any checks of when the medicine was opened to ensure it was not being used after the recommended disposal date. Another liquid medicine had been dated as opened on 12 July 2016 and had not been disposed of after the appropriate period of time.

The home's policy stated that 'medication that may be PRN or antibiotics and is not in blister packs must be carried forward to the new chart by inserting the number in the carry forward box'. This was not carried out in practice. Stock levels had been monitored through a monthly stock check of all medicines; however, this had been completed for the month of September or November 2016. This meant it was not possible to maintain a clear audit trail and account for all medicines that had been received into the service.

There was a high number of sharps boxes that were waiting to be disposed of in the treatment room. Although some of the boxes were labelled with an assembly date there were five boxes that had not been dated when they had been assembled. This meant it was not possible to ensure they were sealed and appropriately disposed of within the correct timeframe. An oxygen cylinder was stored in the treatment room, but this was not secured in accordance with relevant guidance. There were no instructions in the home's medicine's policy concerning how oxygen should be secured when it is stored.

People's medicines had not always been managed in a safe way or in line with the registered provider medicine policy. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staff were trained to administer medicines and checks were made to ensure that they were competent to do so. We observed senior care staff members administering medicines and saw that this process was completed with appropriate checks made to ensure that people received their medicines as prescribed. Senior care staff were positive about the opportunities they had been given to develop skills such as administering medicines and taking blood pressure. One staff member told us 'We're not just on the floor, we can do other things as well'. Nurses working in the home were given opportunities to develop their skills and understanding through attending study days. For example, nurses had received additional training on the use of syringe drivers. We saw that medicines administration records (MAR) were complete and included information about allergies and route of administration. However, not all handwritten entries in the MAR sheets were signed by two members of staff in accordance with the home's medicines policy. Medicines were stored securely and staff locked the medicines trolleys when they were not attended. There was guidance in place for staff concerning how and when to administer medicines that were prescribed to be taken 'as required'. This included information about how people communicated if they were in pain.

Cleaning schedules were in place to ensure that all areas of the home were cleaned regularly including people's bedrooms and bathrooms, however we found that some areas of the home were not kept clean to ensure adequate standards of hygiene and reduce the risk of infection spreading in the service. We had concerns about the condition of floors within some of the bathrooms and the storage of items such as linen and clean incontinence pads close to clinical waste bins. The flooring in one bathroom was damaged due to the removal of a bath. An old hoist, parts of the removed bath plumbing and some bathroom equipment were stored in this area. Another bathroom had flooring that was not properly sealed around the edges and it was dirty at the edges. This made it difficult for housekeeping staff to ensure these areas were kept clean and hygienic to reduce the risk of the spread of infection.

We saw in two bathrooms that clean towels and clean incontinence aids had been placed on top of clinical waste disposal bins. In one bathroom the clinical waste bin was situated next to the clean linen cupboard which did not shut properly. This meant that there was a risk of clean linen coming into contact with soiled waste. We saw four bathrooms and these had dirty light pull switches. Infection control audits were carried out regularly within the home. However, these audits did not include checks concerning the cleanliness and safety of bathrooms within the home and had not been effective in identifying these concerns.

The registered provider had not ensured that the service was clean and hygienic to reduce the risk of the spread of infection in the service. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staff were observed using personal protective equipment (PPE) such as gloves and aprons appropriately. There were handwashing facilities available throughout the home and guidance was on display concerning hand washing techniques. Staff reported that they had received infection control training and this included the use of PPE and handwashing guidance. One staff member told us that the manager was particularly careful to make sure that good hand hygiene was maintained.

The registered manager described recent changes to the provision of nursing staff in the service. These changes had been implemented in June 2016 in response to difficulty the registered provider had in recruiting nurses. The registered manager was not able to demonstrate that the new staffing levels for nurses had been determined based on assessments of individual nursing needs. On most days during the week only one registered nurse worked in the service to provide nursing care to 49 people. The registered manager told us that on Mondays and Fridays two nurses worked in the service to deal with GP appointments, however the rota showed that this was not taking place consistently. Staff spoken with confirmed that there was usually one nurse on shift. In addition to the registered nurse on duty a senior staff, who had been trained to give medicines, was allocated to work in each of the two wings of the service. Team meeting minutes showed that senior care staff had raised concern that they were being taken away from care duties to assist nursing staff with wound dressings. The registered manager told us that they did not feel this was required, however there was not assessment of the nursing tasks required for each person to enable the registered provider to establish the correct nursing staff numbers. The registered provider had not referred to published guidance on staffing levels in nursing homes for example, the Royal College of Nursing 'Guidance on safe nurse staffing levels in the UK' issued in 2010. We recommend that the registered provider review nursing staff numbers to ensure the provision of nursing staff reflects the needs of people using the service.

In addition to nursing staff employed in the service there was a team of care staff employed to meet people's needs. We saw that sufficient numbers of care staff were available to respond to people's needs and requests. There were a number of vacancies for care and nursing staff and agency staff were used frequently in the service. A team of housekeeping staff, catering staff and a maintenance worker also worked in the service.

The registered provider followed robust procedures for the recruitment of new staff. The registered provider had made checks of the staff files and these contained interview records, references and a disclosure and barring check. Gaps in employment history were explained. Confirmation of appropriate pre employment checks had been obtained from the agencies before agency staff were allowed to work in the service. All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. New staff were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were fit to carry out their

duties.

Risks to individuals had been assessed as part of their care plan. This included the risk of developing pressure wounds, skin tears, falls and poor nutrition and hydration. An action plan was in place to minimise the risk of harm and staff we spoke with were clear about the action they were required to take to keep people safe. We saw that staff followed the actions detailed on the risk assessments, for example by using equipment to safely move people who had limited mobility. There was guidance available to staff on reducing the risk of malnutrition by providing fortified foods and drinks. People who were living with dementia had risk assessments that identified risks that were a result of their condition. There were action plans in place to support people to reduce these risks, for example the risk of anxiety, by using methods that were known to provide the person with comfort.

Equipment was maintained in good order and had been checked and serviced at appropriate intervals to make sure it was safe to use. Maintenance staff tested the temperature of the water from various outlets each month to ensure people were not at risk of water that was too hot. There was a procedure in place for evacuating people from the building in the event of an emergency, such as a fire. People had individual evacuation plans outlining the support and equipment they would need to safely evacuate the building. Staff had received fire training and were aware of the evacuation procedures.

Requires Improvement

Is the service caring?

Our findings

People, and their relatives, told us they felt the staff were caring and treated them kindly. One person told us, "The staff are ever so kind". Another person said, "They are lovely people" and "He is a wonderful man [about a particular staff member]". However, people and their relatives told us that, whilst they felt the staff were kind they did not always spend time talking with them. One person told us, "The staff are very busy, they have no time to chat". A person's relative told us, "There doesn't seem to be much interaction between staff and people. [Their relative] will be given a drink, or a cup of tea, but there is no conversation". The relative commented that the staff talk to them more than to their relative who was living in the service.

During our inspection we saw that staff did not always spend time engaging with people outside of providing for their direct care needs. For example, we saw that people were supported to prepare for their lunchtime meal. Whilst waiting for the meal to arrive staff stood in a group in one of the lounges and chatted rather than spending time talking with people using the service. However, a member of staff in another lounge spent time singing with the people using that room. We saw that many of the people who used the service spent their time sleeping in their armchairs throughout the day with staff waking them for meals and drinks. We saw that some group activities took place in the service during the morning in one of the lounges, but there was a lack of records to show that people were supported to engage with staff and others in a social way. This was particularly in relation to people who remained in bed. For example, one person who remained in bed had a weekly entry in their daily care notes showing social engagement with the activities coordinator, but no other entries to show staff had supported them to be socially occupied at other times. During the morning we saw that a staff member was allocated to supervise people in the lounge. They were careful to observe people to see if they had any physical needs, but they did not initiate conversation with them outside of offering drinks or helping people to the bathroom.

Staff did not always take opportunities to meet people's social and emotional needs and interact with them in a personalised way. We recommend that the registered manager review the practice of staff to ensure they are meeting people's social and emotional needs.

Whilst staff did not always take opportunities to interact with people outside of direct care delivery the interactions they had with people were respectful and positive. Staff spoke kindly to people, did not rush them and addressed them in the way they preferred. Staff knew people well and understood what care they needed. When a person was seen to be sitting in their overcoat at lunchtime staff encouraged them and supported them to change into more comfortable warm clothing. Staff noticed and responded when people needed support, for example if they tried to get up from their chair and required assistance.

A person was confused and anxious about when their relative was visiting. A staff member was kind and patient when assuring the person about the time they were visiting. The staff member offered to support the person to telephone their relative. People's relatives told us they were invited to visit whenever they wished without any restrictions.

People's right to privacy and dignity was not consistently respected. We saw that two bathroom doors did

not shut properly which compromised people's dignity whilst they were using these facilities. Five bathroom doors did not have working locks. Staff told us that many people using the service needed to have staff with them in the bathroom, but we saw some people using these bathrooms independently and they were unable to lock the door.

People's right to privacy was not consistently promoted. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staff had supported people to dress in a way they preferred and to wear their glasses, dentures and hearing aids if they needed these. Staff spoke with people in a respectful way and addressed them by the name they preferred. People's records were kept securely to maintain confidentiality.

Staff encouraged people to do as much as possible for themselves. People's care plans reflected where they could do things for themselves and where they required support. Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote their independence. People were provided with equipment, where needed, to enable them to move around independently and to eat without assistance. We saw that guidance was available to staff about appropriate finger foods to enable people to eat independently if they were unable to use cutlery or if finger foods met their needs more effectively.

People were involved in their day to day care and were mostly supported to make decisions about their care and treatment. However, we found that one person was subject to the use of a CCTV camera in their bedroom to ensure their safety. This had been agreed with their family, but there was a lack of evidence to show that the person themselves had consented to the use of the camera. The registered manager told us that the person would be unable to provide this consent. The Mental Capacity Act 2005 requires that an assessment of their capacity to consent to this decision should be carried out in this situation; however there was no evidence that this had been completed. If an assessment finds that the person lacks the capacity to consent the Mental Capacity Act requires that a decision should be made on behalf of the person in their best interests. This decision must be recorded and should involve relevant parties including the person's family and their allocated care manager from the local authority. There was no recorded evidence of how a best interest decision had been reached.

The requirements of the Mental Capacity Act had not been consistently followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Clear information about the service was provided to people and their relatives to enable them to make a decision about using the service. A brochure was provided to people that gave information about the services and facilities provided. There was a clear complaints procedure which was made available to people. People's relatives were kept informed about and involved in their care where the person wished for this to happen.

Requires Improvement

Is the service well-led?

Our findings

People's relatives told us the registered manager listened to their views and responded to their concerns. One person told us, "Anything we point out, they do." However, we found that the service was not well led.

The registered manager had not ensured the culture of the service was consistently person centred. The service was organised and operated in a way that responded to people's physical needs, but did not always meet their social needs. There was a lack of evidence of social activities for people who remained in bed and staff did not always take opportunities to talk with people outside of providing for their physical care needs. We saw that the organisation of meal service was slow on the day of the inspection and left people waiting for long periods of time until their meal was delivered to them. Care staff supported everyone to sit at a table or tray table ready for their meal, but meals were served in one wing first leaving those in the other wing waiting over half an hour before their food was served to them. We heard two people commenting that they had been seated for lunch a long time before it arrived. The registered manager told us that this was because the regular cook was not on duty that day and the relief cook was covering. The registered manager had systems in place for monitoring the delivery of care, but this focused on aspects of people's personal and physical care needs rather than assessing the culture of the service to ensure it was person centred.

The registered manager had systems in place to monitor the quality and safety of the service provided, but these systems had not always been effective in ensuring improvements were made to the service. For example, senior staff had completed observational checks of staff performance in supporting people with their personal care needs. We saw two of these checks had identified staff performance as being rated as 'poor', but there was no recorded action taken to address the shortfalls. The registered manager told us that they intended to collate the information and address it with the staff team at the end of a month. This did not ensure that timely action was taken to respond where shortfalls in the quality of service delivery were identified. An infection control audit had been completed, but this had not identified the areas of concern we raised with the registered manager about the cleanliness and hygiene of bathrooms in the service. We found that checks of the operation of pressure relieving mattresses had not been completed consistently. The checks had not been completed on one wing for three days in the month of November and December 2016. A nurse told us that 'It may be because there wasn't a senior on shift'. Whilst there people did not have pressure wounds in the service the registered manager had not identified that these checks had not taken place which could increase the risk of people developing wounds. Medicines audits that had been completed had not been effective in resolving the shortfalls we found at this inspection.

The registered manager understood the requirements of their role, but they had not always taken action to assess and report safeguarding matters appropriately. The service's policies were appropriate for the type of service. All policies and procedures had been reviewed and updated. Staff were able to describe the key points of significant polices such as the safeguarding, infection control and complaints policies. They were aware of where to access the policies when they needed them.

Systems for assessing and improving the quality and safety of the service had not always been effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Records relating to the care of people using the service were accurate and complete to allow the registered manager to monitor their needs. The records included information about day to day care and professional input when it was provided. The records were detailed about people's physical and personal care needs, but did not include information about how people's social needs were met. We recommend that the system for recording the delivery of care to people on a daily basis is reviewed to ensure is includes people's social and emotional needs.

Staff were positive about the support they received from managers within the home. They reported that they were able to ask for help when required and they were confident that they would receive support and guidance.

The registered manager described the action they had taken to meet with the family of a person who had been subject to a theft of their property in the service. They told us that they had taken action to ensure the person was reimbursed for this loss.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's right to privacy was not consistently promoted when using bathrooms. 10 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the Mental Capacity Act had not been consistently followed. 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines had not always been managed in a safe way or in line with the registered provider medicine policy. 12 (2)(g) The registered provider had not ensured that the service was clean and hygienic to reduce the risk of the spread of infection in the service. 12 (2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for assessing and improving the quality and safety of the service had not always been effective. 17 (20(a)(e)