Bexhill Care Centre Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Bexhill Care Centre is located on the main road between Eastbourne and Bexhill with parking on site. The original building has been extended, made up of two units with communal areas and lifts to enable people to access all parts of the home. There are gardens to the front and rear which are wheelchair accessible.

The home has accommodation for up to 41 people with nursing and personal care needs. There were 16 people living at the home at the time of the inspection. Some people had complex needs and required continual nursing care and support, including end of life care. Others needed support with personal care and assistance moving around the home due to physical frailty or medical conditions, and some were living with dementia.

A registered manager had not been in place since September 2015. A manager had been appointed and had applied to register at the time of the inspection. 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.'

This inspection took place on the 5 February 2016 and was unannounced.

People were supported to make choices about the support and care they received and staff were kind and respectful. However, there were not enough staff with the appropriate experience and skills to meet people's individual needs. This meant that people were not being helped by staff who knew how to assist them to move safely or protect them from harm.

The information in care plans was limited; risk had not been assessed for some people and, there was no clear guidance for staff to follow to support people.

Systems were not in place to monitor the support and care provided and, staff were not clear about their individual responsibilities or accountability for their actions.

The atmosphere in the home was relaxed and comfortable and a relative and visitor felt people were safe and well cared for.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not consistently safe.

There were enough staff working in the home, but they did not have the skills or a clear understanding of people's needs.

Risk to people had not been assessed appropriately.

Staff had attended safeguarding training, they had an understanding of abuse, but were unable to provide support safely.

Is the service well-led?

Inadequate

The service was not consistently well-led.

There was no clear operational leadership and staff were not sure of their roles and responsibilities.

The care planning system was not robust, it did not clearly reflect people's needs or include appropriate guidance for staff to follow.

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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.

This inspection took place on the 5 February 2016 and commenced at 06.30. It was a focused inspection because of concerns we had received regarding staffing and, the impact this may have on the support and care provided for people living in the home. It was undertaken by one inspector and was unannounced.

During the inspection 8 people told us about the care they received and we spoke with one relative and one visitor. We spoke with 10 members of staff, which included housekeeping staff, maintenance staff, the chef, care staff, senior nurse, deputy manager and the manager.

Some people were living with dementia and were unable to verbally communicate their needs. We spent time observing the support and care provided to help us understand their experiences of living in the home.

We observed care and support in the communal areas, during breakfast and midday meal and we looked around the home

We looked at a range of documents. These included assessment records, two care plans, daily records and staff rotas. We spoke with the local authority following the inspection.

Inadequate

Is the service safe?

Our findings

People living in Bexhill Care Centre said they felt safe and their relatives supported this. People told us, "I think they look after me quite well, but I would rather not be here" and, "I feel as safe as I can be, the staff are very good and look after me well." A relative said, "I think people are safe here. I haven't seen anything I am concerned about" and, a visitor told us, "People seem well cared for." Despite people and relatives sharing positive views about how safe they felt, we found that improvements were needed to make sure people were safe at all times.

At our inspection on 17 and 21 December 2015 people, relatives and staff were concerned about the changes in staffing and the ongoing use of agency staff. We found there were not enough staff working in the home that had the skills or an understanding of people's needs to ensure they were met. The care plans were not consistent; some risk assessments had not been completed and there was no clear guidance for staff to follow to support people safely. We observed this had an impact on all aspects of the support and care provided and people's needs were not always met.

We found the provider had not ensured safe care and treatment for people. There were not enough staff with a clear understanding of people's needs to provide the support they needed and risk assessments had not clearly identified people's needs to ensure their safety. This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

At this focused inspection, we found the provider had continued to employ staff through a recruitment agency and some said they had attended safeguarding training provided by the agency. Two of these staff had worked in the home for two months and had recently been offered permanent posts and, the senior nurse said they planned to offer other agency care staff permanent work. Two staff said they had attended training as part of their induction with the agency, but one said they had not attended any training with the agency as they had certificates to show they had completed the training with a previous employer. There was no system in place at the home to ensure agency care staff had attended appropriate training.

Staff had some understanding of protecting people from abuse and had some knowledge of their roles and responsibilities, but were unable to explain why they had failed to ensure people's safety during the inspection. For example, two staff assisted one person to transfer from a wheelchair to an armchair in the lounge. They asked the person to stand up and held onto their hand and put their other hand along the person's back for support. The person started to stand up slowly and, to assist them one of the staff held on to the back of their trousers and pulled on these to help the person to stand and turn onto the chair and then to position them on the chair. When asked why they had used the person's trousers to lift them they said, "I don't know. I know I shouldn't have." They told us they had attended moving and handling training and understood what they should do. This was an inappropriate transfer, which placed the person at risk of injury and, failed to consider the person's dignity or treat them with respect. This showed the staff did not have a clear understanding of their responsibilities with regard safeguarding and, therefore did not ensure people were protected from harm.

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We found the provider had not ensured safe care and treatment for people. There were not enough staff with a clear understanding of people's needs to provide the support they needed and risk assessments had not clearly identified people's needs to ensure their safety. This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014).

During this inspection we found the breach of regulation 12 continued with no improvements. We started the focused inspection at 6.30am so that we could talk to the night and day staff. We found that the night care staff had been working at the home for several months and had a good understanding of people's support needs. They said they had assisted people to be comfortable to remain in bed if they chose and, we found the lights were dimmed and people were sleeping unless they wanted to get up. The night staff were supported by an agency nurse who worked one or two nights a week at the home. The nurse contacted the recruitment agency to book an agency care worker to cover for sickness. From our observations and discussions with staff we found the night staff were meeting people's needs. However, during the day we found people continued to receive unsafe or inappropriate care.

The day staff consisted of one nurse, who had worked at the home for one month, and five care staff; including the two who had recently started on a permanent basis and one who had no experience of working at the home. The nurse allocated staff to work in pairs with permanent care staff working with those who had not worked at the home before, "So that you can support them and make sure they know what support people need." However, we observed that despite the allocation staff did not always consider people's preferences, the support they provided was not based on people's individual needs and, people were at risk when they were supported by staff to move around the home.

For example, we saw care staff place porridge and a drink in front of one person in the lounge, they then left the lounge to assist someone else. The person was living with dementia and needed assistance and guidance with their meal. The person was helped by another member of staff, not care staff. We asked them why they had left the person and they said they thought someone else was going to do it, but there were no other care staff in the lounge. The person was also given scrambled eggs and the same care staff assisted them, but they stopped the person using their fingers to pick up the meal. Another member of staff then intervened and said, "Let them eat it on their own if they want to." This meant some staff were not aware of, or did not understand, people's preferences and failed to encourage people to use the skills they had, such as using their fingers to eat. The staffs lack of understanding of people's needs and failure to provide appropriate support was also evident when we found a call bell had been placed in the bottom drawer of a person's bedside cabinet. They had been identified as being at risk of falls, but staff had not enabled them to call for assistance, which put them at risk of harm. This showed staff did not have an understanding of this person's needs and how to support them safely.

On two separate occasions the same staff failed to use appropriate moving and handling techniques to support people safely. People who wanted to sit in the conservatory for lunch were asked by staff to stand up, "So that they can sit where they want to have lunch." The people used zimmers, a walking aid, to help them walk around the home with support from staff. One person pulled on the zimmer when they tried to stand up and staff put their hands on the person's back to assist. We asked staff what they had been told

during moving and handling training and, they then proceeded to use the safe procedure to support this person. This meant the person placed their hands on the arms of the chair and pushed themselves up and, when upright they used the zimmer to lean on to walk with staff support. Another person pulled on the zimmer to stand up with one member of staff leaning on the zimmer to prevent it from falling onto the person and two other staff assisting them by supporting their back. They were able to stand up and then walked to the conservatory for lunch. Staff said they had attended moving and handling training and knew the correct ways to support people safely; they agreed they had not followed them, but were not sure why. This meant people were at risk of harm, because staff may not follow safe systems for supporting people to move around the home.

We looked at the care plans and risk assessments for two people. We found that the risk assessments were not specific; they had not identified people's individual needs and, there was no clear guidance for staff to follow. This meant the support provided may not have been appropriate for each person. For example, one person was living with dementia. The care plan stated that the person wanted to go home, but a risk assessment had not been completed to address this and, there was no guidance for staff to follow to reduce this person's anxiety when they had been unable to leave the home. Another person was at risk of falls and although the care plan identified this there was no guidance for staff to follow and, the person had two falls. This meant there were no clear systems in place to inform staff about people's support and care needs and how staff were to meet these and people were at risk of harm or injury.

The provider continued to provide care and treatment for people that were not safe. There were not enough staff with a clear understanding of people's needs to provide the support they needed and risk assessments had not clearly identified people's needs to ensure their safety. This is a breach Regulation 12 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

The atmosphere at the home was relaxed and comfortable. Staff asked people where they wanted to sit in the lounge and some people sat in the conservatory for lunch. People told us, "The food is very good." "I am comfortable here." I like the staff, they are very nice" and, "I have no complaints really, they do their best I think." People did not have any complaints about the support and care provided; they said the staff were very nice and, "They ask if I am ready to have a wash and wait for me to be ready." From our observations staff were kind and compassionate and mostly spoke with people as they assisted them.

Inadequate

Is the service well-led?

Our findings

People, a relative and a visitor felt that staff provided the care people needed and that the staff were very good. Staff said the care planning system was still being developed and a number of improvements had been made since the last inspection. We found that the care provided remained unresponsive to people's needs.

At our inspection on 17 and 21 December 2015 we found that people's needs had been assessed before they moved into the home and, they had been offered a place based on the nurses view that their needs could be met. However, the care plans did not have enough information about people's individual needs for staff to be able to plan and provide appropriate care and support. There was no evidence that people were involved in writing the care plans or that people's views and opinions were central to the decision making process. There were gaps in the records kept in people's rooms, including food and fluid charts and, staff had not attended record keeping training.

We found the lack of accurate and complete personal records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the breach of Regulation 17, the lack of accurate and complete personal records, had not improved. We looked at the information about the two people admitted since the last inspection. The care plans, daily records and the records kept in their rooms and, we observed the care and support provided for people living in the home.

Care plans contained some information about people's needs. However, the information was not specific and the records did not include guidance for staff to follow to ensure the support provided was appropriate. For example, one person was living with dementia and the care plan showed that they had been admitted from hospital for end of life care, to be comfortable and pain free. The care plan stated the person moved around the home independently and were able to look after their own personal care needs with support from staff and, they wanted to go home. The daily records showed the person had been distressed and their behaviour had been challenging and, there was no guidance for staff to follow to ensure this person's needs were met. For example, 'Wandering and agitated after start of shift. Around 21.30 appeared aggressive wanted to go home. Banging on the bedrails, kicking on bedroom door. Challenging behaviour, wash completed. Re-assured, eventually settled slept well.' The manager was not aware that this person's behaviour had been challenging when they first moved into the home and, staff told us they were happy during the day because, "They sit in the lounge all day and seem very happy with everyone else." This showed that communication between staff had not been effective and that the person may not have received appropriate support and care.

The pre-admission assessment for another person had identified they were at risk of falls and they had a history of dizzy spells. We looked at their care plan, daily records and their folder to see what systems had been put in place to support them and reduce the risk of injury. This person told us they had fallen twice and accident records supported this. Appropriate risk assessments had not been completed, a pressure mat was

in the room, but its position and use was not recorded in the care plan or daily records and, there was no clear system in place to reduce the risk of falls. The deputy manager said, a 'Care plan at a glance' had been developed and was kept at the front of the folders in people's rooms, "So that staff can look quickly and see what support people need." However, this was not in place when we looked at the records and was put in place during the inspection. This meant staff did not have the information and guidance to provide appropriate support for this person.

We spoke with the person and they said they liked to be independent as a care package was being set up for them to go home. They had poor eyesight and said they had lost some of their confidence after falling before going into hospital and then while they were in Bexhill Care Centre. We saw an alarm mat had been put on the floor between the chair, bed and door to the bathroom. The person was sitting in the chair and said they used the Zimmer to walk to the bathroom. The alarm mat prevented them doing this safely, as to do so the person needed to see the mat clearly and would have had to lift the zimmer over the edge of the mat to prevent it getting stuck and risking a fall. Staff said the person had been asked and reminded to call for assistance rather than try and walk on their own, but they had been unable to call for assistance because the call bell was not connected. Staff said the alarm mat and the call bell used the same socket, so they could only us one at a time. No action had been taken to address this and it was not clear who had decided to connect the mat and not the call bell. Staff were unable to discuss the support and care they provided for this person, they were not sure when the alarm mat had been put in the room, they did not know how many falls the person had had and, were not clear how much support they needed. This showed staff had been unable to provide the care and support the person needed or reduce the risk of falls, which meant the person was at risk of harm or injury.

The provider did not have accurate, completed and cotemporaneous records is respect of these two people, including the care and treatment provided and, decisions taken in relation to the care and treatment. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager if the assessment of people's needs included a look at the availability of rooms and if their position in the home was reviewed as part of the assessment process. The manager said they did not know if the nurses considered this when they assessed people. The two people who had moved into the home since the last inspection were allocated rooms at the end of the corridors on the ground and first floor. There was minimal 'traffic', which meant they may not have seen staff very often. We observed that staff did not go along the ground floor corridor unless they were providing personal support and answering call bells. Staff were not aware that not providing regular checks on people who chose to remain in rooms some distance from the lounge may affect their safety and well-being.

The deputy manager and senior nurse told us that although they had only been working at the home for a month they felt they worked well together with the manager and provider. They said that enough permanent care staff would be working in, "About four weeks" and, they would have the skills they needed to support people appropriately. However, we asked how agency care staff had been assessed, while working at the home, to ensure they were competent. For example, what training had been provided to enable staff to understand their roles and responsibilities and what was expected of them. Had they been observed and assessed to ensure that the support and care they provided was personalised and, that people were involved in decisions about the support and care they received. We were told staff attended training provided for all staff, but there was no specific competency assessment for agency care staff, although they had been offered permanent employment. This showed why staff had not provided personalised support and care, such as supporting people to move around the home safely and providing appropriate support with meals. This meant that people's needs may not have been met and they were at risk of harm or injury.

Staff said they enjoyed working in the home. They felt supported by the management and said they provided the care people needed. One member of staff told us, "We look after people well. We support them to be comfortable and eat and drink." Staff told us they were kept up to date with any changes and people's support needs during the handover session at the beginning of each shift. However, we found the handover provided very basic information about people's needs for that night and, did not show how people had been supported to have a good nights sleep. The senior nurse said the handover discussion was usually much more informative and, they would be discussing this with agency staff for future sessions.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain secure and accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured safe care and treatment for people. There were not enough staff with a clear understanding of people's needs to provide the support they needed; risk assessments had not clearly identified people's needs to ensure their safety and the provider did not ensure the proper and safe management of medicines.

The enforcement action we took:

Issued warning notice