SHC Clemsfold Group Limited

Beech Lodge

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

About the service
Beech Lodge is a residential nursing home providing personal and nursing care to 40 people with learning disabilities, physical disabilities and a range of neurological conditions such as autism. The service comprises of three separate buildings: Beech Lodge, Oak Lodge and Redwood House. At the time of this inspection Redwood House was not being used and did not form part of this inspection, and only one person was living in Oak Lodge. The service is located in a rural setting and is purpose built to provide ground floor accommodation for people with complex health needs and disabilities. At the time of this inspection 21 people were living at the service.

Beech Lodge is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found
There was unsafe monitoring and management of risks around epilepsy, constipation, medicines, and behaviours that may challenge others. People were not being protected from abuse or neglect and we raised safeguarding concerns for some people at Beech Lodge.

Staff did not always have the correct training and competencies to support people with their needs. Medicines were not being managed safely and audits for medicines did not highlight issues we found.

The provider had acted to manage infection risks during the Covid-19 pandemic. Additional infection prevention and control measures in line with Department of Health and Social care guidelines had been put in place to ensure people's safety. During our inspection the service was clean, and staff had access to and wore appropriate personal protective equipment. Relatives told us the service was clean and well looked after with no bad odours.

There was a lack of sustained learning when things went wrong. Previous concerns around person centred care and people's independence were still present at this inspection. There was a lack of good governance, and systems to drive improvements were not effective despite input from partner agencies such as the local safeguarding team and health team.

The culture in the service was poor and we saw examples of care and support that were not respectful or promoted independence, such as turning a TV off without asking people who were watching it. One relative told us they were worried about their loved one and kept visiting to check on them.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for

granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of Safe and Well led the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• Model of care and setting did not maximise people's choice, control and independence.
• The service was rural and located in private grounds. Opportunities for people to access the community were limited.

Right care:
• Care is not person-centred and did not promote people's dignity, privacy and human rights.
• People did not receive person centred support. For example, activities were in groups and not personalised.
• Staff did not always know when people may be in pain or distress.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives
• The service did not have a positive culture and people were not supported to be as independent as they could. Some people were left for long times without engagement.

Rating at last inspection and update.
The last rating for this service was Inadequate (published 23 March 2021).

After the last inspection where we found breaches of regulation, the provider completed an action plan to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

We carried out an unannounced comprehensive inspection of this service on 12, 13 and 15 October 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve person centred care, dignity and respect, safe care and treatment, good governance, and staffing.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.
The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has stayed at Inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Beech Lodge on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person centred care, dignity and respect, safe care and treatment, safeguarding, good governance and staffing.

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

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

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Beech Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and a medicines inspector on the first day, and two inspectors and an inspection manager on the second day.

Service and service type
Beech Lodge 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we held about the service. We considered the information that had been shared with us since the last inspection by the provider, the local authority and other partner agencies and health and social care professionals. 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.

During the inspection-
We spoke with four people who used the service and two relatives about their experience of the care provided. We spoke with twelve members of staff including the provider, registered manager, assistant manager, senior care workers, care workers and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at a variety of records relating to the management of the service, including policies and procedures which we reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at care records and quality assurance records. We spoke with some relatives and staff.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, and learning lessons when things go wrong

- At our last inspection in October 2020 we found a continued breach of Regulation 12 as there had been a failure to assess, monitor and mitigate risks in relation to people's epilepsy, behaviours, medicines and choking. At this inspection we found these risks remained and also found additional areas where risk was not safely managed.
- People were not being supported to eat and drink in a safe way. Some people living at Beech Lodge had guidelines written by Speech and Language Therapists to help them to eat and drink safely and reduce the risks of choking or aspirating (inhaling particles of food or fluid into their lungs). We saw that people did not receive the support with their meals as described in their specialist guidance.
- For example, one person who needed a headrest on the back of their wheelchair, to reduce the risk of choking when they ate, did not have this on during a breakfast service. Another person was coughing repeatedly throughout their mealtime but was continued to be supported to eat and was not offered a drink. This put people at risk of choking.
- Risks around behavioural support had not been mitigated. The provider had appointed a Positive Behaviour Support (PBS) practitioner. PBS is an approach that seeks to understand the reason for inappropriate or challenging behaviour and reduce the behaviours. One person received additional funding due to concerns about their behaviours but did not have a PBS plan and had not been referred to the PBS practitioner. Staff who worked with the person told us they thought the person needed a PBS plan to keep them safe and had identified a risk to the persons safety and wellbeing from their behaviours.
- We reviewed some PBS plans that had been competed for other people, but these did not reflect known factors that can cause incidents. For example, food was the cause of three of the previous six incidents for one person, but their PBS plan did not reference food or how to reduce the risks around this.
- One person required a form of restraint to support them with their behaviours. This form of restraint was not being managed safely. Staff we spoke with were not confident about how to restrain people and described different processes. There was no care plan for how to do this safely.
- Risks associated with epilepsy were not being managed safely. One person had a rescue medicine for prolonged seizures that could not be administered to them whilst they were sat in their wheelchair. There was no care plan or risk assessment for how to give this medicine to the person when in their wheelchair, despite the fact they spent most of the day in their wheelchair. As a result, staff had hoisted the person during a prolonged seizure which was a high risk and unsafe practice and put them at risk of injury.
- Another person had a rescue medicine for prolonged seizures or cluster seizures. Cluster seizures are seizures that can start and stop but closely follow each other. However, the person's care plans did not set out at what point the medicine should be given, for example after five seizures, or after 4 minutes of seizures. This left the person at risk of not having their medicine when they needed it.
- Another person had rescue medicines for seizures and could have two doses of the medicine. However,

they had different instructions around how long to wait before giving the second dose. This could put the person at risk of not having their rescue medicine in time.

● Risks associated with people's constipation care were not managed safely. People with a learning disability may be prone to constipation and at risk from the effects of poor bowel care. One person had been prescribed two different medicines to relieve their constipation but had received these medicines late for several days, meaning they were constipated for longer than they needed to be.

● A second person had the same medicines and suffered constipation for longer than they needed on two occasions. We spoke with a registered nurse and they were unable to tell us when to administer this person's constipation medicines as their care plans were contradictory and not clear about when medicines should be given. This left people at risk of poor health.

● People who were prone to deteriorating health were monitored with a tool called the National Early Warning System (NEWS). NEWS is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. This involves taking a baseline for a person's normal temperature, pulse rate and oxygen saturations. It then states what actions should happen if results are recorded outside of the baseline.

● For one person nurses were not consistently taking NEWS scores or vital signs after seizures, as required by care plans and assessments. When NEWS scores indicated a repeat observation was needed, this has not always been done. This left people at risk of not receiving assistance if their conditions deteriorated.

● Some people living at Beech Lodge had specialist physiotherapy treatments such as footwear or hand splints. One person with splints to stop their muscles from contracting was not receiving the correct care and support with their splints.

● We found risks relating to reflux and aspiration that were not being managed safely. For example, one person needed not to be laid flat for 30 minutes after eating to reduce the risk of from reflux. The persons care records showed times where this had happened, which put them at risk from choking or aspirating as a result of reflux.

● We looked at peoples care records to review the support people had received with their feeding tubes and positioning and found poor recording that put people at risk. Some people received their food fluids and medicines via feeding tubes directly into their stomachs. To reduce the risk of poor health, such as from aspiration or choking, people needed to be positioned correctly during and after receiving anything via their feeding tubes. One person was not recorded as having this support correctly. This put them at risk of choking or aspirating.

● People were being supported to receive their personal care on shower trollies. This was not suitable for some people and could pose choking or aspiration risks as well as being undignified and had not been assessed for use. For example, for people who could not be laid flat there was not a consistent recording that their head had been elevated.

Using medicines safely

● At our last inspection in October 2020 we found a continued breach of Regulation 12 as there had been a failure to ensure people received their medicines at regular times, and PRN ('when required') protocols were followed correctly. At this inspection we found these risks remained.

● Protocols for PRN medicines were not sufficiently person centred to enable to staff to administer when appropriate, nor was the information documented consistent with people's care plans. This may result in people receiving medicines when it is not appropriate or at the incorrect times.

● Allergies were not consistently recorded, which could put people at risk of receiving a medicine which they are allergic to. Care plans did not give assurance that medicines were managed safely for all people as there were inconsistencies and missing information. Covert administration of medicines did not follow best practice or the provider's policy.

● Physical health monitoring required was not always included within medicines care plans. For example,

when healthcare professionals visited people it was not always clear who made changes to medicines or the reasons for the changes. This may put people at risk of receiving a medicine when it was not appropriate.
The failure to provide safe care and treatment was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Systems and processes to safeguard people from the risk of abuse
● Systems had not always been effective in keeping people safe from the risk of abuse. For example, during our inspection we found issues with safety concerns for people relating to constipation care, epilepsy, choking risks, and medicines. Following our inspection, we raised these concerns with the local safeguarding adults' team as they had not been identified or reported by the provider.
● Audits and processes to highlight safeguarding concerns had not been effective in identifying shortfalls and protecting people from possible harm. The service had been receiving support from the local authority as part of operational provider concerns under the Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk.
● However, despite input from different agencies we did not see an improvement in the protection of people from neglect or abuse. Assurances that improvements to care had been made were not demonstrated in the provider concern meetings and a high number of incidents and concerns were still present.
The failure to implement systems that effectively prevent abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Staffing and recruitment
● At our last inspection in October 2020 we found a breach of Regulation 18 as there were not enough skilled and competent staff to keep people safe. At this inspection we found some improvement, but other risks remained.
● Although the provider had increased staffing levels so there was an extra staff member during the daytime we found that there were times when people were left with little or no support. We have reported on this more fully in the Well led section of this report.
● Staff did not have the necessary skills, training and competencies to support people safely. Staff had not been trained to undertake safe, lawful restraint techniques, despite one person's risk assessment setting out the need for this.
● Other staff did not have sufficient skills and training to support people with behaviours that may challenge others. For example, one staff member we spoke with did not use person centred language to describe people's behaviours and did not have training in positive behaviour support.
The failure to ensure sufficient numbers of suitably qualified, competent and skilled staff to meet the needs of the people using the service is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● One relative told us that Beech Lodge was always clean when they visited.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care, how the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- At our last inspection in October 2020 we found a breach of Regulation 9 as people were not supported appropriately with emotional distress, some people were ignored, and others were left with a lack of structured meaningful activities. This breach was reported under the key question is the service caring at our last inspection. At this inspection we looked to see if the provider had made improvements and found not enough improvement had been made and the breach remained.
- Following our last inspection, we raised concerns about poor practice and a lack of person centred care and were given assurances that improvements were being made. However, during this inspection we found further concerns.
- Some people were left for long periods of time with no or with very limited interactions. We observed three people who were left for long times, up to two hours, sat amongst other people but with very little or no interaction. In one person's case the lack of support was raised during a previous inspection in October 2019 but there was no sign of improved engagement for this person. A visiting professional had also reported poor practice around lack of interaction.
- Most activities were group-based activities with approximately eight people sitting around a table, and some people had very minimal support with these activities. One cooking activity was over very quickly and there were no jam tarts made or smoothies as people had been told at the start of the activity.
- People did not always get support they wanted. For example, one person asked to go for a walk. Staff acknowledged the request but did not take or arrange for the person to be taken for a walk.

The failure to ensure that people receive person centred care and treatment that is appropriate to their needs and reflects their personal preferences is a continued breach of Regulation 9 of the Health and Social Care act (Regulated Activities) regulations 2014. Person centred care.

- At our last inspection in October 2020 we found a breach of Regulation 10 around a lack of independence and dignity for people. This breach was reported under the key question is the service caring at our last inspection. At this inspection we looked to see if the provider had made improvements and found not enough improvement had been made and the breach remained.
- One person's activity care plan stated they needed support to get involved in activities and they liked holding sensory items. We observed the person did not have these items to hand and spent long periods with no interaction. When the person was approached by an activity staff, the interaction only lasted for two minutes. The provider had not assessed how the persons sensory needs affected their ability to engage with activities and as a result the person was left isolated for long periods. This was not respectful of the person's

needs.
● Another person was observed sitting alone in their bedroom with nothing to look at and no stimulation. In addition, their trousers had slipped down. We asked staff to attend to the person. Their activity care plan stated they liked to be sociable and involved in activities and that is was important that they had a sensory item with them. The person did not have the item listed when they were alone in their room.
● Other support we observed was not respectful, such as poor support at mealtimes. Some people were being supported by staff who did not interact with them during the mealtime for example to say what the person was being fed. Other people at mealtimes did not have the support as described in care plans.
● People were not always being supported to be as independent as possible. For example, one person was able to walk with support and staff explained how this would be done. However, we saw two staff put the person straight in their wheelchair, without offering the person the opportunity to walk, when taking them to their room.
● We observed some language that was not person centred or respectful when a staff member was speaking about a person's behaviours of concern. We have reported on this in the Safe section of this report.
The failure to treat people with dignity and respect is a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● At our last inspection in October 2020 we found a breach of Regulation 17 around a failure to assess, monitor and to improve the quality and safety of the services provided. At this inspection not enough improvement had been made and the breach remained.
● At our last inspection we raised concerns around closed cultures, a lack of independence and person-centred care for people, safety concerns regarding epilepsy, medicines, complex eating and drinking needs and aspiration. At this inspection these concerns remained as we found risks with epilepsy, constipation, medicines, poor culture, lack of independence, lack of person-centred care and lack of effective management action to put things right.
● Our previous inspection found five breaches of regulations relating to person-centred care, dignity, safe care and treatment, good governance and staffing. At this inspection all five breaches remained. In addition, we identified a breach of Regulation 13 related to safeguarding people from abuse.
● Beech Lodge has been subject to operational provider concerns under the Sussex Multi-Agency Policy and Procedures for Safeguarding Adults at Risk. This involved regular meetings with partner agencies such as local safeguarding team, CCG and health professionals in order to drive improvement in the service. Despite this the provider was not able to demonstrate sustained improvements or give assurances that improvements were effective.
● Beech Lodge had not been rated as Good in Well-led for the last five inspections going back to July 2015. In the last two inspections the ratings of the Safe and Well led domains had deteriorated and both remain rated Inadequate at this inspection. This is because the provider has failed to make improvements to the safety and governance of the service provided.
● The provider's quality audits had not been effective in identifying the areas of concern we found, or in responding to concerns we had previously identified. The Service Improvement Plan (SIP) was not effective in driving improvement. For example, one action from our previous inspection was for people with behaviours of concern to have a PBS plan. This action was marked as complete and an action recorded on 01 June 2021 that all people who required a PBS plan had been referred to the PBS team. However, during our inspection we found the person at greatest risk from behaviours of concern had not been referred to the PBS team and did not have a PBS plan.
● Similarly, the SIP gave assurances that actions for 'as required medicines' protocols and gaps in staff knowledge were complete. This was not found to be the case during our inspection
● Medicines audits were not reflective of issues found at this inspection, such as around the recording of people's allergies. Audits were not effective at identifying and implementing learning and appropriate

changes to practice.
● In December 2018 we imposed conditions on the provider's registration. The conditions were therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at several services operated by the provider.
● The conditions mean that the provider must send to the CQC, monthly information about accidents and incidents, unplanned hospital admissions and staffing and how they are acting to resolve any risks to people's safety and wellbeing. We also imposed conditions on the location in January 2021 setting out the need for a monthly report on how people's needs had been assessed and monitored in relation to the management of epilepsy and seizure treatment, choking, and the management of behaviours that may challenge.
● The provider level conditions and location level conditions and reporting of information about themes of unsafe care for people being supported by the provider had not led to similar risks to people at Beech Lodge being reduced.
● Concerns about risks associated with constipation, epilepsy, feeding tube management, effective use of NEWS, behaviours that may challenge others, and moving and handling people have all been repeatedly highlighted to the provider at other of their services. This information had not been properly shared or used to improve safety and quality at Beech Lodge.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There was a registered manager in post at Beech Lodge. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.
● At our last two inspections the registered manager had told us about action they had taken to put things right. At our last five inspections the registered provider had told us they would take action to make improvements. We found this had either not happened or any improvements were not embedded. At this inspection not enough action had been taken to make improvements and breaches of Regulations remained. The registered manager and the registered provider have a duty as part of their registration with CQC to ensure the service was compliant with Health and Social Care Act (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● During this inspection we looked at breaches of Regulation 9 and 10 as reported above in this section. People's experience was not person centred and their independence was not being promoted fully. Activities were delivered in groups and some people were not able to fully participate or did not show any interest.
● People were not empowered to communicate. We spoke with staff who were not clear about when people would be in distress or pain. People had DISDAT tools to describe when they would be in distress or pain but staff either described different signs to the plan or gave different responses from each other. This left people at risk of not being understood when they were in pain or upset.
● People had Abbey Pain Chart. An Abbey Pain Chart is a tool designed to assist in the assessment of pain in people with communication problems. The pain charts we reviewed had not been completed for people that had displayed behaviours that may challenge others.

Working in partnership with others
● There was not an effective relationship with all partner agencies in sharing information. Healthcare professionals had not always been able to meet with managers to discuss people's care as managers had

not attended appointments.
● Information was not always sent to other providers to help them support people.
The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people.
The failure to maintain accurate and contemporaneous records of people's care was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● In response to Covid restrictions the service used technology such as video and telephone calls to encourage people to have communication with their loved ones.
● The service had sent email's to relatives giving updates on Beech Lodge. A keyworker role was developed to encourage people to engage. Some people had gone to parental homes overnight after social distancing and Covid restrictions were eased.