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

About the service
Bexhill Care Centre is registered to provide personal and nursing care for up to 41 older people who are living with dementia and/or have physical disabilities. There were 34 people living at the home during the inspection

People's experience of this service
The provider did not have an effective quality assurance and monitoring system to assess the services provided and ensure people had appropriate care and support. The provider did not have oversight of the service, which meant they had failed to identify areas where improvements were needed, and placed people at risk of harm.

People's health, safety and well-being were not always protected, because pre-admission assessments had not identified people's specific needs before they moved into Bexhill Care Centre. The care plans and risk assessments based on the pre-admission assessments therefore had not always reflected people's needs or provided clear guidance for staff.

There was some guidance for staff to follow to protect people, such as, those at risk of falls. However, from our observations and records staff did not always follow this guidance and people were at risk of falls. Where accidents and incidents had occurred the registered manager or staff had not made referrals to the local authority under current safeguarding procedures. They had not kept CQC informed of these incidents and lessons had not been learnt to prevent re-occurrence.

Medicines were not managed safely. The ordering, checking and storage of medicines had not followed relevant guidelines and people had not consistently received their medicines as prescribed.

There were not enough staff working in the home with the right skills and knowledge to provide personalised care to people, based on their needs, preferences and choices. There was an over-reliance on agency staff, nurses and care staff, and there was no clear process to assess the competence or suitability of agency staff before they worked at the home.

There was ongoing maintenance at the home. However, some immediate action was needed to make safe the environment to protect people and this had not been done, which meant people were at risk of harm.

Recruitment procedures were thorough to ensure staff were suitable to work in the care setting.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The service was last rated Requires Improvement. (Published 22 February 2019).

Why we inspected
We received concerns in relation to the management of medicines, people's nursing care needs, staffing and overall management of the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection. Areas where improvements were needed have been consistently found during inspection since this service started in 2015. Where some improvements have been made they have not been sustained and people continue to be at risk of harm.

Enforcement
Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up:
Following the inspection we took action to ensure the provider improved the safety in the service. We informed the local authority and clinical commissioning group (CCG) of our concerns.

The overall rating for this registered provider is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, 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.

Bexhill Care Centre Limited

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.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Bexhill Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 we reviewed the information we held about the service and service provider. We looked at the action plan provided to CQC following our last inspection and information received from health and social care professionals, the local authority and commissioners of care.

During the inspection
We spoke with 12 people who used the service and one relative. We spoke with 10 members of staff, including the registered manager, nurses, care staff and chef.

We reviewed a range of records. This included five people's care records, incident and accident records,

medicine administration records and four recruitment files. We spoke and corresponded with the provider after the inspection.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection the provider had failed to provide safe care and treatment for people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider was still in breach of regulation 12. We found the provider, registered manager and nurses had not accepted responsibility for planning and delivering safe care and people were put at risk of harm. We found an additional breach of regulation.

- The management of ordering, checking, storing and administration of medicines was not effective, and did not ensure people were given their prescribed medicines when they needed them.
- We found errors and gaps in recording, in the medicine administration records (MAR), which meant people may not have been given their prescribed medicine. For example, one person was prescribed blood thinning medicine to reduce the risk of a stroke. This medicine was to be given daily and staff were required to count the medicines that remained when it had been given. We saw from the MAR and the numbers of tablets remaining that the medicine had not been given on one day.
- Another person's medicine had been out of stock for five days. No-one had re-ordered the medicines, staff had not taken responsibility for ensuring the person had the medicines they had been prescribed. The person had not received prescribed medicines and left them at risk of their health and well-being deteriorating.
- As required medicines (PRN) such as pain relief, had been prescribed. There was no guidance for staff to assess if these were needed. This is essential, for people living with dementia and/or unable to communicate verbally. There was a reliance on agency nurses who did not know people well. To assist agency nurses the guidance should have included details of how the person expresses themselves when in pain or discomfort.
- From the MAR we saw people were regularly given pain relief. However, a pain chart had not been used to assess people's level of pain or if pain relief had been effective in reducing a person's pain when given. This meant people may have been taking medicines they did not need or remained in pain, because the medicine was not effective.
- Each MAR requires a front sheet, with a photograph of the person, details of their allergies and specific information about their support needs with medicines. This assisted nurses who did not work at the home regularly to identify people who they were unable to respond verbally if asked for their name. These had not been completed for two of the people at the home. There was a risk of people receiving incorrect medicines.

Assessing risk, safety monitoring and management

● Staff said risk assessments had been completed for each person before and after they moved into the home, and if a risk had been identified support would be put in place to address this.

● We found that risks had not always been identified during the pre-admission assessment, which meant the care plan and guidance for staff to follow to reduce risk was incorrect. For example, the report from the mental health unit where a person had previously received treatment stated that the person should not be placed in a unit with people living with dementia. This had been based on the health professional's assessment of the person's needs and the changes in behaviour which may occur due to their mental health needs.

● This person had been placed in Lavender unit with people living with dementia. Their behaviour changed in response to other people in the unit, which put them, other people and staff at risk. Staff said the person reacted to people living with dementia who were loud at times and called out. They addressed this by moving the person with mental health needs to Poppy unit. The person was then unable to access their bedroom, there was no evidence that they had been consulted about this or that their choices and preferences had been considered.

Staffing and recruitment; safety monitoring and management

● There were not enough staff with the appropriate skills and knowledge to understand people's needs and provide the support and care they needed.

● Information received from the external professionals and staff was that there was an overreliance on agency staff, who did not always have the skills to support people. This included knowledge and understanding about behaviour that challenges peoples and staff safety. We asked two agency staff if they had attended training to support people whose behaviour may change due to their dementia or mental health needs and they said they had not.

● This inspection started at 7.30am so that we could look at staffing levels and join staff for the handover from the night staff.

● One of the nurses was permanent staff and had worked at the home for a month, the second was an agency nurse and had done one shift previously.

● The agency nurse was allocated to Lavender unit with two agency care staff. This meant that the nurse was unable to start giving out medicines at 8am as prescribed because there was not enough staff in the unit. A member of staff was always required to remain in the lounge to reduce the risk of falls and injury. One person needed one to one support, as they preferred to walk around the room and they moved tables and chairs. The nurse remained in the lounge to support people, so the medicines round was delayed.

● Permanent staff said the reliance on agency staff meant they spent time supporting them as well as providing care for people. One member of staff told us, "We tell them who to support and check when we can, but we don't always have the time when we are looking after other residents" and "There may be enough staff but if they don't know the residents then it is difficult."

● Staff were concerned about the lack of security in Lavender unit. They told us the locking mechanism on the door at the top of one flight of stairs was not working, which put people at risk of injury. The registered manager said this had been identified as a risk on Friday 7 June. However, records showed that on 19 May one person had got through the door and had gone down the stairs to the ground floor door, which at the time was locked.

● We checked the doors and found the locking mechanism on both doors were not working. This meant people on the first floor would be able to get to the ground floor and/or were at risk of falling down the stairs.

● Key pads were in use. The code needed to leave Lavender was written above the keypad. People, who were subject to Deprivation of Liberty authorisations, may have been able to leave the unit.

● At the last inspection we saw some of the flooring in Poppy was damaged and splitting. Tape had been

used to cover these areas and staff told us the flooring was being replaced. At this inspection we found the flooring had not been replaced; the tape used to cover damaged areas has worn away and there were trip hazards in the corridor and at the entrance to Poppy lounge.

● Emergency equipment, such as a suction machine to clear a person's mouth or airway, should be available when needed. Staff said there was a suction machine in the home but, they were not able to locate it. This meant staff would have been unable to provide emergency treatment for people who had been assessed as being at risk of choking and needed assistance.

Learning lessons when things go wrong

● Staff said they recorded all accidents and incidents and gave this information to the registered manager. However, we found accident and incidents forms had not always been completed when people had been injured, and action plans to reduce the risk of incidents re-occurring had not been recorded or followed. Lessons had not been learnt and people continued to be at risk of injury and harm.

● For example, in one care plan we found a photograph of a wound dated 28 March 2019. There was no information about the cause of the wound, which limb had been injured or what action staff had taken to support the person. An accident form had not been completed and a referral had not been made to the local authority.

● We saw one person with a facial wound. Records showed that appropriate action had not been taken following the fall. The person was assisted to bed and given night sedation; there was no evidence that observations had been taken for possible head injury. An accident form had not been filled in and a referral had not been made to the local authority.

● Records showed that the person was at high risk of falls; staff were aware of this and said they always observed the person. However, we saw the person leaving their room and calling for help. They were not using their walking aid and were at risk of falling. We supported them to return to their room. We found there was no sensor mat or motion detectors to inform staff if the person was walking around and the call bell was not within reach.

The provider had not ensured safe care and treatment for people. This is a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding systems and processes

● Staff said they had completed safeguarding training and they would tell the nurse or registered manager if they had any concerns. They knew about the whistleblowing policy and some had used this to raise issues with CQC.

● Information received before the inspection from the local authority and whistleblowers told us that incidents and accidents had occurred. However, staff had not referred these to the local authority and had not followed current safeguarding guidance. For example, one person had left the building through an unlocked door. They were at risk of harm and staff had to intervene and support them to return to the home. Staff were advised by management that this was not a safeguarding referral and therefore the local authority were not informed until staff had contacted an external professional and CQC.

● Staff said they would inform the registered manager or nurse if they had any concerns and they expected them to make the referrals if they were needed.

● During the inspection we found accidents and incidents had not been referred to safeguarding.

The provider had not ensured that people were protected from harm and had not made referrals to the local authority in line with Sussex Safeguarding Adults Policy and Procedure. This is a breach Regulation 13 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

Preventing and controlling infection

● Staff said they had completed training in infection control and we saw they used gloves and aprons (Personal protective equipment) when supporting people with personal care.

● The home was clean and tidy. Housekeeping staff had a schedule to follow; although they also said they had to prioritise their work as there were not enough staff to do the work every day.

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.

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.

Managers and staff being clear about their roles and understanding quality performance; continuous learning and improving care

At our last inspection the provider had failed to provide safe care and treatment for people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider was still in breach of regulation 17. The provider had failed to develop an effective monitoring system to identify areas of concern; people continued to be at risk of harm and injury, and we found an additional breach of regulation.

- The management processes at Bexhill Care Centre were not effective. There was a lack of provider oversight to ensure people had the care they needed or, that staff were supported to provide person-centred care.
- There was no quality assurance system in place and audits had not been used to monitor the services provided.
- The registered manager said the clinical lead had been responsible for auditing the medicines and MAR but, was unable to produce the audits. The clinical lead had resigned four weeks before the inspection and a medicine audit had not been done since April 2019. There was no ongoing monitoring of medicines. Therefore, the concerns we found during the inspection had not been identified or addressed by the registered manager or provider.
- For example, one person was given medicines covertly. Covert medicines are added to a person's food or drinks and they are not aware that they are taking medicines when they have the drink or meal. The expectation is that people should be offered the medicines, possibly more than once, and only when they continue to refuse should medicines be given covertly. This means they are involved in decisions about their care as much as possible. There was no evidence that an assessment had been completed, that medicines were offered to the person and only as a last resort they were given covertly.
- One person had a transdermal patch for pain relief. A transdermal patch is a medication adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin to the blood stream. To ensure patches provide the same level of medicines consistently they should be applied to a different part of the body each time and this should be recorded, on the MAR or a body map. One of these patches had been applied on 6 June 2019, details of where it had been applied had not been recorded and records had not been updated since 29 May. This meant the person had received a consistent level of pain relief.
- The provider had introduced a new format for care plans. Information was stored on a computer and staff

could record the support and care provided using ipads. We looked at the paper records and those on the computer and found gaps in essential information. Care plans had not been regularly reviewed or updated when people's needs changed. Such as following a fall. The person's mobility had not been reviewed and an action plan had not been developed to provide guidance for staff and reduce the risk of further falls.

● Records were kept when people's behaviour had changed. However, there was no information about triggers that might cause these changes or what support staff could provide to distract people. One record stated de-escalation failed; it was not clear what staff had done to distract the person and there was no evidence of additional support to reduce risk. These issues left people at risk of inappropriate or inconsistent care because the provider had not ensured people's records reflected all their needs.

● Staff said people were weighed regularly; we asked to see an overview of people's weights, but this was not available.

● The poor record keeping meant permanent staff did not have access to up to date information about people's needs, and with the high reliance on agency staff people may not have received the care they needed or wanted.

● We consistently found that records were not up to date and they had not been reviewed when people's needs changed or regularly to ensure they reflected people's needs. Audits had not been carried out to ensure the health and safety of people and risk assessments had not identified people's individual needs and the support and care they received was not always appropriate.

● There was no learning from accidents and incidents to reduce the risk of them re-occurring. People's needs had not always been assessed after an accident. Their care plans had not been updated; an action plan had not been developed to support people as safely as possible whilst encouraging their independence.

● Support had been provided from external health professionals and the market support team from East Sussex County Council. They had offered guidance and advice about improving the services and ultimately people's lives. There was little evidence to show the provider, registered manager or nurses had actively responded to the advice or guidance.

● Some improvement had been made about safeguarding referrals following visits from the pharmacist and market support, but this has not continued. We asked for additional information during the inspection about a specific accident and this has not been sent to us.

The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support. This is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks and regulatory requirements; how the provider understands and acts on duty of candour responsibility

● Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services.

● They are required to inform CQC if there are 'insufficient number of suitably qualified, skilled and experienced persons being employed for the purposes of carrying on the regulated activity'. We had not been informed of the difficulties recruiting enough staff and nurses. Agency staff had not completed relevant training to support people with behaviour that may challenge; the provider and registered manager were unable to show that staff continuously provided appropriate support and care for people living in Bexhill Care Centre.

● They are also required to inform CQC if 'safety devices in premises owned or used by the service provider for the purposes of carrying on the regulated activity where that failure or malfunctioning has lasted for longer than a continuous period of 24 hours'. Such as the doors on the ground and first floor in Lavender unit not locking and putting people at risk.

● The registered manager had not sent in notifications to CQC following incidents, accidents or admissions

to hospital. They said they had not known CQC should be informed of allegation of or actual abuse.

This provider had not informed CQC of incidents that affected people's health and welfare. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; continuous learning and improving care; working in partnership with others; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We saw examples of staff being lovely in their approach to people. They understood how to offer appropriate support and, this had a positive impact on the people concerned. For example, the agency nurse had lunch with a person, at a dining table in Lavender unit, as they needed one to one support. The nurse chatted as they encouraged the person to eat their lunch.

● We saw agency care staff sitting and chatting to people in the afternoon, which people enjoyed, but this was not common staff practice. One member of staff said, "We are a bit rushed at times, I think it is because there are so many agency staff, we don't have the time to spend with people."

● We found the overall culture in the home was not person-centred; good outcomes for people were not consistently provided and staff responses to queries from relatives needed to improve.

● The registered manager said staff sat with people at the dining tables for meals. We saw other people were not supported to use the dining tables, they remained in their armchair or their room and they did not have their meal with staff.

● We saw staff using negative responses when they spoke with people when their behaviour changed. One member of staff said to one person, "Go and sit down" and "I will be with you in a minute."

● A relative spoke to a nurse and senior care staff about their family member and were concerned that they seemed a bit down. The nurse responded by saying the person seemed fine the day before and said, "I will check on them later." They then continued with what they were doing in the office. Another relative said they had concerns about the care provided and had spoken to the registered manager about this.

● Care and support was at times task orientated and staff did not always think about the small choices people made and how these supported people to have an enjoyable life. For example, we sat near a person when they asked for the roast dinner choice with roast potatoes for lunch. Staff gave the person the roast meal with boiled potatoes. The person told staff they asked for roast potatoes and staff said, "Are you sure? This is based on the list the chef has." They then walked away. The person said again they asked for roast and staff told them, "This is very nice." We advised staff the person had asked for roast potatoes and they then went to get some.

● Staff spent more time with people who were at risk of falls, because they chose to walk around the home, while those that sat quietly had long periods of no interaction with staff.

● One person was sitting in the office in Poppy unit at the start of the inspection. Staff said, "They walk around a lot and like to do things like sweeping up, but they are also at risk of falling." The person joined staff in the conservatory during handover, because of the risk, while staff discussed other people's needs. We were concerned about confidentiality and staffing levels. We asked if there were enough staff to look after the person in the lounge and were told there were. One member of staff told us, "The resident can sit in the lounge with staff in future, there are enough."

● There was a lack e of continuous learning and improving care. There had been no competency assessment for permanent or agency nurses, to ensure they were able to give out medicines safely. The concerns about medicines have been continually found since the service opened in 2015.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to inform CQC and other relevant bodies of incidents that affect the health, safety and welfare of people who use the services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of medicines. The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks. The provider had not ensured there were enough staff with the skill and knowledge to provide support and care that met people's needs. The provide had not ensured that the premises were safe and well maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were protected from harm or that people were safeguarded from improper treatment. The provider had failed to follow safeguarding

guidelines and had not worked in partnership with other relevant bodies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that an effective monitoring and assessment system was used to protect people from inappropriate and unsafe care and support. The provider had not maintained complete and contemporaneous records in respect of each person, including a record of the care and treatment provided and decisions taken in relation to the care and treatment provided.