Sovereign Care Limited

Filsham Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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

People's experience of using this service and what we found
There were systems and processes to assess and manage risks to people, however these had not sustained the service through management changes and had not identified some of the shortfalls we found in the management of risk. For example, fire exits were not all clear to evacuate safely in the event of a fire and the sluice areas were not fit for use. Records for people's well-being and safety were not all up to date or accurate, for example, peoples changed mental health and related mental capacity to make decisions, oral health and nutritional well-being. The cleaning of the premises needed to improve to ensure all areas of the home were clean and hygienic for people.

There were some good examples of risk management but this was not consistent for all people.

People received care and support by enough numbers of staff who had been appropriately recruited and trained to recognise signs of abuse or risk. Medicines were stored, administered and disposed of safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The manager and staff team were committed to continuously improve and had plans to develop the service and improve their care delivery to a good standard. Feedback from staff about the leadership was positive, "Really good," and "A good place to work we are well supported and feel valued."

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

Rating at last inspection and update
The last rating for this service was good (published 23 August 2021)

Why we inspected
We received concerns in relation to staffing, risk management and the safety of people As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all

care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Filsham Lodge on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified a breach in relation to good governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Filsham 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 Health and Social Care Act 2008

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 team consisted of two inspectors.

Service and service type
Filsham Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Filsham Lodge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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 the time of our inspection the registered manager was on extended leave. There was a manager in post who was in day to day charge of the home.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We looked around the service and met with the people who lived there. We spoke with eleven people to understand their views and experiences of the service and we observed how staff supported people. 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 spoke with the manager, clinical lead, provider and eight further staff members.

We reviewed the care records of five people and a range of other documents. For example, medicine records, staff training records and records relating to the management of the service. We also looked at staff rotas, and records relating to health and safety.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with three relatives and two health care professionals.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People were not always protected from potential harm. One emergency fire exit on the first floor had been blocked by clinical bins and a medicine cabinet attached to the wall. This would impede an evacuation in the event of a fire. This was immediately actioned during the inspection by the maintenance person and the risk mitigated.

● The management of peoples' oral health was not consistent and poor oral health had the potential to impact negatively on peoples' overall health and eating and drinking. Peoples dentures were found in their en-suites unprotected on a shelf. Some people had no toothbrush or toothpaste in their rooms. There was no assurance that mouth care was offered and that staff checked peoples' mouth health. The manager said that this would be addressed immediately.

● On reviewing peoples' weights, it was identified that there were people whose weight was decreasing. There was evidence that the GP had been informed, but some peoples' nutritional risk assessment did not always reflect the actions staff took to fortify food to reduce further weight loss. The food records had not identified how much the person had eaten. There was a lack of oversight of peoples' nutritional intake and risk.

Environmental risk assessments whilst being completed had not identified the shortfalls found Superficially the home looked clean but surfaces in people's rooms were thick with dust; tables were sticky and bathroom hoists unclean. The sluice rooms were very cluttered, grubby and were not fit for purpose., as debris was on top of the sluice machines and the room full of clinical bins which meant you could not access the sluice room. There was some furniture and fittings such as bed rail covers whose outer layer was broken and therefore a cross contamination risk as it could not be cleaned effectively.

● The provider used a computerised care system with care plans and risk assessments. Some information in the care documents was not fully reflective of peoples' changed needs, such as mental capacity, skin integrity, skin injuries and nutrition. This has been reflected in more detail in the well-led question as the manager had taken steps from her first audit in April 2022 as manager to mitigate risk. For example, we saw evidence that staff were being reminded to check peoples skin integrity regularly.

The provider had failed to assess, monitor and mitigate risks to people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and each person had a

personal emergency evacuation plan (PEEP).
● Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.
● Risks associated with the safety of the environment and equipment were identified and managed appropriately.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
The overall cleanliness of the home needed to be improved to ensure that people lived in a clean and hygienic environment.

● 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.

Following the inspection, we were told that the premises had been deep cleaned, extra hours were allocated for cleaning, a management daily walk around the home was undertaken and the sluice areas cleared and fit for purpose.

The provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● Not all accidents and incidents were documented and recorded. We saw that some incidents/accidents were responded to by updating people's risk assessments, but some skin tears and injuries were not mentioned in risk assessments and were therefore unexplained. One person had a dressing on their arm but there was no linked accident record or treatment plan.

This is an area that needs to be improved.

● Learning from incidents and accidents took place. Specific details and follow up actions by staff to prevent a re-occurrence were clearly documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. For example, looking at medicines and their possible side effects such as increased sleepiness or agitation.
● Staff took appropriate action following accidents and incidents that ensured people's safety without restricting their freedom and this was clearly recorded. For example, people who were at risk of falls had sensor mat to alert staff that the person was up and at risk. Staff also told us that they looked at peoples' footwear to ensure that they were fitting properly.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. For example, an DoLS application for use of specific medicines had been submitted for one person and the condition of GP medication review every 3-6 months had been met and the restriction reviewed monthly and documented in the care plan.

Systems and processes to safeguard people from the risk of abuse

● There were clear systems and processes to safeguard people from the risk of abuse. Staff told us they received training in equalities and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination.

● People told us they felt safe. Comments included, "I do feel safe here, the staff are very good," "Kind staff," and "I am looked after and feel safe."

● Staff knew their responsibilities to safeguard people from abuse and any discrimination. Staff could tell us of the signs of abuse and how they could report safeguarding concerns. They were confident the management team would address any concerns regarding people's safety and well-being and make the required referrals to the local authority.

● There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority. Staff confirmed that they had read the policies as part of their induction and training.

Staffing and recruitment

● Staff numbers and the deployment of staff had ensured people's needs were met in a timely manner and in a way that met their preferences. Care delivery was supported by records that evidenced that people's care needs were being met.

● People told us that there were enough staff, one person said, "Always staff when you need them."

● There had been recent staff pressure due to an outbreak of COVID-19. During this time there had been a high use of agency staff to ensure people were supported appropriately. Staff were now all back to work and the use of agency reduced.

● Safe systems were used to recruit staff. Appropriate checks were made before staff began working with people including Disclosure and Barring Service (DBS) checks and references. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. Appropriate references had been obtained prior to staff being appointed. All registered nurses had a record of their personal identification number (PIN) and this was checked by the provider to ensure they were safe to practice.

Using medicines safely

● Medicines were stored, administered and disposed of safely. Medicines were ordered in a timely way. The service used an electronic medication administration record (E-MAR). The clinical fridges and the clinical

room temperatures were checked daily to ensure they kept medicines at the correct/safe temperature.

● We asked people if they had any concerns regarding their medicines. One person said, "I get my pills, the nurse always asks me if I need anything for pain."

● Staff who administered medicines had the relevant knowledge, training and competency that ensured medicines were handled safely. This included senior care staff as well as registered nurses. We observed staff administering medicines safely to people ensuring that they were offered the medicines, given time to take them in the way that they preferred and signed for once they were taken.

● Protocols for 'as required' (PRN) medicines such as pain relief medicines described the circumstances and symptoms when the person may require this medicine. We saw that people had received pain relief when requested.

● Medicine audits were completed on a daily through the E-MAR and weekly for all other medicine checks.

Requires Improvement

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager had been on extended leave for six months. During this time there had been two changes of manager, a change of deputy manager and clinical lead. This had led to an unsettled period at the home and there has been a decline in the oversight and management of risk.
- The current manager had been in post since March 2022. They undertook a thorough audit in April 2022 which had identified shortfalls in risk management , such as weight loss, people not being re-positioned, poor moving and handling, poor food and fluid records and poor personal care. Actions were in progress to address these issues. Staff were receiving moving and handling refreshers, and senior staff were checking on positioning changes of people to prevent skin damage. However, there had not been time for these to be fully implemented and we found further areas that required action to keep people safe.
- Environmental health and safety audits had not identified, until April 2022, that a major fire exit was blocked by a medicine cabinet and clinical bins. The manager said it was noted in March/April 2022 but had not been actioned. This meant that people had been placed at risk from unsafe evacuation.
- The premises, whilst superficially clean needed improvement. Peoples rooms were dusty and surfaces unclean. Sluices were not being used, due to clutter and this meant that staff were not pro-active in encouraging continence for those without an ensuite facility. This had not been identified through the audit system / had been identified but not addressed?
- People's records were not always accurate. Some people were found without access to a call bell and were shouting out for assistance for some time with their door closed. On talking to staff and looking at their care plan and risk assessments, there was some confusion regarding some people's capacity to use a call bell and what they may have wanted. The records did not reflect what staff were saying. There was no further reflection of how to enable people to request assistance if they didn't have a call bell facility. This meant staff could not respond to people's needs in a timely safe way.
- There were care plans and risk assessments for oral health, but despite being reviewed these were not accurate. People were not all receiving adequate support with their dentures or mouth care. Some peoples' dentures were not being used, this was not reflected in their risk assessment or care plan. This had the potential to impact on people appetite and ability to eat.
- There were gaps in peoples' nutritional care plans and fluid and food records were not always accurate and were completed retrospectively. This had placed people at risk of dehydration and weight loss.

The provider had failed to assess, monitor and improve the service. The provider had failed to assess, monitor and mitigate risks to people. The provider had failed to maintain accurate, complete and contemporaneous records. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The management team demonstrated a commitment to improving outcomes for people. It was acknowledged that there was work to do, but all the staff were enthusiastic about the changes introduced and felt included in the plans going forward.

● All staff attended daily meetings led by the management team to share information and ensure all staff had the same information. One staff member told us, "We are building up good communication and we feel supported and part of the team."

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. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider and manager understood their responsibilities under duty of candour. The Duty of Candour is to be open and honest when untoward events occurred. We have received notifications as required.

● People and relatives confirmed that the provider kept their website up to date with changes from the government regarding visiting and COVID-19.

● Quality assurance surveys had been sent to people, staff and health professionals and an overview of actions from those put in place. For example, meal choices.

Continuous learning and improving care

● The manager told us they used accidents, incidents, complaints and safeguarding as learning tools to improve the service. We were able to confirm this by reviewing the documents seen and from the staff we spoke with. One staff said, "we discuss bruising, skin tears to see if it could be avoided." The lessons learnt were used to enhance staff knowledge and to improve on the service delivery.

Working in partnership with others

● The manager was positive and enthusiastic when discussing the areas for development identified at the inspection. Immediate action was taken in respect of and included reviewing all care plans and risk assessments to ensure all are current and reflective of individual needs.

● The manager had kept up to date with changes in best practice guidelines and was proactive in supporting its implementation. For example, changes to GP and pharmacy services during the pandemic.

● The manager had developed links with the local community and worked in partnership with health and social care professionals. This included GPs and social services, who were contacted if there were any concerns about a person's health and well-being. For example, the manager was in close contact with the CCG, mental health team and the GP service.

● The manager and staff had professional links with social and health care professionals and promoted effective working relationships. One professional told us, "They contact us when they need to, communication has been a problem, but that's from both sides and due to restrictions."

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the service. The provider had failed to assess, monitor and mitigate risks to people. The provider had failed to maintain accurate, complete and contemporaneous records. Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.