Bexhill Care Centre Limited

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Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

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

The home has accommodation for up to 41 people with nursing and personal care needs. There were 19 people living at the home at the time of the inspection. Some people had complex needs and required continual nursing care and support, including end of life care. Others needed support with personal care and assistance moving around the home due to physical frailty or medical conditions, and some were living with dementia.

A registered manager had not been in place since September 2015. A manager had been appointed and was applying to register at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

This inspection took place on the 17 and 21 December 2015 and was unannounced.

People were supported to make choices about the support and care they received and staff were kind and respectful. However, because of staff sickness and the use of agency staff people were not confident that staff had a good understanding of their needs and were unable to provide the care they needed without being directed by the people they supported. There were not enough staff with the appropriate experience and skills to meet people's individual needs.

The information in care plans was limited; risk had not been assessed for some people and, there was no clear guidance for staff to follow to support people. The quality assurance and monitoring system was not robust and had not identified the shortfalls we found during this inspection, including staffing, care plans and record keeping.

People had access to healthcare professionals, including the GP, optician and chiropodist. Choices were available for meals and people were consulted about the menu. Relatives and friends could visit at any time and they were made to feel very welcome.

There was a calm, relaxed atmosphere in the home and communication between people, visitors and staff was friendly and open. People said they could talk to the staff and the manager and provider were available if they wanted to discuss anything. Concerns had been addressed promptly.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009). You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

The staffing levels were not sufficient and staff were unable to evidence that they met people's needs.

Risk to people had not been assessed appropriately.

The systems for the management of medicines were not consistently safe.

Recruitment procedures were not robust to ensure only suitable people worked at the home.

Staff had attended safeguarding training, they had an understanding of abuse, but were not sure what action to take if they had any concerns.

Is the service effective?

Requires improvement

The service was not consistently effective.

The training plan was not up to date and not all staff had a clear understanding of the training they had attended.

Staff had an understanding of the Mental Capacity Act 2005, but Mental capacity assessments had not been completed as people moved into the home.

People were provided with food and drink which supported them to maintain a healthy diet.

Staff ensured people had access to healthcare professionals when they needed it.

Is the service caring?

Requires improvement

The service not consistently caring.

The use of agency staff and changes in staffing levels meant care and support was not consistent.

The staff approach was to promote independence and encourage people to make their own decisions.

Staff communicated effectively with people and treated them with respect.

People were encouraged to maintain relationships with relatives and friends, and they were able to visit at any time.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

The care planning system was not robust and did not reflect people's need or the support provided.

There was a list of activities, but these were not provided for people to participate in if they wished.

People and visitors were given information about how to raise concerns or to make a complaint.

Is the service well-led?

Requires improvement

The service was not consistently well led.

There was no clear operational leadership and guidance for staff.

The quality assurance and monitoring system was not robust and did not identify areas where improvements were needed.

People, staff and relatives were encouraged to be involved in developing the support provided.

Bexhill Care Centre Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 17 and 21 December 2015. It was undertaken by an inspector and inspection manager.

We reviewed the records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events with the service is required to send us by law. We also spoke to the commissioner of care from the local authority before the inspection.

During the inspection 19 people told us about the care they received and we spoke with five relatives and one friend. We spoke with 14 members of staff, which included housekeeping staff, maintenance staff, the chef, care staff, registered nurses, the manager and provider.

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

We observed care and support in the communal areas, the breakfast and midday meal, medicines being administered and activities, and we looked around the home

We looked at a range of documents. These included assessment records, care plans, medicine records, staff training, recruitment and supervision records, accidents and incidents, quality audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

Feedback from people living in Bexhill Care Centre and their relatives varied. People told us, "I feel safe with them, but they keep changing so I have to keep telling them what to do" and, "I don't feel safe as there are so many staff I don't know who they all are." Relative's comments included, "Yes, I think my mother is safe here, the best place for her." "I think they are well looked after, I haven't seen anything I am worried about" and, "I do feel she's safe." People, relatives and staff said there had been too many changes with the staff team and this may have affected the support people received. Despite people sharing positive views about how safe they felt, we found that improvements were needed to make sure people were safe at all times.

Training records showed that permanent staff had attended safeguarding training and had a good understanding of abuse and what action they should take if they had any concerns. They had read the whistleblowing policy and were confident that they would be able to talk to the manager if they had concerns and, they would contact the local authority or the Care Quality Commission if they felt appropriate action had not been taken. However, most of the staff working at the home during the inspection had been employed through a recruitment agency. They said they had attended safeguarding training but were unable to articulate what they had learnt or what action they would take if they saw something they were concerned about. One of the care staff said they would talk to their colleagues or the nurse. This showed that staff were unable to demonstrate an understanding of their responsibilities with regard to raising concerns to ensure people were safe, which meant people were at risk of harm. The manager and provider told us they had been assured by the recruitment agency that staff had attended relevant training, but they had no evidence to support this.

The provider had not ensured that people were protected from harm or that people were safeguarded from improper treatment. This is a breach Regulation 13(4) of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014).

People, relatives and staff were all concerned about the staffing levels in the home, and the ongoing use of agency staff. One person told us, "They do not know what support and care we need." The provider said a number of staff were off sick and they had increased the use of agency staff until the permanent staff returned to work. However, we were also told that the contract with the recruitment agency had been in place before staff went off sick. If the agency care staff had the skills and wanted to work in the home, they would be offered permanent positions.

The first day of the inspection started at 6am because we had received concerns about staffing at the home. An agency nurse and three agency care staff were responsible for providing the care and support for the 19 people living in the home the previous night. On the first floor one agency care staff said they had been responsible for checking the six people on that floor every half hour, "So they are comfortable, offer a drink and are ok" and, they had signed records to show they had done this. The agency care staff had not worked at the home before; they had not read the care plans and were unable to discuss people's individual needs. Two other agency care staff and the agency nurse had worked at the home once and twice before respectively and were also unable to demonstrate that they had an understanding of people's needs. The day staff included three agency care staff, two had not worked at the home before and one of these had no previous experience in care. This meant there were not enough staff working in the home that had the skills or a clear understanding of people's. We observed this had an impact on all aspects of the support and care provided and people's needs were not always met. For example, we saw an unsafe transfer. One person was moved from their room to the lounge using a wheelchair; the chair was balanced on the rear wheels only, there were no foot plates to support the person's feet and they were wheeled backwards so could not see where they were going or what was happening. Staff did not understand our concerns about the person's safety and, the risks to the person; such as them falling forward out of the chair or getting their feet caught under the chair if the wheelchair was put on four wheels without warning.

Care plans had some information about people's needs, but there was no consistency; some risk assessments had not been completed to identify people's needs and therefore there was no guidance for staff to follow to meet them. For example, the care plan said 'Communication. Mild memory loss. 2 hearing aids and glasses. Is a care plan required? No.' The areas that required specific support had been identified and recorded, but there was no additional information for staff to follow to support this person with

Is the service safe?

any potential difficulties with their memory, sight or hearing. The care plans were locked in a cupboard in the lounge and were only accessible using keys held by the nurse. The permanent care staff told us they had not read the care plans as they did not have the time; so staff may not have been aware of people's individual needs unless they had been discussed during handover, or if the person or their relatives had told them. The lack of up to date information about people's needs and the changes in the staff team meant people may not receive the support they need and want and, may be at risk of harm. For example, we saw agency staff left people who they had been assisting to get washed and dressed to ask the one permanent staff member working what support the person needed.

The nurse responsible for the ordering and checking of medicines was not working during the inspection. We observed agency nurses giving out medicines. They did not know all of the people living in the home, and some of the Medicines Administration Record (MAR) charts did not have pictures of recent admissions to the home. Nurses asked some people sitting in the lounge what their names were. Some of these people were living with dementia and may not have been able to respond appropriately. This meant some people may have been at risk of receiving medicines they were not prescribed.

Fire system checks were carried out regularly and records showed that permanent staff had attended fire training. However, from our observations and discussions with staff, there was no evidence that agency staff had been given instructions on what action to take if the fire alarm sounded, or how to support people and where the fire escapes were positioned.

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

Recruitment procedures were in place for permanent staff, to ensure that only suitable staff were employed. We looked at the personnel files for four staff. These contained relevant checks on prospective staff's suitability, including completed application forms, two references, interview records, evidence of their residence in the UK. A Disclosure and Barring System (Police) check, which identify if prospective staff had a criminal record or were barred from working with children or adults, had been completed for all staff. However, the provider had not carried out similar checks for the agency staff working at the home. The manager and provider told us they had been assured that checks had been completed for all agency staff by the agency itself, before they were allocated to care homes, but there was no evidence to support this.

Agency nurses demonstrated an understanding of ordering additional medicines and responding to the list of actions in the diary, such as arranging doctors' visits and tests. Medicines were delivered and disposed of by an external provider and the management of this was safe and effective. The MAR charts had clear records of the medicines prescribed, with details of allergies and there were no gaps in the records, which meant people had received the medicines they had been prescribed. Records were kept of medicines given as required (PRN), and the reasons they had been given were recorded on the reverse side of the MAR chart, such as paracetamol for pain relief. People's medicines were kept separately in a locked trolley in a small locked room on the ground floor, with additional medicines stored in locked cupboards. A fridge was available for medicines that required a cooler temperature and this was monitored to ensure medicines were correctly stored and safe to use. We saw and the nurses told us giving out the medicines took a considerable amount of time, as people needed support and may have had difficulties swallowing. One nurse was working through her induction and was being supported by the lead nurse; they were not available to observe the care and support provided, which meant there was no system in place to ensure people were supported appropriately.

Access to all parts of the building was through secure doors, visitors and people had to ask staff to enter and exit. Bedrooms were on both floors of the building in use and 19 of the 24 rooms available were occupied. There was a large communal area, with a range of seating areas, which enabled people to watch TV, listen to the radio or sit with relatives and friends. The conservatory leading off the lounge was available for use as a dining room and some people preferred to use this at mealtimes.

People's personal space and communal areas were clean and a cleaning schedule was in place. Housekeeping staff

Requires improvement

Is the service safe?

discussed their role in keeping the home clean and doing the laundry, they had attended relevant training, including infection control, safeguarding and Control of Substances Hazardous to Health (COSHH).

Staff said they provided a safe environment that enabled people to live comfortably and there was ongoing maintenance and repair of the building and equipment used. There were up to date records to show relevant checks had been completed, including lighting, hot water, call bells and electrical equipment and, the maintenance staff demonstrated a good understanding of their roles and responsibilities.

A range of pressure relieving mattresses and cushions were in use. The nurses said they checked the settings for each mattress during each shift, and demonstrated what settings were required for the different mattresses, based on people's weights and build. We saw they were on the right settings. The maintenance staff was responsible for the mattresses and cushions and records were kept of the ongoing maintenance. Evidence of maintenance of the hoists and lift was also available and there were records to show that there were systems in place to deal with an emergency or if people had to leave the home at short notice.

Requires improvement

Is the service effective?

Our findings

People said some staff did not know them well enough to really look after them. One person said, “They are all very nice, but I have to tell them what I need” and, “There are too many carers that are not the same.” People said the food was very good. One person told us, “They do ask what we would like to have and there are choices for each meal.” One person and a relative said the evening meal was not always very good. Relatives said, “I think they are doing a good job on the whole” and, “They haven’t got their act together yet.” People had access to GP’s and other health professionals if they needed to. One person told us, “I see the doctor if I need to and I am waiting for the chiropodist, but I need a specialist one and there is a long waiting list so I have to wait.”

We agreed with people that there were improvements needed to ensure the support and care provided met people’s individual needs.

Staff records showed that they received regular and ongoing training which included essential training such as safeguarding, infection control and moving and handling. Permanent staff told us they were required to attend some training, such as moving and handling, and they completed other training on line using the e-learning system. However, staff had not attended additional training, such as supporting people whose behaviour may put themselves, other people and staff at risk and people living with dementia. This meant staff may not be able to provide appropriate support and care. Agency staff were not sure if dementia awareness had been included in the training they completed, some thought it had, but none were sure. Agency staff said they had attended moving and handling training as part of their induction training with the agency. However, we observed agency staff using unsafe moves when assisting people. For example, staff assisted two people to transfer by lifting them under their arms, which is an unsafe lift and puts the person and staff at risk of injury.

The provider had not ensured that staff employed by the home were suitably qualified, competent, skilled and experienced to understand and meet people’s needs safely. This is a breach Regulation 18 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

The manager and permanent staff had completed training and demonstrated an understanding of the Mental Capacity Act 2005 (MCA). The MCA aims to protect people who lack capacity, and enabled them to make decisions or participate in decisions about the support they received. Mental capacity assessments had been completed for some people living in Bexhill Care Centre and staff were aware that some people were unable to make some decisions without support. However, the care plans were not up to date and additional information was required to ensure the assessments were appropriate to each person. For example, one person was living with vascular dementia. A mental capacity assessment had not been completed; there was no care plan in place to support the person and no guidance for staff to follow. This meant staff may did not have a clear understanding of people’s capacity to make decisions and ensure they were safe. This is an area that needs improvement.

There were records in place for staff to record people’s daily intake of food and drink. However, we found gaps in these records and the manager said it had been difficult to ensure staff completed them. Senior staff and nurses were required to check the records throughout the day to ensure they had been completed, but this had been difficult, “As staff are off sick and agency staff are covering.” Staff were aware of the importance of ensuring people had a, “Good diet, with enough to eat and drink, to make sure they are well.” Although we saw one person did not want their meal and was not offered an alternative. People’s weights had been recorded, although in the care plans we did not see relevant guidance for staff to follow if people refused or staff were unable to weigh people. Staff had a good understanding of the importance of a good diet and the monitoring of weights. One said, “We need to see what they weigh so we check if people lose weight or are not eating properly. If they lose weight we tell the nurse and they contact the GP for them to visit of refer to the dietician.” Another staff member said, “We know if people are not eating properly. Some people have off days and eat less, but we keep an eye on them and know what they have over a few days so they are ok.” The lack of relevant information meant staff were unable to show that they had a good understanding of people’s dietary needs and that these were met.

Deprivation of Liberty Safeguards (DoLS), which is part of the MCA, is to ensure someone, in this case living in a care home, is deprived of their liberty in a safe and appropriate way. This is only done when people are unable to tell staff about their wishes and need support with aspects of their

Requires improvement

Is the service effective?

lives. Decisions about their support is made during best interest meetings and agreed by relatives, health and social care professionals and staff, when there is no other way of safely supporting them. A relative said they understood that to ensure people were safe there may have to be some restrictions on what they can do and they had no concerns about this. Another relative told us, "Staff use bed side to make sure my mother is safe, which is a good idea, but I know it has to be agreed and she couldn't do that." The registered manager said DoLS was in place for one person and the use of bed rails and locked doors meant that applications were required for everyone living in the home; these had been completed and they were waiting for a response from the local authority.

Staff asked people for their consent before they provided care and support; people made decisions about how they spent their day and they were assisted to sit in the lounge or remained in their rooms. One person said, "I was watching TV until the early hours so I have just had my breakfast and will be having a wash in a bit" and, "I am having a lie in I suppose, they don't mind if I wait a bit." Staff said it was important to involve people in decisions about the support provided and told us, "We always ask people for their consent before we provide any support" and, "If they don't want to get up or want to stay in their room rather than the lounge then it is up to them." We observed staff talked to people quietly about what they wanted to eat and where they wanted to sit in the lounge. Some people had their preferred seats and were able to sit in them with assistance from staff using stand aids and hoists. We observed staff used hoists appropriately to transfer people from their bed to wheelchair and them into armchairs in their own rooms or the lounge.

Food was freshly cooked each day and the menu was based on people's preferences and choices. The chef told us they decided what food was bought; they were continually reviewing the menu and had made changes based on what people said and what their response was to the meals. They said, "We aim to give people the food they like and we are happy to make changes and introduce things if they want them." The chef and staff had a good understanding of people's dietary needs in relation to specialised diets for example diabetic or soft diets. People said they were asked what they wanted to eat and we observed staff asked people and recorded their responses. One person said, "The food is very good, they ask us what we want and we can change our minds." One relative told us, "Yes the food is good, they can have what they want and my Mum has a soft diet which is what she needs." Another relative said that the evening meal, "Can be a bit basic, for example sausages and beans" and the time of the meal can vary; although they thought the food was good. We observed staff giving out breakfast and lunch, choices were provided and people could have three hot meals a day if they wished. On the second day of the inspection a Christmas buffet had been arranged between 11am and 3pm, with relatives and friends invited to join people. The food was good and a number of relatives joined people in the lounge and their own rooms. Staff told us everyone knew about the buffet and they had asked people if they wanted to sit in the lounge. All of the staff provided people with support in using the buffet as required; they prompted some people and assisted others.

There was an induction programme in place when permanent staff started work at the home. The registered manager said all staff had worked with more experienced staff until they were competent and felt confident looking after people. Permanent staff said they had completed an induction programme and as they had worked at the home since it opened and had previous experience in care they supported new staff. One member of staff told us, "When all the senior staff are in place, some have just started, including the nurses then I think a better system will be introduced." The registered manager showed us that all new care staff would be required to complete the Skills for Care Certificate training as part of staff induction. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life, so that they have the knowledge and skills to support people and meet their needs. Staff said if they wanted to do any additional training they felt they could ask the registered manager.

Records showed that a supervision programme was in place and permanent staff said they had this regularly to discuss any concerns or training needs. One member of staff said, "Yes we have supervision, but to be honest we can talk to the manager at any time if we need to and they are very supportive." Another member of staff told us, "The manager and provider are always around and they ask people and staff if everything is ok and does anyone need anything. So it is very open and relaxed, which is really nice for people living here."

Requires improvement

Is the service effective?

People had access to health care professionals and there was evidence of good communication in the management of people's care between the provider and external professionals, such as Speech and Language Team, dentists, opticians and chiropodist. GPs visited the home as required. Appointments and any outcomes were recorded in the diary and care plans which included any changes to the support provided. One person said, “If I need a doctor, they will organise it” and, “I am waiting to see an occupational therapist to help me get up walking again, I think they are coming tomorrow and I am really looking forward to that.” A relative told us, “They tell me if there have been any changes and if they have to ring the doctor. I think they know what they are doing.”

Requires improvement

Is the service caring?

Our findings

People told us, "I think they are very kind and do their best, but I have to tell some of them what to do." "The staff are very kind" and, "They are very good." A relative said, "I come visiting at any time and the staff are always welcoming and friendly." Another relative told us, "The staff know what support my mother needs, they are very caring." Staff said they provided the care and support people needed.

Due to staff sickness most of the care staff working in the home did not have a clear understanding of people's needs. Although they involved people in decisions about the support they provided people felt the staff changes meant they had to, "Keep telling them what I need." One person said, "I don't have any complaints about them, they are kind and help me, but it is time consuming when I have to tell them what to do." Another person told us, "It is stressful when we don't know who is going to turn up to help us." The manager was aware that using agency staff was not ideal and said, "This is the situation we are in at the moment, one of those unexpected developments and we have to make sure there are enough staff working in the home to ensure people are safe" and, "The clinical lead and permanent care staff will provide support." People were supported by staff who did not have a clear understanding of their needs, which meant they may not have had the support they wanted or needed.

The home had a calm atmosphere. At 6am the lights in the home were dimmed, people were asleep and staff said they waited until people wanted to get up, although they had checked that people were comfortable in bed. People were supported to get up, washed and dressed, most after the handover at 8am. Staff asked people what they wanted to do and provided the support people needed. Some people had their breakfast in bed, while other used the conservatory; it was their choice where they sat.

People were assisted to use the lounge if they wanted to. We observed staff calling people by their preferred names; they waited for a response when they asked questions. Such as were they comfortable, if they wanted a drink and if they wanted the TV on. One person liked to watch TV and sat close by. They said, "I usually sit here with my friend and we watch TV. I like the cookery and gardening." Some people chose to sit in another part of the lounge and the radio was put on at their request and they tapped their feet along to the music.

Communication between people, relatives and staff was relaxed and friendly. Although agency staff did not know people well we saw that all of the staff talked to people quietly and respectfully and, held their hand or touched their arm to encourage a response when they asked spoke to them. Staff consistently took care to ask permission before intervening or assisting. Staff said they always asked people if they needed assistance, they never made decisions for them and it was clear that staff respected people's choices. People, where possible, were enabled to express their needs and receive appropriate care. Staff asked people if they needed assistance with personal care in a quiet and respectful way, and discretely asked if they needed assistance to use the bathroom.

Staff respected people's privacy and dignity, bedroom doors were closed when they assisted people with personal care and remained closed if people preferred this. Staff regarded information about people was confidential. One member of staff said, "All the information we have about people is confidential. We do not talk about people's needs in front of other people and if relatives ask we refer them to the nurse or the manager." Care plans were secure in a locked cupboard in the lounge.

People's preferences were recorded in some care plans and although staff said they had not read these they were aware of how some people liked to spend their time. One member of staff told us each person was different, they had their own personality and made their own choices, some liked music or watching TV, while others liked to sit quietly in their rooms, and they enabled people to do this as much as possible.

Relatives said they could visit at any time and were always made to feel very welcome and, people said their visitors could come when they wanted to. Permanent staff knew the relatives very well and there were friendly conversations between them when they visited the home. One relative told us, "The staff are very good, they are always around when we visit to let us in and answer any questions if we have any."

Requires improvement

Is the service caring?

End of life care had been discussed with people and their relatives where appropriate and, this had been recorded in the care plans. Do not resuscitate forms had been discussed with healthcare professionals and completed by people or their relatives.

The manager said advocates were available to support people if they had no relatives or representatives and information was available in the office. They said this service was not needed at the time of the inspection

Requires improvement

Is the service responsive?

Our findings

People knew some of the staff had worked at the home since it opened, but they felt there had been so many changes with the staff that they did not know who would be looking after them on a day by day basis. One person said, "They do their best I suppose but I think they should know more about us and what we need before they come in." Relatives said there were some minor issues that still needed to be resolved, such as staffing, activities and some aspects of personal care like regular haircuts. Staff said if they could improve anything it would be the activities, so they were based on people's individual preferences.

People's needs had been assessed by the Head of Care, before they moved into the home to ensure the staff could provide the support and care they needed. One person said, "I didn't want to move here, but I have to have some help until I am well enough to look after myself." Another person told us, "I was quite happy to move out of the hospital and someone came to see me before I moved here. I like my room and feel they look after me quite well, if only they had the same staff working here." The information from the assessments was used as the basis of the care plans.

Care plans contained some information about people's needs. However, information about people's individual needs varied. For example, waterlow assessments. These look at a person's risk of developing pressure sores and, some had not been completed for people who were unable to move independently although pressure relieving mattresses were in use.

There was a lack of guidance for staff to follow to support people and, as permanent care staff had not read the care plans there was no supporting system in place to ensure staff had enough information about people's needs to provide appropriate support. This was evident during the handover on the first day of the inspection when information from the night nurse was minimal and consisted of short comments like, 'no change'. Staff were then allocated to support people using room numbers, agency care staff were not given any more information about people's needs and from our observations and discussions they asked the permanent carer if they had any queries, but did not have any additional support. This meant that people did not always receive the support and care they needed.

The care plans did not identify how staff supported people to be independent and make choices about the care they received; they did not show that people's views and opinions were central to the decision making process and there was no evidence they included things that mattered to people. For example, where a person's behaviour may put themselves and other people at risk there was no clear guidance for staff to follow to support people to be independent. Although the care plan stated the person liked to be with other people and socialise, there was no evidence that staff supported them to do this. From our observations and discussions with staff the person spent most of their time alone in their bedroom. This meant this person did not receive the support and care they need.

Some records were kept in people's rooms, including food and fluid charts, turn charts and bowel charts. Care staff were expected to complete these, but we found gaps in the records and although the registered manager and provider had identified this as a concern it had not been effectively addressed. Staff told us they had not attended training in record keeping, they said they meant to fill them in, but they were often called away and then forgot about them. Senior care staff and nurses were expected to remind staff to complete the records. However, it was not clear how this was done when the majority of staff working in the home during the inspection were agency nurses and agency care staff. Staff were not up to date with record keeping and people were put at risk of harm, because there was no guidance in place to ensure consistency. Such as where specific dietary needs had been identified there was no clear evidence that staff were aware of these, we saw one person was given sandwiches, cheese, quiche and pizza although their nutritional assessment had identified that they needed a soft/pureed diet because they had difficulties swallowing.

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

From our observations and discussions with staff there was no system in place to encourage people to continue with their hobbies and interests. Staff said they did not have the time and it was not clear if the agency staff under stood that activities are essential to people's well-being. The manager said an activity co-ordinator had been employed and a programme would be developed on people's preferences. On the second day of the inspection an

Requires improvement

Is the service responsive?

outside entertainer joined people during the Christmas buffet and sang a range of songs, which people sitting in the lounge enjoyed. However, one to one support was not provided for people who remained in their rooms. This is an area that needs to be reviewed and improvements made to ensure that support and care is based on all aspects of people's needs, including their hobbies and interests.

There was a complaints procedure which was displayed in the entrance. Information about making a complaint was included in the statement of purpose, which was given to people and their relatives when they moved in. The manager said complaints were recorded with actions taken to address them and the outcomes of the investigations. Records confirmed that complaints were answered in good time and there were comments to each point raised. A complaint had been raised about there not being enough staff working in the home, the management disagreed and the complaint was closed. It was not clear if this complaint had been investigated fully; there was no clear explanation as to why they felt there was enough staff working in the home. The concerns raised by people, relatives and staff on both days of the inspection was the change of staffing and how this impacted on people's care and the potential for harm or injury and, we found there were not enough qualified staff working in the home. The manager and provider said they were aware of the staffing issues and had been reviewing the staffing arrangements.

Another person said they had complained about the lack of lighting at the entrance to the car park and this had been addressed.

Requires improvement

Is the service well-led?

Our findings

From our discussions with people, relatives, staff and the management team, and our observations, we found the culture at the home was open and relaxed. People said they received the care they wanted, although they often had to wait and, felt improvements were needed with the management of staff. They said the provider and manager were available and if they were in the building they generally, "Pop in and ask how I am." Relatives said the home had only recently opened and although they had some good things in place the service was still being, "Set up and developing". Permanent staff felt supported by the management and were able to talk to them at any time.

The manager had applied to CQC to be the registered manager of Bexhill Care Centre and said she was responsible for the day to day management of the home. The manager and provider explained the difficulties they had experienced with staffing and how they planned to resolve them. A deputy manager had been appointed and was at the home on the first day of the inspection, a Head of Care and a nurse had recently been appointed and they had advertised for care staff and interviews were planned.

However, because of the staffing issues the management structure at the home was not clearly defined and there were no clear lines of accountability. This meant staff did not understand their roles and responsibilities and, did not have a good understanding of the support and guidance they provided as part of their role. We observed inexperienced agency staff working together supporting people with no supervision, while the clinical lead supported a nurse who was doing her induction training. They told us the nurse was being supported to do the medicines and, they had decided this was the best use of their time. There was no evidence of any support for agency staff to ensure they offered appropriate care. For example, some people were not supported to transfer safely and the system in place to ensure people had sufficient to eat and drink was not effective.

The manager and provider were aware of the staffing issues and had arranged with a recruitment agency to allocate care staff to the home on a temporary/permanent basis. However, the agency staff said they were not looking for a full time post and had no intention of staying at Bexhill Care Centre as permanent staff. The manager and provider were not aware of this, which meant they had not ensured the contract with the agency was appropriate or that the agency staff had an understanding of their allocation to the home. This meant people were not supported by regular staff, who had a good understanding of their needs and, their needs may not be met.

The provider did not have an effective quality assurance and monitoring system in place. This meant that the issues identified during the inspection had not been identified and appropriate action had not been taken to address them, including the care plans, staff training, records, support plans and audits. The manager and provider were aware of areas for improvement and had developed an action plan to identify and prioritise any changes. It was evident that the priority had been to ensure that there were enough staff working in the home and other areas for improvement had not been addressed.

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 breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider and manager are required, by law, to inform us of any important events that occur in the home, which may affect people living in the home and the support provided. We found during the inspection that incidents had occurred. For example, the provider was required to inform CQC if there was 'an insufficient number of suitably qualified, skilled and experienced persons being employed for the purposes of carrying on the regulated activity'. We spoke to the provider in November 2015 and they said there were difficulties employing staff, particularly nurses. The manager is not a nurse and as Bexhill Care Centre is a nursing home a nurse must be employed to provide nursing care when required.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009).

The provider and manager discussed their philosophy and the aims of the home and, were quite clear that they aimed to ensure the support people received was appropriate and enabled people to have comfortable and rewarding lives. However, they also realised that this would not be achieved until the staff team was in place and they worked together as a team. We discussed the staffing levels at the home before the inspection with the provider. We had been

Requires improvement

Is the service well-led?

assured that people would not be offered places in the home until sufficient staff were in place, although people were admitted, without sufficient staff being in place. This assurance was given again following the inspection.

Staff said they had attended a staff meeting, although this was with the previous manager and a lot had happened since then. They felt able to talk to the management about their concerns and if any improvements or changes were needed, but did not feel they worked as a team with the nurses, "It could be because they are usually agency and they don't really know people so we are supporting them really." The manager said this would change when the newly appointed deputy manager and nurses started working at the home. A nurse and the deputy manager were working in the home on the first day of the inspection, they said they were seeing how the, "Systems worked" and, "Observing the support and care provided."

The manager and provider said they sought feedback from people living in the home, their relatives and health professional visiting the home. The provider said they were open to any suggestions and welcomed people raising concerns, "Unless we know about it we cannot fix it." Relatives were clearly aware of the staffing levels and had discussed their concerns with the registered manager and provider and they were concerned about the future of the home. One relative said, "My mother is really comfortable here, she likes the staff and I don't think she would want to move. So I hope everything is sorted out quickly."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 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.** Regulation 13(4)

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 safe care and treatment for people. There were not enough staff with a clear understanding of people's needs to provide the support they needed; risk assessments had not clearly identified people's needs to ensure their safety and the provider did not ensure the proper and safe management of medicines.** Regulation 12(1)(2)(a)(b)(c)(g)

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 that staff employed at the home were suitably qualified, competent, skilled and experienced to understand and meet people's needs safely.** Regulation 18(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain secure and accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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. Regulation 17(2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not fulfilled their statutory obligations to the CQC with regard to notifications. Regulation 18 (2)b(ii) 2e.