SHC Clemsfold Group Limited

Beech Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Beech Lodge provides nursing and personal care for up to 40 people living with physical disabilities, learning disability and a range of neurological conditions. At the time of our inspection, 22 people were living at the service. The service comprises of three separate buildings: Beech Lodge, Oak Lodge and Redwood House. At the time of this inspection Redwood House was not being used and did not form part of this inspection. The service is located in a rural setting and is purpose built to provide ground floor accommodation for people with complex disabilities.

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

People's experience of using this service and what we found
Risks to people's health and wellbeing were not consistently managed. People did not always receive safe support in relation to their epilepsy, medicines and complex eating and drinking needs. People's risk of aspiration was not always documented and this was an area that required improvement. Systems used to monitor people's health were not always applied consistently. This meant people could not be assured of receiving appropriate care and treatment and were placed at increased risk of avoidable harm. Staff practice did not always ensure people received safe care.

There were not adequate processes in place for assessing and monitoring the quality of the services provided and that records were accurate and complete. Systems had failed to identify that people were not always protected from avoidable harm. Safe care practices were not always recorded accurately within people's care records. Medicine audits failed to identify shortfalls found at this inspection. Action was not always taken to make changes or sustain improvements following the previous inspection report.

The delivery and planning of care was not consistently person centred and did not always promote good outcomes for people. Support plans did not contain detailed and person-centred information and therefore these did not always accurately reflect the needs of those who used the service. Staffing levels were not sufficient in meeting people's care needs in a person centred way. People were not always treated with dignity and respect.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People and their relatives told us that they felt safe at the service. Recruitment procedures ensured only

suitable staff worked at the service. Staff supported people using appropriate equipment to ensure infection control procedures were followed.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture.

Right support: The model of care and setting did not maximise people's choice, control and Independence and measures had not been taken by the provider to mitigate this. The service was in a rural location which did not form part of a local community and there was an absence of local amenities and public transport options. External and internal signage identified the service as a care home and staff wore uniforms which clearly identified they were employed to support people.

Right care :There was a lack of person-centred care and the support people received did not promote dignity, privacy and human rights. People's needs and preferences were not always known respected. People did not have access to meaningful occupation or opportunities to join local clubs, interests groups and form friendships away from the service. The building did not respect people's privacy and dignity for example, there was a lack of assistive technology to promote people's independence and nursing stations and offices were situated close to the communal areas and people's bedrooms. The provider had taken measures to ensure people's bedrooms were personalised with photographs and personal effects.

Right culture :The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives. People were not empowered to have choice and control over their lives. People did not always receive person centred support to live meaningful and active lives. People did not have opportunities to form community connections and make choices about who they lived with and the support they received.

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 requires improvement (published 11 December 2019) and there were two breaches of the Health and Social Care Act 2008 (Regulated Activities) in relation to Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance).The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding, unsafe care practices, staffing and the culture and leadership of the service. A decision was made for us to inspect and examine those risks.

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 coronavirus and other infection outbreaks effectively.

In January 2018 the Care Quality Commission imposed provider wide conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

We carried out an unannounced comprehensive inspection of this service on 17 and 18 October 2019. Breaches of legal requirements were found in relation to Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance) . The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Caring and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified two continued breaches and three new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care, safe care and treatment, good governance, staffing and dignity and respect.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Beech Lodge

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection took place over three days. On all three days the inspection was undertaken by two inspectors.

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and 12 relatives about their experience of the care provided. We spoke with 14 members of staff including the registered manager, nurses, clinical leads, senior care workers, care workers and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 12 people's care records and multiple medication records. A variety of records relating to the management of the service, including policies, recruitment and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received feedback from seven professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At the last inspection in October 2019, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because there had been a failure to assess, monitor and mitigate risks in relation to people's epilepsy, behaviour, pressure care and choking.

At this inspection, not enough improvement had been made with regards to managing risks associated with epilepsy, behaviour and risks of choking and the provider remained in breach of Regulation 12.

● There was a continued risk of choking because guidance to mitigate this risk was not being followed. For example, we observed a person being given a tablet dissolved in 100mls of water. As the person swallowed the liquid, they made choking, snorting and rasping sounds. The CQC inspector raised concern to the supporting staff member who advised the person had their tablet dissolved in this way every morning and always made those sounds. A review of the person's eating and drinking guidelines produced by a speech and language therapist (SaLT) showed the person required all liquids to be thickened to International Dysphagia Diet Standardisation Initiative (IDDSI) level 2, mildly thick consistency. The 100mls of water used to dissolve the tablet had not been thickened. (IDDSI is used to describe food textures and drink thickness for people who require a modified diet).
● Two employed staff informed us that the 100mls of water used for the tablet was never thickened. This was confirmed by the nurse on duty. The risk of choking or aspiration by failing to thicken the water had not been considered, including the risk of the person developing an infection from liquids being aspirated into their lungs. We made the registered manager aware of our concerns and they took immediate action to address this. Following the inspection, we spoke to the SaLT who confirmed that all liquids including the 100mls used to dissolve the tablet should be thickened. CQC raised a safeguarding concern to the local authority about the risk of choking for this person.
● We reviewed the SaLT guidance for three people living in the same lodge. We found that all three people were not having their fluids thickened to the level they were assessed as requiring to mitigate their risk of choking. All three people were receiving fluids thickened to half the consistency required. This was due to a longstanding and consistent misinterpretation of IDDSI levels by staff that had gone unnoticed by nurses and quality checks. This placed people at increased risk of aspiration and choking. We informed the registered manager of our concerns and they provided verbal assurance that the error would be communicated to all staff and immediately rectified. CQC raised a safeguarding concern to the local authority about the failure to follow SaLT guidance leading to an increased risk of aspiration and choking.
● At the last inspection positive behaviour support (PBS) plans were not consistently in place. At this inspection there remained a lack of guidance for staff in how to support people's behaviour. Some people

who had been identified as having distressed behaviours did not have behaviour support plans in place. This posed a potential risk to the person as staff did not have access to guidance on how to support the individual in a structured and consistent manner.

● For example, we observed a person who was very distressed being taken from the sensory room to their bedroom where an electric toothbrush was placed in their mouth. The person continued to scream loudly whilst the toothbrush was in their mouth, the staff member responded by saying several times " let me clean your teeth." The person's communication care plan said the person would scream if they were in pain or discomfort. The staff member told us the toothbrush was used as sensory behaviour strategy to calm the person when they were screaming or distressed. The persons distress levels were not reduced by this intervention and they continued to scream. This technique was not recorded in the person's care plan and there was no PBS guidance to support what the staff member was saying. We made the registered manager aware of our concerns. They confirmed they did not know this technique was being used and took immediate action for it to stop. They informed us they would research more appropriate sensory stimulation aids for the person. CQC raised this as a safeguarding concern to the local authority.

● People did not always receive safe epilepsy support. This is because processes were not in place to ensure staff were trained to use the equipment people needed to manage their epilepsy. One person had a Vagus Nerve Stimulator (VNS) to manage their epilepsy. A VNS consists of a small electrical implant in the persons chest wall and is used to treat seizures which are not controlled by medication. At the onset of a seizure a special VNS magnet is passed over the stimulator to provide a stronger impulse . This may prevent a further seizure occurring and reduce the time it takes the person to recover.

● The epilepsy care plan for a person with a VNS implant guided staff to act quickly at the onset of a seizure to swipe the magnet. Should this not be effective the person would require emergency rescue medicines to be administered after five minutes. During the inspection some staff supporting this person did not know about their VNS device or the specific action required at the onset of a seizure. For example, we observed one staff member supporting four people in the lounge including a person with a VNS device. The staff member was new and was not aware one of the people they were supporting had epilepsy or a VNS device. This lack of knowledge had placed the person at risk of avoidable harm because staff supporting them were unaware of their specific epilepsy needs and required action.

● The epilepsy care plan for the person with the VNS device did not inform staff where the VNS magnet was kept. Employed and regular agency staff provided us with different accounts of where to locate the VNS magnet should a seizure occur. This included, on the person's wrist like a watch, in their bedroom and on the handle of their wheelchair. The lack of guidance in the person's care plan and inconsistencies in staff knowledge meant the person was at risk of not receiving their epilepsy rescue interventions in a timely way. This could lead to the person experiencing prolonged or further seizures and deteriorating health. We made the registered manager aware of our concerns and they took immediate action to ensure the person was supported by staff trained to use a VNS device. CQC raised this as a safeguarding concern to the local authority.

● Three people in Oak Lodge used audio and video systems to alert staff when they were experiencing a seizure when they were alone in their bedrooms. We observed all three monitors between 8.20am and 8.50am. All three people were in bed and their audio and video monitors were on mute. Two of the monitors were audio only which meant staff would not be alerted to a person's seizure by sound. Processes were not in place to undertake physical checks on people and staff told us this was because they replied on the audio monitor. Our observations were shown to the registered manager who confirmed our findings and adjusted each monitor to relay sound.

● One person had a video monitor. We observed their video monitor constantly between 9.50am and 10.30am during which time the person remained in bed. Their care plan said they should be monitored every 15 minutes as part of their seizure management. During our monitoring period no staff looked at the monitoring equipment and staff did not undertake physical checks on the person. This meant there was a

risk of the person's seizures going unnoticed. All three people had been placed at risk of avoidable harm because measures designed to keep them safe had not been followed appropriately or consistently. We made the registered manager aware of our concerns and they took immediate action to introduce an epilepsy monitor protocol for day staff. CQC raised this as a safeguarding concern to the local authority.

The continued failure to assess, monitor and mitigate risks meant that there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Staff understood that for people with a Percutaneous Endoscopic Gastrostomy (PEG) in situ were at high risk of aspiration. A PEG is a feeding tube into a person's stomach and is used to provide the person with the nutrients and fluids they need. People who have a PEG are at an increased risk from aspiration especially when lying flat as fluid can travel up the oesophagus from the stomach and into a person's lungs. We observed PEG feeds being paused for 30 minutes prior to personal care and people laying at 45 degree angles in bed. These measures are consistent with those required to mitigate the risk of aspiration. However, this information was not consistently reflected within people's care plans. This was discussed with the registered manager during inspection and is an area that requires improvement.
● At the last inspection mattress settings were not set at the correct setting to support people's pressure care and skin integrity needs. At this inspection we found improvements had been made and mattress settings were consistent with people's weight and pressure care requirements. For example, we observed one person's mattress setting had been adjusted to take into consideration the weight of their sleep system.
● Epilepsy protocols were in place which included guidance on when to administer emergency rescue medicines and when to contact 999. NEWS (National Early Warning System) records were being completed correctly and we saw people's vital signs were monitored following a seizure. The NEWS scores were used appropriately to seek medical assistance.
● We observed safe moving and positioning practices including the use of overhead and mobile hoists. Moving and positioning was undertaken in a safe and dignified way ensuring, on each occasion, the person was informed of what was happening. Equipment was maintained through regular servicing.

Staffing and recruitment
● Prior to our inspection we had received information of concern about insufficient staffing levels. The registered manager told us a dependency tool was used to determine the number of care staff required on each shift. The registered manager told us following recent feedback from staff they had increased staffing by one support worker between 9am and 6pm in Oak Lodge.
● Our observations were there were not enough staff in the mornings to meet people's personal care needs in a person centred and timely way. A review of people's care records showed that on a regular basis some people were spending up to 15.5 hours in bed at night. Our observations were, and staff confirmed, this was due to the capacity of staff and not the personal preferences of people. We observed the morning routines to support people to get up. These took until 11.45am to complete. Some people had been awake for up to three hours before they had a drink or breakfast. During this time, they remained in bed without any stimulation and with curtains closed.
● People received their breakfast after their personal care needs were met and we observed this to be anytime between 8.30am and 11.45am. Some people receiving a late breakfast had not eaten since teatime the previous day. There was no evidence to suggest that staff had considered people maybe hungry in between these times or that snacks had been given. Lunch was served around 1pm and adjustments to these timings were not made for people who had received a late breakfast.
● Some people received additional funding to provide them with 1-1 support. We observed this was not always used for the purpose it was intended. For example, one person had 1-1 support from 8am to 8pm daily. Their care plan stated this was to keep them safe. We observed this person to be awake in bed

between 8.15am and 10.30am. During this time their 1-1 support was used to support other people with personal care and checks were not carried out to ascertain the person's safety or well-being. On all three days of the inspection we observed this person's 1-1 support being used to support other people including two occasions when they were supporting up to 5 people in the lounge. Therefore, staff had not been deployed in appropriate numbers to provide the 1-1 support required to keep this person safe.

● There was a high reliance on agency staff, and we received mixed feedback about this. Some staff felt that the constant use of agency staff placed added pressure on permanent staff. Other staff felt that regular agency staff were well trained and skilled and provided a degree of consistency to the people who lived at the service.

● Families were concerned about the high reliance on agency staff. Some felt this had a negative impact on their loved ones and we were given examples where people had not been supported in line with their care needs. One relative shared with us an example of poor practice that had led to a safeguarding investigation, another said that they found one or two regular agency staff abrupt and rude and this had been addressed by the manager.

There was a failure to ensure sufficient numbers of suitably qualified, competent and skilled staff to meet the needs of the people using the service. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The provider was actively recruiting care staff to current vacancies. Staff new to the service told us they had received a comprehensive induction process which included training and shadowing more experienced staff. Safe recruitment processes were in place including robust safety checks to ensure staff were suitable to work at the service. Pre-employment checks were undertaken including references, identity checks and interview.

● Agency profiles were obtained prior to new agency staff working in the service. This demonstrated to the provider agency staff had undergone safe recruitment processes and their training was in date and relevant to the needs of the people living at the service.

Using medicines safely

● People did not always receive their medicines safely. Processes were not in place to ensure people received their medicines at regular times. Some people were prescribed medicines for epilepsy that were important to be administered at regular intervals. This is required to reduce the risk of seizures or to control unwanted side effects. We observed breakfast medicines, including those for epilepsy, being administered between 8.15am and 11.40am. Medicine Administration Records (MAR's) did not provide the time medicines needed to be administered and staff confirmed medicine times varied. Medicines were administered in the dining room with breakfast after people were dressed and had their personal care needs met. Subsequent to the inspection the registered manager sought professional medical support to have medicine times added to the MAR with a timeframe in which people should receive their medicines.

● Processes to ensure people received their medicines in line with the prescriber's requirement were not always followed. For example, a person who was prescribed 'as and when required' (PRN) laxative for constipation had been administered this medicine when it was not required. This is because staff had failed to follow the person's PRN protocol and prescriber's instructions.

Failing to ensure the proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Medicines were stored in line with safety guidance. Regular medicine and pharmacy audits were undertaken and there were processes in place for stock control, ordering and disposal. Medicines were

administered by nurses and staff who were trained in the administration of medicines.
● Oxygen was administered by nurses and protocols were in place for this. Some care staff had been trained to administer oxygen in an emergency and when people were undertaking activities away from the service.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes to protect people from the risk of abuse were not operating effectively. Staff practice failed to demonstrate an understanding of their responsibilities for identifying and reporting concerns. During the inspection we observed staff practice that led us to raise five separate safeguarding concerns to the local authority. These were in relation to unsafe practices in the management of epilepsy, eating and drinking and behaviour support. We made the registered manager aware of our concerns at the time and they took immediate action to mitigate risk of further potential harm. However, this was reactive to our findings rather than having been proactively identified by staff or management. We have explored this in more detail in the well-led domain.
● Safeguarding training was completed by new staff during induction and there was a system to ensure staff undertook refresher training. Staff we spoke with had an awareness of the signs indicating a person might be vulnerable to abuse.
● We received mixed feedback from families about their loved one's safety. Some relatives told us they had raised concerns about their loved one's well-being, including concerns about the conduct and skills of staff and the way individual incidents had occurred or been managed. Others felt the service provided a safe environment that met their loved one's needs.
● Relatives who said they were able to communicate with their loved one told us they would know if they were upset or frightened. For example, one relative told us their loved one used a communication book and would be able to express to them if they were unhappy about something.
● Due to the current Covid 19 pandemic families had been restricted from visiting the service. Families were visiting less and had to trust the provider to protect people when they were not around to see or hear concerns. Relatives told us they had trust in the providers processes to act upon concerns in their absence and ensure their loved one's were protected from abuse.

Preventing and controlling infection
● The service has had two outbreaks of COVID 19 with confirmed COVID 19 related deaths. Families told us they were saddened to learn that some people had passed away due to COVID 19 and this had been a worrying and upsetting time for everyone.
● Families said they felt reassured by the measures that had been put in place to mitigate the risk of their loved one contracting the virus. Restrictions on visiting had been difficult but these were viewed as positive measures to ensure their loved ones well-being. Garden visits were arranged as soon as it was safe to do, and some people had been supported to spend time at their family home with a test and isolation procedure in place.
● We received mixed feedback about communication during the pandemic. Some relatives said communication was better at the onset and had tapered off over time, and some felt they were not kept up to date with COVID testing within the service. Others told us they had received good communication and regular contact by way of telephone and the opportunity to use video calling with their loved one.

● We undertook an audit of infection control procedures within the service.
● 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 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.

Learning lessons when things go wrong
● Accident and incident records were reviewed by the registered manager and as part of the quality audit process. There was an opportunity to learn lessons when things had gone wrong and use this as a tool to drive improvement. For example, following a request to the pharmacy for emergency medicine stock improvements had been made to the process for receiving and booking in of medicines. This mitigated the risk of shortages of medicines. For another person their protocol for administering anticipatory antibiotics held by the service was amended following a hospital admission. This enabled nurses to administer the medicines in a timely way prior to seeking medical authorisation, mitigating the risk of rapid deterioration and hospital intervention.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

● People's individuality was not always respected, and people were not always supported in a non-discriminatory way. Not all staff had received training in equality and diversity, and we observed that staff did not always know how to support people in a way that took account of their abilities and lifestyle choices. For example, staff told us that a person's preference to be supported by female staff was not always respected due to staffing availability. We observed two staff supporting the person with their morning personal care routine. One of the staff was male. Care plans lacked details about people's preferences and abilities and what they were able to do for themselves to promote and maintain their independence.
● Care plans were not always written respectfully in a way that demonstrated an understanding or compassionate approach to the person's support. For example, the terminology in some care plans lacked compassion and understanding and failed to demonstrate respectful and dignified approaches to people's support.
● Staff did not always respond in a compassionate, timely and appropriate way when people were expressing emotional distress. The Disability Distress Assessment Tool (DisDAT) is a universal tool used to help identify cues in people who have severely limited communication. There was no record of the DisDAT tool being used currently within the service. Previous DisDAT assessments had been archived and information had not been transferred to people's care records. This meant people's levels of distress or discomfort could go unnoticed because staff did not have the skills required to recognise when people were unhappy or required assistance.
● For example, we observed staff ignore a person who a screamed consistently for 5 minutes. A review of this person care plan showed they would scream if they were unconformable or unhappy. This was a demonstration of how a person's unique communication methods were not responded to by staff.
● People were not always central to discussions about how they wanted to receive their care and support. Staff did not always demonstrate an understanding of people's communication needs; this knowledge is required to support people to make choices and decisions about their care and daily life. For example, a person's care plan said they used basic Makaton sign language to communicate. During the three day inspection none of the staff providing 1-1 support to this person had received Makaton training. Over the three day inspection we observed a lack of meaningful engagement and communication between the person and staff supporting them.
● Due to the Current COVID 19 pandemic people were not leaving the service other than to go on a drive in the minibus or walk around the grounds. Consideration had not been given to exploring with people some

of the activities they had previously enjoyed before the pandemic restrictions, to seek ways of recreating them in a safer way. There was a lack of awareness of the positive benefits for a people being engaged in suitable meaningful occupation to improve their quality of life.

● There was a lack of activities to support people's wellbeing and provide meaningful stimulation and occupation. Visitors and staff told us that people often spent most of the day in the dining room and there was a lack of stimulating activities that gave purpose and pleasure. For example, we observed a craft session where six people sat around a table and watched a staff member cut out bats, and sensory session where two people were positioned in their wheelchairs in front of a bubble tube. In both sessions provision was not made for people to be actively engaged within the activity and there was minimal staff interaction.

● Consideration had not always been given to ensuring the environment was a pleasant place to be in. Over lunch and during some activities times, the radio and television were on at the same time in the dining room This impaired people's concentration and made it difficult for people to hear guidance from staff . It also demonstrated a lack of staff awareness of environmental factors and how these can impact people. The garden and grounds were littered with items of discarded furniture, such as a bed base and upturned and broken garden chairs and orange industrial fencing. The lack of consideration to ensure that the home environment was organised and pleasant was particularly poignant at the moment as during the COVID 19 pandemic people's only opportunity to be in the fresh air was to walk around the grounds with staff.

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

● Relatives told us staff treated their loved ones with kindness and ensured they were happy and healthy. A relative told us about the kindness and care their loved one had received when they had contracted Covid 19. The person recovered in the service and the family attributed this to the care and compassion they had been given by nurses and staff.

● People had personalised bedrooms which reflected their personalities and displayed photographs of their families and keeps sakes which were important to them. We observed staff knocking on bedroom doors before entering people's rooms. Staff were very discreet when asking people if they needed assistance.

Respecting and promoting people's privacy, dignity and independence;

● People were not supported to be as independent as possible within their own capabilities. There was a lack of assisted technology within the service to promote independence and support people's to engage in activities of everyday living.

● Staff did not actively seek to promote opportunities for independence or respect people's capabilities. For example, we observed staff feeding a person who had been assessed as requiring support to eat independently. The person refused the food that was offered to them on a fork. Consideration was not given to exploring with the person their reasons for not wanting the food or seeking alternative way of encouraging them to eat, such as eating independently. The person subsequently went without a meal.

● People did not always receive care in a dignified way. We observed a video monitoring device playing in a communal hallway showing a person receiving intimate personal care. At the time there were contractors in the service, and this could have been viewed by other people and visitors to the home. The CQC inspector asked staff to turn off the video which they did immediately.

● There was a disregard to people's privacy and dignity when information was being shared verbally. For example, we observed people being present during staff hand over in both lodges whilst personal information, such as, overnight continence and medical information was shared. This demonstrated a lack of understanding and consideration to ensuring people's right to privacy and dignity was respected and upheld.

People were not always treated with dignity and respect. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● The service had implemented an innovative way to support people to make choices about their meal preferences. This was currently being trialled in one of the lodges. The chef had developed a visual system to support people to make their food choices. This was displayed on a screen in the dining room and included photographs of meals presented on the various plates and equipment used by people, and information about their dietary needs, preferences and allergies. The chef showed us feedback comments entered by staff about the person's like or dislike of the food and these were used to create a more personalised menu for people.
● There were some individual examples of positive interactions between staff and people. For example, a person who was able to communicate effectively was observed talking to staff and giving instructions about their care. The person was leading their own support and told us they were happy with the staff and the care they received.
● A member of staff reading stories to a person in their bedroom was observed to be promoting good interaction and the person was expressing their enjoyment of this activity. This staff member demonstrated kindness and compassion and had developed a positive rapport with the person. For another person when they did not want their lunch the chef made them an alternative meal and took time to find out why the person did not want the one, they had originally chosen.
● Professionals have told us that people had been supported to take part in video calls to discuss their health needs. This supported people to be included in decisions about their health

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. 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, risks and regulatory requirements; Continuous learning and improving care

At the previous inspection there was a was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of the failure to maintain accurate and cotemporaneous records in respect of each service user. There was a failure to assess, monitor and to improve the quality and safety of the services provided.

At this inspection not enough improvement had been made and the provider remained in breach of this regulation.

● There was a lack of effective oversight and monitoring of the service. Strategic governance and quality monitoring processes had failed to ensure compliance with the regulatory breaches identified at the last inspection. There had been a failure to ensure organisational risks had reduced or embed changes to drive service improvement.
● Processes for quality monitoring had failed to identify the need for additional staffing at particular times to support people in a person centred way and to ensure that funded 1-1 care was being provided as intended. The registered manager informed us they had recently included an additional staff member to the morning rota at the request of staff. The effectiveness of this had not been monitored or assessed. There had been a failure to considered or review the accuracy of the staffing dependency tool which had failed to identify that additional staff were required.
● Management skills, knowledge and oversight did not foster a culture that protected people from avoidable harm. The provider's processes for monitoring records and quality assurance audits had failed to identify some of the significant concerns we found. For example, the registered manager had failed to ensure an accurate transfer of care records onto the electronic care records system (ECR). This included the failure to identify risk assessments for people living in Oak Lodge had not been uploaded on to the system. The lack of operational oversight and quality checking meant people could not be assured staff had all the information required to care for them in a consistent and safe way.
● Systems and processes for quality monitoring had failed to identify the lack of accurate and contemporaneous information in people's care records. For example, there was no behaviour support plan for a person whose social and emotional care plans referenced them as having behaviours that were disruptive and potentially harmful to themselves and others. For another person their care plan for 'breathing and respiration' had not been completed although their epilepsy and medicines care plans had

identified a history of asthma, pneumonia ,aspiration and recurrent chest infections. The provider could not be assured of people receiving appropriate support to manage their health and well-being because information to guide staff to the signs and symptoms of a person's deteriorating health were not available.

● Risk assessments and management plans were not always followed or in place. For example, quality monitoring had failed to identify the service was not following SaLT guidance in relation to people's modified textured diets. This meant the provider could not be assured correct consistency food and drink were being served to people to reduce the risk of significant harm.

● Robust processes were not in place to monitor the quality of care plans and risk assessments. This had led to a failure to identify people's care records did not always reflect their risk of choking. For example, a person had recently bitten off and swallowed the head of their toothbrush and had required support from the emergency services. Their care records had not been updated to reflect this risk. The person's oral care plan did not reference the risk of biting the toothbrush and there was no risk assessments or guidance to mitigate a further occurrence. For another person their choking risk assessments had been archived and this risk had not been transferred onto the electronic care records. Both people were at risk of choking because action and information required to keep them safe had not been made available to staff. We made the manager ware of our findings and they informed us of the action they would take to address these failing and ensure people's safety.

● We found inaccuracies in people's daily records. For example, we observed a person in bed at 9.15am when their daily records had recorded, they had got up at 8.15am. Another person's breakfast entry was recorded as a 'late entry' (term used to enter an activity at a time later than it actually happened). We had observed the person having their breakfast at the time the late entry was made. Robust processes and checks were not in place to assure the accuracy of information being included within people's daily notes or that it was a true reflection of the care and support they were receiving. This meant the provider could not be assured people were receiving safe care and support in line with their assessed needs and preferences.

● The provider's medication audits had failed to identify the lack of processes to reflect the time people received their medicines. This is important because it ensures medicines are appropriately spaced and provides an accurate audit trail for handover between staff or in the case of a transfer to another setting such as hospital. Medicine Assessments Records (MAR) did not reflect the time people received their medicines and the ECR reflected the time the entry was made rather than when the medicine was administered. We reviewed a person's ECR an hour after we had observed them having their epilepsy medicines and the entry had not been made. There was an inconsistent approach by nurses when completing the ECR record. For example, one told us they completed ECR at the time medicine was administered, another told us they updated the ECR during quieter times and made several entries together. This meant there was no clear audit trail documenting the time medicine was administered.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to ensure safety checks were undertaken. There was a process to ensure equipment was regularly maintained.

● Processes were in place to record staff supervision and training. A training matrix was used to track and identify staff training including the need to undertake refresher training.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The service did not reflect a culture that empowered people to achieve good outcomes and be equal partners in their care. We observed routines to be institutionalised and task focused and a lack of respect and dignity for people. Prior to the inspection CQC had received information of concern about inappropriate practices of staff, lack of respect and person centred care and bullying within the staff team. Our observations during inspection upheld the concerns we had received and were inherent of a closed culture. A closed culture is a poor culture in health and social care that increases the risk of harm. This includes abuse and human rights breaches. We made the registered manager and chief operating officer aware of our concerns and observations. The provider was required to take immediate action to address these concerns and provide assurance of people's immediate safety and well-being. Subsequent to the inspection the provider submitted to CQC an action plan to show the action they would take, and measures already implemented.

● There was a lack of positive engagement between staff and people using the service and staff did not always have the right skills , training or experience to support people safely and effectively. People were not always able to speak up for themselves and there was a lack of independent advocacy services. We observed practice that did not respect or promote people's voice. For example, we observed a person pointing to sad in their communication book. The supporting staff member said, " Oh you are sad", then walked away, without attempting to ascertain why the person was feeling sad. We observed many examples where people's communication needs were not met because staff were not skilled in or aware of the person's preferred communication methods. In some of these circumstances people's communication was ignored or viewed as problematic behaviour.

● People lived in an environment that was isolated and did not establish itself as part of a local community. The rural location of the service meant there were no pavements for safe walking routes or public transport. Volunteers and community transport options had not been explored and people were reliant on staff to arrange activities away from the service. Staff told us community activities had been on hold since March 2020 due to the national Covid 19 pandemic. Prior to this people had not been provided with opportunities to form any meaningful community connections and did not belong to any local clubs or organisations.

● There was a lack of consistency within the staff team and a heavy reliance on agency staff and nurses. We received feedback from several staff about a culture of bullying within the staff team and examples were given where the recording and reporting of people's care was not always a true and accurate reflection of the care provided . Staff told us that they had not addressed these concerns with the provider for fear of reprisals such as losing their employment or living accommodation(Some staff lived in accommodation on site). During the inspection some staff did share their concerns and experiences with the management team and action was taken to address issues raised.

● People and staff were provided with an opportunity to provide feedback about the service. Staff meetings were held which provided staff with a forum to raise concerns and discuss ideas. 'Resident' meetings were also held and the minutes of these were available in easy read format. Staff had regular supervision to discuss their performance, development needs and wellbeing. Relatives said they have received surveys in the past but were not always sure of the outcomes of these. Recently video meetings had been implemented in place of relatives face to face meetings.

● Families told us when they visited their loved ones looked well cared for and were happy. Families who visited regularly prior to the pandemic told us they had been anxious about not visiting their loved ones during lockdown. Some told us having to put all their trust in the staff to ensure their loved one was being cared for in a safe and compassionate way had been emotionally difficult. Most families thought the care their loved ones received was safe and appropriate to their needs.

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

● Prior to our inspection the provider had received information of concern about the care and treatment of

people. The provider had failed to notify CQC of the allegations of potential abuse and had not considered these allegations in line with their own safeguarding policy or the local authority's safeguarding guidance. Subsequent to the inspection the provider made retrospective notifications to CQC and safeguarding.

● During the inspection further concerns were made directly to the provider. The registered manager was open and transparent in sharing this information with us. We were made aware of the immediate action the provider was going to take to address the concerns and mitigate the risks to people. This included changing rotas and mixing staff between the services. On day three of our inspection we observed that these changes had been made.

● We received a variety of feedback from families about their experiences of transparency. Relatives said they were contacted when things had not gone according to plan. Some felt the provider was not good at keeping them up to date with next steps and outcomes.

● Relatives who told us they had raised concerns were not assured that subsequent actions and improvements were being maintained. We received feedback about the rudeness of some staff when relatives had raised issues . Others felt the constant churn of new and agency staff made it difficult to raise matters because they didn't always know who the staff on duty were. One relative told us they could not be assured of honest feedback from staff who did not know their loved one .

● Positive feedback about the management team and staff included experiences of openness and honesty. Relatives told us they were more inclined to raise their concerns to the registered manager. One relative said, " The manager will usually respond quite quickly especially if you email him."

Working in partnership with others

● The service worked in partnership with healthcare professionals and services from a variety of disciplines and commissioning authorities. During the national Covid 19 pandemic there had been a reduction in professionals visiting the service. Provision was in place to enable video meetings and telephone consultations to take place instead of face to face meetings. Where practically possible, and where there was a need, healthcare professionals had visited the service over the last few months.

● We received mixed feedback from professionals about their experiences of the service and how this impacted people. Some feedback raised concerns about the provider and the way the service was run on a day to day basis. We were given examples of poor skills of staff and where professionals guidance was not being implemented and had led to safeguarding concerns. There was a shared concern about the isolated location of the service and lack of community engagement and meaningful activities. Positive feedback included examples of good communication, leadership and care

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 9 HSCA RA Regulations 2014 Person-centred care There was a failure to ensure that people receive person centred care and treatment that was appropriate to their needs and reflected their personal preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a continued failure to assess, monitor and mitigate risks. There was a continued failure to ensure the proper and safe management of medicines.

The enforcement action we took:

We have imposed condition on the providers registration for this service.

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 there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care.

The enforcement action we took:

We have placed conditions the providers registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure sufficient numbers of suitably qualified, competent and skilled staff to meet the needs of the people using the service.

The enforcement action we took:

We have imposed condition on the providers registration for this service.