Shaw Healthcare Limited

The Martlets

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Martlets is situated in East Preston, West Sussex. It is one of a group of homes owned by a national provider, Shaw Healthcare Limited. It is a residential 'care home' providing care for up to 60 people who may be living with dementia, physical disabilities, older age or frailty as well as up to 20 people who may require nursing care. At the time of inspection there were 68 people living at the home.

People's experience of using this service and what we found
The provider had received support from the local authority and external healthcare professionals to help support them to make the required improvements, yet had not always implemented these. We found the provider lacked oversight to ensure actions were taken to improve the safety of some people's care and treatment and had not taken enough action before the COVID-19 pandemic to ensure improvements were made. Because of this, when staff had to deal with the unprecedented and daily challenges the pandemic posed, the pre-existing concerns about people's safe care and treatment were compounded. The provider and staff had worked hard to help ensure people were protected from the risks posed by COVID-19, yet had not always acted to ensure people received safe care and treatment when there were other concerns about their health. This included poor medicines management and a lack of action when there were changes in some people's health needs. People were not always protected from the risk of malnutrition or dehydration. One person had been provided with the incorrect texture-modified diet and this exposed them to risk of harm. Lessons had not always been learned when people experienced falls and injuries to their heads as the provider had not always ensured people were adequately monitored to help identify changes or deterioration in their condition.

People, relatives and staff provided mixed feedback about staffing levels and staff's ability to appropriately respond to people's needs in a timely way. Not enough action had been taken by the provider to ensure staff were fully supported, trained and competent to meet all people's needs. People were not always supported to have maximum choice and control of their lives and staff did not always 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. The provider had not met the enforcement actions that were served at the last inspection.

People and relatives spoke of a dedicated staff team who had worked hard throughout the pandemic to ensure people were protected from the risk of COVID-19. They told us staff were kind and caring and our observations of staff's interactions with people confirmed this.

Rating at last inspection and update
The last overall rating for the home was 'Requires Improvement' (Report published 19 December 2019). The home had been rated 'Requires Improvement' on five consecutive occasions. There were multiple breaches of regulation. We served three Warning Notices and the provider was required to be compliant by 31 January 2020. The provider also completed an action plan after the last inspection to inform us what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was

in continued breach of regulations.

Why we inspected
We undertook this announced, focused inspection on 3 September 2020. This was based on the previous rating and enforcement action to check the provider had complied with the Warning Notices issued at the last inspection and to confirm they had followed their action plan and now met legal requirements.

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 home can respond to coronavirus and other infection outbreaks effectively.

We contacted people, staff and relatives and viewed records in relation to people's care on 4, 5, 6 and 7 August 2020. We gave the provider 24 hours notice of the inspection to enable CQC and the provider to consider any infection prevention and control protocols due to the COVID-19 pandemic. We also established if people had COVID-19 or associated symptoms. This report only covers our findings in relation to the Key Questions of Safe, Effective 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 home 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 The Martlets on our website at www.cqc.org.uk

Enforcement
We have identified breaches in relation to people's safe care and treatment, staffing and the leadership and management of the home. Full information about CQC's regulatory response to the more serious concerns found during inspections is added after any representations and appeals have been conducted. We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account when it is necessary to do so.

Follow-up
We fed back our findings to the provider prior to the site visit, on the day of inspection and following it so they could take action to mitigate risk. Due to the serious concerns we found at the inspection, we wrote to the provider to seek assurances and evidence of the care people had received following the inspection. The information received did not always provide assurances that risks to people's care had been minimised.

We will continue to maintain ongoing monitoring of the home and work with the provider and partner agencies. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least 'Good'. We will work with the 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.

The overall rating of this service had deteriorated to '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 six 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, 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 of 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 or overall, 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 effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

The Martlets

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 home in preventing and managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by a total of five Inspectors. Two inspectors undertook remote phone calls to people, relatives and staff. Three inspectors undertook an inspection site visit.

Service and service type
The Martlets 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 home did not have a manager who was registered with the Care Quality Commission. A new manager had recently started working at the home and had started the process to become registered manager. This means the provider is legally responsible for how the home is run and for the quality and safety of the care provided.

Notice of inspection
We initially announced the inspection on 3 August 2020, but had to pause the site visit due to infection prevention and control procedures at the home, due to COVID-19. During this time we conducted the inspection remotely and reviewed the care some people had received. Prior to the site visit, we gave the provider 24 hours notice to enable CQC and the provider to consider any infection prevention and control protocols due to the COVID-19 pandemic. We also established if people had COVID-19 or associated symptoms.

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We had asked the provider to submit a provider information return (PIR). A PIR is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We took this into account, alongside the evidence gathered, when making our judgements in this report.
Before we undertook the site visit to the home, we spoke with four people, one member of staff and 12 relatives. We also contacted a social care professional for their feedback. We requested documents relating to quality assurance and oversight as well as care plans and risk assessments for eleven people.

During the inspection
At the site visit, we observed the care and support people received. 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 aspects of care 13 people had received which included care plans, risk assessments and medicine administration records. We looked at staff rotas and staff files in relation to staff's training and competence. We spoke with four people, five members of staff, the deputy manager, the manager, a quality improvement manager and the regional operations manager.

Following the inspection
We continued to seek assurances and information from the management team and provider that could not be provided at the inspection site visit. We wrote to the provider to seek assurances and evidence of the care people had received following the inspection. The information received did not always provide assurances that risks to people's care had been minimised.

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. Risks had not been appropriately managed. Medicines were not always managed safely or effectively. The provider was in breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a Warning Notice and the provider was required to become compliant by 31 December 2019.

At this inspection, not enough improvement had been made and the provider's oversight of risks relating to some people's care had deteriorated further. The provider had not complied with the Warning Notice and was in continued breach of Regulation 12. People had not always received safe care and treatment and the rating of this key question has deteriorated to Inadequate. This meant people were not always safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- The provider had not made enough improvement before the COVID-19 pandemic to ensure people received safe care and treatment to meet their assessed needs. During the pandemic, the provider and staff had focused their efforts to help ensure people were protected from the risks posed by COVID-19. This had an impact on their oversight of other risks associated with people's health conditions and had compounded the concerns found at the last inspection.
- People were not protected from the risk of unsafe care or treatment. One person had a history of Transient Ischaemic Attack (TIA) and had recently been admitted to hospital where they were prescribed medicines to help maintain their health. A TIA is sometimes referred to as a 'mini stroke' and is caused by a temporary disruption in the blood supply to part of the brain. Following this hospital admission, staff had not been provided with guidance to inform them of the signs and symptoms that might indicate the person was at risk of experiencing another TIA. One month after the person's TIA and hospital admission, staff had documented the person was leaning towards their left side, the left side of their face was painful and their speech was slurred. Staff had taken observations of the person's condition yet had not contacted an external healthcare professional to inform them of changes in the person's condition or to seek medical advice. We asked the management team for assurances that staff had sought external medical advice when the person showed signs of a potential TIA or stroke, they informed us this had not occurred. The person had not received appropriate or safe care and treatment.
- At the last inspection, one person had been assessed by a Speech and Language Therapist (SALT) as requiring a texture-modified diet. They had been admitted to hospital with aspiration pneumonia, a breathing condition in which there is a swelling or infection of the lungs or large airways. This can occur when food, saliva, liquids or vomit is breathed into the lungs or airways. When the provider was asked for assurances about the type of food the person had been provided with prior to their hospital admission, they were unable to provide assurances. At this inspection, staff had noted the person had been coughing and choking when eating their meal. When the management team had looked into the care the person had

received prior to this, they found the checks that should have been in place to ensure the person was provided with the correct texture-modified diet, had failed. They found there had been a lack of oversight by staff and the person had been provided with the incorrect texture-modified diet to meet their assessed needs. This placed the person at risk of harm.

● Five people had been assessed by the provider as being at increased risk of malnutrition. The provider's policy advised on the frequency that people should be weighed as well as the need to provide high-calorie and high-protein snacks and drinks to help minimise further weight loss. All five people had not been supported according to their assessed needs or the provider's policy. Staff had been advised one person who was living with dementia, preferred finger foods and should be provided with these as well as regular snacks, yet it was not evident this had occurred. The person had not been weighed as frequently as the provider's policy and records showed and staff confirmed they had continued to lose weight, losing one third of their body weight within a six-week period. This person and one other were assessed as being underweight and had been prescribed nutritional supplements to help maintain their weight. Records showed this had not been administered to the person for a period of up to 16 days and the other person for three days. When the provider was asked why people had not been given their prescribed supplements, they advised staff had not noticed they needed to be given. The provider had not ensured people were protected from the risk of malnutrition.

● Another person's relative told us their loved one had lost a large amount of weight since moving into the home and they were concerned about the lack of action that had been taken. Records showed and staff confirmed the person was weighed when they moved into the home but was not weighed again until almost five months later which showed they had lost almost 15 per cent of their body weight. Staff had miscalculated the person's weight loss and had not identified the amount the person had lost or that the person's risk of malnutrition had increased. When we asked for assurances that the person's unexplained and unplanned weight loss had been discussed with external health professionals to determine any underlying causes, staff confirmed this had not happened after the person had experienced the weight loss. When we fed back our findings to the provider, staff contacted the person's GP who took immediate action to minimise further risk.

● Three people were at increased risk of dehydration and there was insufficient oversight to ensure they were provided with enough fluids during a heatwave to meet their assessed needs. Staff had not been provided with guidance about how much fluid they should encourage people to consume to help maintain hydration. When staff had recorded people's fluid intake, it was not always evident what action had been taken when people had consumed low amounts of fluids. One person had been prescribed antibiotics as they had a urinary tract infection (UTI). Records to document the fluids the person had consumed during this time showed they had consumed low amounts and it was not evident what action had been taken to encourage further fluids to help relieve the symptoms caused by the UTI.

We wrote to the provider following the inspection to seek assurances they had acted to ensure people received sufficient hydration, nutrition and their specific healthcare needs were met. The provider offered assurances about their intended actions to help make improvements. From the information supplied by the provider following the inspection, we found some improvements had been made in relation to some people's hydration and nutritional needs.

Learning lessons when things go wrong

● The provider had not always learned from themes or incidents that had occurred within two of their other services within the West Sussex area and this increased the risk of harm to people's health at The Martlets. The provider had made changes to their falls policy to ensure people were adequately monitored should they fall and injure their head. At this inspection, three people had experienced falls, some of which had resulted in them hitting or injuring their heads. The provider had not considered medicines that were prescribed to all three people which increased their risk of bleeding should they fall. Staff had not always

ensured they sufficiently monitored people to help identify any changes or deterioration in people's health when they had hit their head or had a head injury. This meant people had not always been protected from the risk of avoidable harm.

● Not enough action had been taken to minimise risks when people were assessed as being at increased risk of falls. One person had experienced 20 falls in nine months. Records showed that when the person had seen an external healthcare professional for another matter, the professional had noted the person's toe nails were so long they had curled around and under their toes. It was not apparent that staff or the provider had identified that this could be a contributing risk factor to the person's falls. Once our findings were raised to the provider, they informed us the person would often refuse treatment from the chiropodist yet they were unable to provide evidence of this. It is acknowledged that chiropody visits had been postponed due to COVID-19, yet neither staff or the provider had acted to mitigate this contributing risk. Records showed staff had made a referral to the falls prevention team so they could provide advice and guidance on how to minimise falls, however, staff had not made the referral until the person had experienced 19 falls.

We wrote to the provider following the inspection to seek assurances they had acted to ensure people received safe support if they experienced a fall or a head injury, as well as to ensure the oversight of such incidents had improved. The provider informed us and provided evidence to show people had been supported safely, were appropriately monitored and medical advice had been sought following falls. They explained that actions had been taken and improvements were continuing to be made in relation to the recording of falls to allow improved oversight and monitoring of all incidents.

Medicines Management

● People had not always been provided with medicines prescribed to help manage their health conditions. Records and staff confirmed this was because medicines were not always available or due to staff errors. One person who was living with dementia and required support from staff to have their medicines, had been prescribed medicines to treat heart failure. Records to document the person's care showed staff had contacted the person's GP in June 2020 as their medicines had been missed. Records for July 2020 showed again the person had not been administered their medicines for four days and staff had contacted the GP once more for advice. One week later the person was admitted to hospital. The person had not been supported to have their prescribed medicines to help manage their health condition and this placed them in a potentially life-threatening situation. When we asked the provider why this occurred, they were unable to provide an explanation.

● One person was living with dementia and sometimes displayed behaviours which challenged others. They had been prescribed medicines to help manage their condition and staff had been advised the person would need support to take these. Records showed the person had not been administered their medicines for up to 11 days as the medicines were not available. This had not been identified by the provider and it had not been considered that this might be a contributing factor to the person's anxiety or behaviours that challenged others. This was immediately fed back to the management team for them to address.

● One person was living with dementia and before moving into the home had experienced a serious incident, following which they were prescribed medicine to help manage their anxiety and distress. During a routine audit, the provider had identified that staff had not recognised the person had gone without their prescribed medicine for a period of 15 days. When we asked staff why the person had gone without their medicines, they told us the medicines were out of stock and there had been a breakdown in communication between the staff team.

● In June 2020, we conducted an Emergency Support Framework (ESF) discussion with the provider to determine if any additional support was required following the initial impact of COVID-19. ESF was introduced so providers could discuss and share information with us to help provide assurances of the care people were receiving during the global pandemic. During the discussion, the provider informed us that

COVID-19 had not affected the supply of medicines for people and people were receiving their medicines according to prescribing instructions. At this inspection, when our findings were fed back to the provider, they were unable to always determine why medicines were not available to meet people's assessed needs. This raised concerns about the provider's management of medicines to ensure there were sufficient stocks of people's prescribed medicines to meet their needs.

We wrote to the provider following the inspection to seek assurances that after these incidents, all three people had received their prescribed medicines. The provider informed us they had and our review of the information supplied by them confirmed this. From the information supplied, it was identified that three other people had not been supported to have their prescribed medicines administered as they were out of stock. The provider told us what action they were taking to help improve the ordering of medicines to ensure these were available to meet people's needs.

Whilst it is recognised that both the provider and staff had focused their efforts on helping to ensure people's safety in relation to COVID-19, they had not assured themselves people were always provided with safe care to meet their assessed needs either before or during the global pandemic. The provider was in continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe and comfortable in the presence of staff and our observations confirmed this. One person told us, "I feel security, if anything goes wrong there is someone to look after me and to get me on the right track again". A relative told us, "One hundred percent safe. Care staff are respectful and caring and look after my relative like they are their family". We observed staff being kind, caring and attentive to people's needs.
● Other people had received their medicines as prescribed to help manage their health needs. Some people were living with specific health conditions which required medicines to be administered at set, prescribed times. Staff had supported people to have their medicines according to the prescriber's instructions and this helped manage any symptoms associated with people's condition.

Staffing and recruitment;
At the last inspection, there was insufficient staff to meet people's assessed needs. The provider was in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served the provider with a Warning Notice and they were required to become compliant by 31 December 2019. At this inspection, some improvements had been made to help assure the provider staffing levels were aligned to people's assessed physical needs, further improvements were needed to ensure staff were appropriately deployed to meet people's holistic needs.

● People and relatives provided mixed feedback about the number of staff and their ability to respond in a timely way. Some people told us they had noticed a positive difference in how quickly staff responded to their needs. One person told us, "Staff are very good, I am always awake very early they check on me all night and all day, if anything is wrong, they stay with me". Some other people told us they sometimes had to wait for support. One person told us, "Often feels like you have to wait a long time, I was wet enough without standing around as well waiting, its very unpleasant. My wet pad can be on for seven or eight hours before getting one for the night time. I have a bell to ring to get to the toilet, sometimes I need it quickly, I often sit on the bed and wait".
● Consideration had not always been given to the deployment of staff when people required two staff to meet their needs. Staff had documented that they could not support one person to get out of bed for over one and a quarter hours as the person required the support of two members of staff and they were waiting for another member of staff to be free to assist them. A relative told us, "When my relative rings the bell to go

to the toilet there is not always two staff to help. When my relative needs to go there is some delay getting someone to help, my relative talks about this regularly. They don't always respond quickly they're rushing around doing their best." The provider was asked how they assured themselves of the time staff took to respond to people's needs. They told us they could monitor the call bell response times but did not routinely do this unless an incident occurred. The manager told us they would review this approach to provide assurances people were receiving support in a timely way.

● Some staff told us there were not always enough staff to enable them to spend time with people or to meet their basic care needs. The provider's dependency tool demonstrated that consideration of people's physical care needs was made and they were providing enough staff to meet people's basic physical needs. Therefore, concerns and comments made by people, relatives and some staff demonstrated that despite staffing numbers being sufficient to meet people's physical needs, these had not always been deployed appropriately to ensure people's needs were met. One member of staff told us, "We do get a bit scared sometimes because very often we're short staffed." Another member of staff told us, "Sometimes people don't have their showers or baths because we don't have time."

● The provider's dependency tool did not consider people's social and emotional needs. Some people and relatives told us there was not always enough staff to help meet their social and emotional needs. One person told us, "I'm not able to go out in the garden very often it depends on the staff." A relative told us, "I'm concerned they don't take my relative down to the garden. I keep asking because they have to go down in the lift and I say, 'Can you take them out into the garden?' Staff tell me, 'We don't have enough staff, so we can't leave the floor'".

Although improvements had been made, the provider had not ensured they had deployed enough staff to meet people's care and treatment needs. This contributed to a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The mixed feedback from people, relatives and staff was fed back to the provider so they could further assure themselves that people's social and emotional needs were considered alongside their physical needs when determining staffing levels and deploying staff.

● Our observations showed staff took time to interact with people. For example, when one person was unwell, one member of staff took time to sit alongside the person, offering reassurance and gently stroking their head, to which the person smiled.

● Since the last inspection, the provider had introduced a tool to enable them to assess people's physical and health needs and determine the amount of staff they required. They told us this was balanced and considered alongside the needs of others. The provider's assessment stated that staffing levels had continued to be maintained throughout the pandemic. Since the last inspection, staffing levels during the day had increased.

● People were supported by staff who the provider had assessed as being suitable for the role. Safe recruitment processes enabled the provider to be assured that staff were of suitable character and had appropriate experience to meet people's needs.

Preventing and controlling infection

● As part of CQC's response to the coronavirus pandemic we are conducting thematic reviews of infection control and prevention measures in care homes. We were assured the provider was following safe infection prevention and control measures and were following Public Health England guidance in respect of COVID-19. The home was clean and processes were in place to reduce the risk and spread of infection. One person told us, "The home is spotlessly clean".

● Staff were dedicated and had worked hard throughout the global pandemic to ensure people continued

to receive care and support. A relative told us, "I've said to staff, we know you've left your families to come and look after ours, and I just want to thank you for that." The provider had introduced clear and robust infection control protocols and people and staff had access to regular COVID-19 testing to help manage the risk of infection and to ensure suitable and timely action was taken when there were concerns. A relative told us, "I've been reassured they have been testing when home testing started. They appear to be testing staff and residents. They are doing everything they can".

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection, the provider had not always ensured staff were suitably trained or competent to provide safe care. They were in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a Warning Notice and the provider was required to become compliant by 31 December 2019.

At this inspection, some improvements had been made yet further improvements were needed to assure the provider that staff had undertaken the required training and held appropriate and competent skills in accordance with the provider's policies. This key question remains rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Agency staff were utilised to help ensure staffing levels were maintained according to the provider's assessment. However, the provider had not always assessed agency staff's competence in accordance with their own policy. They had not always assured themselves agency staff could safely meet people's needs when providing support with administering medicines or supporting people to move and position. People and relatives told us they sometimes noticed a difference in the skills and quality of support provided by agency staff. A relative told us, "There is a core of staff who are good. It's relying on agency staff - they are not as experienced or trained." At the last inspection, the management team told us they were in the process of ensuring that all agency staff had their competence assessed before they started work to help provide assurances they could support people safely, yet this had not always occurred.
- Staff had not always been supported to have regular support and supervision according to the provider's policy. Some staff told us they felt supported by the management team during the pandemic, but since there had been changes in the management team there was low morale and they felt unsupported and devalued by the provider. One member of staff told us they found their work, "Exhausting, debilitating and short-staffed." The provider had identified staff had not had access to the level of support they would expect and were in the process of reinstating regular supervisions.
- The care and treatment some people had received was not always safe and staff had not always acted when there were changes in people's health. This raised concerns about the quality and effectiveness of the training provided, as well as some staff's knowledge and understanding. When our findings were fed back to the manager, they told us they had plans to implement champion roles where staff could receive further training and specialise in subjects to increase their knowledge and skills. They hoped these staff would support others to promote shared learning and enhance all staff's skills.

The provider had not always ensured there were sufficient qualified, competent, skilled and experienced staff to meet people's needs. This contributed to a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● New staff had been recruited during the pandemic and due to this were not always able to complete their induction or the Care Certificate in accordance with the provider's policy. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles within the health and social care sector. The provider had considered this and in the interim had sometimes allocated new staff to work alongside experienced staff so they were able to learn expected standards of care. The provider was in the process of ensuring all staff completed their full induction and training in accordance with their policy.
● The provider had made progress since the last inspection and more staff had completed training which the provider considered essential for their roles. Some people and relatives told us they had noticed an improvement in staff's skills and competence. A relative told us, "Yes, I think they are. I did have my reservations at the beginning of the year, but they are better now."

Ensuring consent to care and treatment in line with law and guidance

At the last inspection, staff had not always considered people's capacity to consent to aspects of their care. People were not always supported in accordance with their assessed needs when they were being deprived of their liberty. The provider was in breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to complete an action plan to show what they would do and by when to improve. The provider informed us they would complete the required actions by 31 January 2020. At this inspection, we found the provider was no longer in breach of the regulation but had not met all of their action plan. The provider needed to embed the improvements made.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● There have been reoccurring themes within some of the provider's services in the Sussex area in relation to their understanding and implementation of MCA and DoLS. At the last inspection of The Martlets, it was identified that when people had a condition which had the potential to affect their decision-making abilities, staff had not always considered their capacity to make specific decisions and had not always worked in accordance with MCA. At this inspection, it was not always evident improvements had been made. When the provider was asked how they had assured themselves of some people's capacity to consent to aspects of their care such as living at the home or consenting to COVID-19 testing, they were unable to provide these assurances.
● Some people had conditions associated to their DoLS. This meant the provider was required to adhere to the conditions to ensure they were legally complying with the DoLS. It was not evident these were always being met. One person's condition required them to be supported to undertake activities outside of the home and to have regular access to garden facilities. Due to the global pandemic, staff had not been able to meet some aspects of the DoLS condition as there were restrictions on people freely accessing the community throughout lockdown. When staff were asked how they had supported the person to enjoy the garden or take part in activities prior to and once lockdown had eased, they were not able to provide

assurances. Following the inspection, staff sent us photographs of the person engaging in activities on two occasions prior to the pandemic. One photograph showed the person enjoying a group activity at the home during the global pandemic. It was not apparent the person had received enough support to meet their social and emotional needs or to comply with their DoLS condition.

We recommend the provider continues to seek advice and guidance from a reputable source to assure themselves people are supported to consent to all aspects of their care and treatment.

● A member of staff told us how they had adapted the way they supported another person whose DoLS condition required them to be supported to access external activities. The member of staff told us, "One person's condition is that they have to go out regularly. COVID makes it more difficult but we used the garden to ensure this happened with social distancing."

Adapting service, design, decoration to meet people's needs
● At the last inspection, we recommended the provider considered guidance on providing stimulating, meaningful and appropriate environments for people who were living with dementia. The provider had worked in partnership with the local authority and external healthcare professionals to develop their own and staff's knowledge about supporting people living with dementia. They were continuing to develop and enhance the service to better meet people's needs.
● When people had mobility needs, they were provided with adequate space to move around the home. People were observed mobilising independently with their mobility aids.
● People had private rooms if they wished to spend time alone and some people had been encouraged to personalise their rooms with items that were important to them. This helped to create a homely environment for them. People told us they felt comfortable living at the home and our observations confirmed this.
● Due to the pandemic, adaptations had been made to how people received visitors. People had been supported to use phones and video calls when there were restrictions on visits to care homes during lockdown. Once restrictions were eased, the provider had purchased a Gazebo so that people could receive visits from loved ones in the home's garden.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet
● One person was living with dementia and diabetes which required staff to monitor and help manage the person's health condition. Staff monitored the person's blood glucose levels but had not acted when these were higher than the person's usual readings. We asked for assurances about the food the person had been provided with on the days their blood glucose levels were raised, this could not be provided. Records to document the medicines the person had been administered each day, showed staff had continued to administer the same amount of medicines to the person, despite their increased blood glucose levels. Staff confirmed they had not sought external medical advice to determine if these should be altered to help manage changes in the person's condition.

Following the inspection, we wrote to the provider and asked them what action they had taken to ensure staff knew what to do should the person's blood glucose levels increase. They provided assurances and evidence that they had sought medical advice and staff had been provided with guidance so they knew who to contact should the person's blood glucose levels increase.

● Technology was used so that people were able to call for staff's assistance by using call bells. For people who were unable to use call bells, due to their level of understanding, sensor mats were used so that when people stepped on these, staff were alerted and were able to go to the person's aid.
● People's needs were not always assessed or met according to best practice guidance. People's oral hygiene needs had not always been assessed and staff had not been provided with guidance which informed them of the type of support people required. However, people were complimentary about staff and told us they were supported appropriately and in accordance with their needs.
● People's physical needs had been assessed and they were provided with equipment to meet their needs. For example, when people had a physical disability, they had access to hoists or mobilising wheelchairs to support them to move and position.
● People told us they enjoyed the food and were provided with choice. If people required a texture-modified diet these were served and presented in an appetising way so people could differentiate between the different foods and tastes.
● People told us if they needed to see their GP, staff arranged phone or video calls so they could continue to have access to healthcare throughout the pandemic.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Inadequate. There were continued concerns about the provider's oversight and ability to maintain and continually improve the standard of care. The provider was in continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a Warning Notice and the provider was required to become compliant by 31 January 2020.

At this inspection, not enough improvement had been made and we continued to have concerns about the provider's oversight of the standard and quality of care people received. The provider had not taken enough action to ensure this improved and had not complied with the Warning Notice. This key question remains rated 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; Promoting a positive culture that is person-centred, open inclusive and empowering, which achieves good outcomes for people;

- There has been an increased focus on the provider's services within the Sussex area by the provider, the local authority, the clinical commissioning group and CQC. This has been due to ongoing concerns about the provider's failure to address and improve reoccurring themes and shortfalls in the standard and quality of care in some services. Although affected by the COVID-19 pandemic, since the last inspection the provider has received extensive support, guidance and resources from these external professionals to help improve the care people receive. Despite this, the provider had been unable to make enough improvement to provide assurances that all people were receiving safe and effective care to meet their needs.
- Since the last inspection, the health and social care sector has faced unprecedented challenges caused by the global pandemic. Both the provider and staff had worked hard and focused their efforts to help ensure people were protected from the risk of COVID-19. However, there was a lack of oversight and actions taken to ensure all people received safe care. Insufficient action had been taken to improve the quality of people's care prior to the pandemic and therefore the daily challenges faced in response to COVID-19 had compounded the pre-existing concerns about the quality and safe standard of care some people received.
- Since the last inspection, the registered manager had left. A new manager was in post for four months but did not continue in their role. One of the provider's quality improvement managers managed the home for a period of four months before a further manager was recruited. The new manager had been in post for two months and was supported by a clinical lead and a deputy manager. A quality improvement manager and the regional operations manager regularly visited the home to help support the management team. During our inspection activity, the clinical lead left their employment. After the inspection, we were informed the deputy manager was also leaving. The management team and staff told us the turnover in management had an effect on their ability to make the required improvements.
- People and relatives told us the turnover in management had not helped the service improve since the

last inspection. One person told us, "She's a lovely lady the manager. I don't think the place is very good, it could be better, you never know what's going to happen". A relative told us, "I don't know the management that well. I've linked with them in the past. They don't seem to know much about my relative. I interact with staff who have an encyclopaedic knowledge of the people on their floor, but I have to tell management about my relative when I talk to them". Another relative told us, "They're slow in improving things, not the staff, the management". A third relative told us, "No one comes back to me with information."

● The provider had a dedicated quality assurance team who conducted periodic audits. An audit conducted in July 2020 showed that although they had not identified the specific concerns we found as part of this inspection, they had identified similar themes. Some actions had been set, yet these were not always specific or targeted to help ensure improvements were made in a timely way. For example, the audit had found that some people had not been supported according to the provider's policy in relation to the frequency required to monitor people's weight or assess their risk of malnutrition. The action set stated, 'Malnutrition Universal Screening Tool (MUST) to be completed correctly for all service users and reviewed monthly or weekly for a score of one or above.' Another action set within the audit stated, 'Fluid charts to document the recommended daily intake, where fluid intake falls below this amount details of the action taken are to be recorded.' These actions had not identified when they needed to be completed by or who was responsible for completing them. Therefore, when we inspected almost two months later the same concerns were found and these actions had not been completed. When we raised this with the provider they told us there was a process to allocate required actions and set timescales for completion, yet our findings showed this had not been implemented in practice.

● The provider operated a service improvement plan (SIP) which incorporated the concerns found at the last inspection, feedback from external professionals' findings and actions resulting from the provider's own audits. The SIP contained a significant amount of required actions, not enough progress had been made to complete the required actions and ensure people were receiving the quality of care they had a right to expect. An audit had been conducted in August 2020 which commented that although the SIP was being regularly reviewed the service was consistently not completing the required actions within the required timeframes.

● Systems in place to ensure people received appropriate and timely support after experiencing an accident or incident were not always effective and did not provide accurate or sufficient oversight of people's care which left people at risk. New auditing systems had recently been introduced which focused more on outcomes for people. These had not always identified the concerns that were found as part of this inspection. For example, a recent audit conducted by the provider had not identified all the medicine errors that had occurred. It had found that all adverse incidents had been investigated thoroughly to identify trends and ensure they were managed effectively. Yet, our findings showed this had not always occurred.

● The provider operated two different systems to provide oversight of accidents and incidents to help assure themselves appropriate actions had been taken and to help monitor trends. They were documenting when people had experienced a fall or if they had been found on the floor on different systems and therefore the systems used had not been effective in ensuring sufficient oversight as it had not identified and collated all incidents. Therefore, the provider could not be assured they were aware of all incidents that had occurred. For example, the provider's system showed that one person had experienced nine falls in nine months. When we reviewed the care the person had received, other records to document their care showed the person had fallen 20 times. The provider's monitoring systems showed another person had experienced nine falls in eight months. When we reviewed the care the person received, other records showed they had experienced 21 falls.

● Some shortfalls in the quality of care found as a result of this inspection, had not been identified by the provider, management team or staff. For example, unexplained and unplanned weight loss for one person had not been identified. Nor had it been identified that external medical assistance had not been sought for one person when they experienced changes in their health needs.

● Staff had worked hard to ensure people felt that the provider's values of wellness, happiness and kindness were implemented in practice. People told us staff were caring and friendly and our observations confirmed this. Information which some staff shared with us, raised concerns that the management team and provider's focus did not fully encompass these values. For example, two staff told us they had been told by a member of the management team that providing care was about "60 per cent records and 40 per cent about the person." This did not demonstrate a person-centred focus on providing appropriate and meaningful care to people.
● The provider was asked for assurances about the care some people had received. They were not always able to locate the documentation they required staff to complete and therefore there was a lack of assurance and oversight about the care that had been provided. Some records were not completed in their entirety or well-maintained. For example, when assurances were sought in relation to people who had experienced unexplained and unplanned weight loss, the provider was unable to show people had been provided with high-calorie or high-protein snacks as was specified within their policy. When assurances were sought in relation to monitoring people's condition in accordance with the provider's policy when people experienced a fall and a head injury, they were not always able to provide these assurances. Required improvements in documentation had been identified by the provider and had featured in all audits and communications with staff, yet this had not been actioned and improved.
● Staff had not always been provided with accurate and up-to-date information about people's needs and this increased the risk that people's needs might not be well-managed, and they could be provided with inconsistent care. For example, one person had been assessed by a Speech and Language Therapist (SALT) and required a texture-modified diet. Staff had been provided with guidance advising them of the type of food to provide. Observations showed the person being given a different level of texture-modified diet and when staff were asked the reasons for this, they explained they had noticed the person had started to cough when eating so had made the decision to puree the person's food and refer them to the SALT for a reassessment. Whilst they did this to ensure the person's safety, this had not been documented within the person's care records and therefore there was a risk other staff or agency staff might provide the person with the incorrect food which could increase their risk of choking.
● At the last inspection, we issued three Warning Notices to the provider for breaches of Regulations. We also asked the provider to complete an action plan to show what they would do to improve and by when. At this inspection, we found the provider had not met the Warning Notices and had not fully complied with their action plan. The provider has been in breach of Regulation 17 (Good governance) at the last four consecutive inspections. The home has been rated as Requires Improvement at the last five consecutive inspections and is now rated Inadequate.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
● The provider had remained in contact with relatives throughout the pandemic via direct communication or information displayed on the home's website. This had advised them of the measures and precautions in place as well as how they were supporting people's needs. Feedback from some relatives raised concerns about openness and transparency. The home had experienced COVID-19, yet some relatives told us they were assured when staff had told them the service had not experienced COVID-19.
● Some staff told us they had been advised by the management team that when speaking to CQC as part of the inspection, they should only provide positive feedback and if there was anything negative, they should not disclose this. This raised concerns about the provider's openness and transparency.
● It was not always apparent how people and their relatives had been involved in discussions in the planning and implementation of people's care. This had also been identified within one of the provider's own audits, yet action had not yet been taken to improve this.

The provider had not taken enough action to ensure improvements were made to the quality and safety of care provided. Systems and processes were not operated effectively to assess, monitor and improve quality and safety and ensure risks were managed. Records to document and provide oversight and assurances of the care people had received were not well-maintained and were not always available. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We wrote to the provider following the inspection to seek assurances about the oversight of people's safe care and treatment. They provided some assurances about the actions taken to help mitigate risk and ensure people's care was well-managed. This included making improvements to medicine management systems, the collating of information relating to falls and enhanced oversight of people's fluid and food intake.

● Within past inspections, there have been concerns that the provider's audits and quality assurance processes have not been effective. The newly introduced audits were still being implemented, yet there is confidence once these are fully embedded, they will help enable the provider to highlight any required actions. For example, a recent audit had found that falls were not being managed effectively, and that insufficient action had been taken to manage weight loss and ensure procedures were being followed. It noted improvements were needed to records to show that people's capacity had been considered and that DoLS conditions were being met. Findings which we also found at this inspection.
● Since being in post, the manager had introduced the provider's revised policy and procedures for monitoring and assessing risk when people were at risk of falls. One person had experienced several falls, the manager had identified this and had consulted with the person's GP to determine if there were any underlying causes.
● The provider had made some positive changes to help provide better assurances about the standard and quality of care. This included the introduction of a tool to enable them to ensure staffing levels were more suited to people's assessed physical needs. However, despite this, and as noted within this report, we found they had not always considered the deployment of staff or people's holistic needs.
● The provider had informed CQC and other external health and social care professionals when care had not gone according to plan. They had notified us of incidents that had occurred to enable us to have oversight to help ensure appropriate actions were taken. Yet, as noted within this report, the provider had not always effectively identified accidents and incidents which had occurred and therefore this could have an impact on our monitoring of people's care.

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
Treatment of disease, disorder or injury	Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered person had not ensured care and treatment was provided in a safe way for service users.

The enforcement action we took:

We have imposed a condition of registration on the provider's registration of The Martlets in relation to oversight and management of risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The enforcement action we took:

We have imposed a condition of registration on the provider's registration of The Martlets in relation to oversight and management of risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person had not ensured that there were: Sufficient numbers of suitably qualified, competent, skilled and experienced people That staff had received appropriate support, training professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

The enforcement action we took:

We have imposed a condition of registration on the provider's registration of The Martlets in relation to the competence of staff and the oversight and management of risk.