Coast Care Homes Ltd

Bexhill Care Centre

Inspection report

154 Barnhorn Road
Bexhill-on-sea
TN39 4QL

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16 December 2020

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bexhill Care Centre is a care home with nursing and accommodates up to 43 people in a purpose-built building. The service provides step down nursing and in commissioned by East Sussex County council to assist social services and the National Health service during the COVID-19 pandemic. The services supports adults whose primary needs are nursing care although some may also be living with dementia. At the time of the inspection there were 32 people living at the service.

People's experience of using this service and what we found
Discrepancies were found on respect forms and do not attempt cardiopulmonary resuscitation (DNACPR) forms with regard to capacity to make decisions. Not all people living with diabetes had a care plan and risk assessment in place to inform staff of risks. Contingencies were not in place to advice staff if a person refused medicines or if a person had low blood sugars, what actions were necessary. Some risks had been managed well for example, regular reviews and monitoring of people's nutritional needs. A new electronic care system had recently been introduced and although this was still being embedded, it had improved the quality of records.

The home had a policy for people who refused medicines however there was no documentation to show what follow up had been made and therefore no record kept of people having medication re-offered, which contravened their own policy. Protocols for 'as required' (PRN) medicines were not in place for everyone that required them. There was no system in place to monitor pain relief, including those who were in receipt of end of life care. Medicines were stored and disposed of correctly. Staff responsible for giving medicines had all been trained and good practice was observed with the use of body maps for recording areas of soreness.

Staff were aware of what action to take with safeguarding issues and were able to describe their training and exactly who they would raise issues to. People told us that they felt safe and relatives told us they had confidence in the staff and were happy that their loved ones were looked after safely. Accidents and incidents were recorded with any serious issues being escalated to the local authority and CQC. Staff were recruited safely and there were always enough trained staff covering each shift. Infection prevention and control procedures were in place and were effective.

Some care plans did not fully reflect people's needs. Some people living with diabetes and others who were towards the end of their lives did not have specific care plans in place to inform staff. Although auditing processes had improved at the service and there was a regular schedule of management oversight, this had not yet fully embedded as evidenced by missing and inaccurate care plans. Accident and incident investigations had improved. The registered manager was a visible presence at the service and created a positive culture among staff. The registered manager understood their responsibilities under the duty of candour.

No formal process was in place for getting feedback from those that lived or worked at the service and most meetings had been suspended due to the pandemic. However, there was positive feedback on websites associated with care home quality and a number of written compliments from relatives had been received.

Although a new pre-assessment form had been developed the process was not yet fully embedded. Professionals expressed concern that sometimes only basic information was recorded. Involving relatives and loved ones in the pre-assessment process was inconsistent. Recording of people's fluids showed daily differences in the amounts offered and the amounts consumed with no information to explain why or what additional action might be required. People's nutritional needs were met. People were supported to access health and social care professionals. The service had a training manager who ran induction course for all new staff, the content depending on past experience. Current training was up to date and there were always enough trained staff on duty each shift. The layout of the service met people's needs.

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

A generic complaints policy was in place but was not easily accessible to everyone. No complaints were recorded nor any minor issues or concerns. We were aware of some issues that had been raised but there were no records to demonstrate they had been addressed. We have made a recommendation about the management of issues.
There had been several people at the service who were at the end of their lives, but no training had been provided for staff to cover this area. Staff however were able to tell us the important aspects of caring for people at that time of their lives and most staff had experience of this aspect of care.

Care plans were in the process of being transferred to a computerised system. It was clear that this new system was more accessible to staff, but it had not been fully transferred yet. Staff knew people and their support needs. People's communication needs were met. The pandemic had meant that group activities had been put on hold, but staff still spent time with people in their rooms, talking to them and supporting them.

People were well cared for and we observed several positive interactions between staff and people. Relatives and professionals told us that the staff were consistently caring and looked after people with compassion. Despite the service following the isolation and zoning guidelines during the pandemic, staff still made time for people and spent time with them whenever possible. Care plans were person centred. People's privacy, dignity and independence were all promoted and supported by staff.

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

Rating at last inspection
A targeted inspection took place (published 15 September 2020) which was not rated. We reported breaches of regulations.

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/ sustained and the provider was still in breach of regulations.
This service was registered with us on 01/05/2020 and this is the first rated inspection.

Why we inspected
This was a planned inspection based on the previous findings at our targeted inspection.

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.

The inspection was prompted in part due to concerns received about management of risk medicines, and governance. A decision was made for us to inspect and examine those risks.

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

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

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 will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management of diabetes with no care plans telling staff how to manage risks to people. There was a further breach relating to medicines with no process to follow when medicines were refused, no PRN protocols in place and no record of pain management. There was another breach relating to ineffective auditing processes.

Follow up
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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bexhill Care Centre

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 was completed by two inspectors.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed the information we held about the service and the service provider. We sought feedback from the local authority, the clinical commissioning group and healthcare professionals that are involved with the service. We looked at notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

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.

Due to the COVID-19 pandemic we needed to limit the time we spent at the home. This was to reduce the risk of transmitting any infection. To minimise the time in the service, we asked the registered manager to send some records for us to review

During the inspection
We spoke to five people who used the service. We spoke with nine members of staff including the registered manager, care manager, two nurses, the training manager, the housekeeper, a carer and two kitchen staff. We spent a short time in the home over two days. This allowed us to safely look at areas of the home and to meet people and staff whilst observing social distancing guidelines. It also gave us an opportunity to observe staff interactions with people.

We reviewed a range of records including care plans, medicine records, four staff files relating to recruitment and supervision and further records relating to the auditing of the service, safeguarding and accidents and incidents.

After the inspection
We continued to seek clarification from the provider to validate evidence found. To minimise the time spent in the service, we asked the registered manager to send some records for us to review after the inspection. These include staff training documents and infection prevention and control policies.

Requires Improvement

Is the service safe?

Our findings

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

This is the first rated inspection for this newly registered service. This key question has been rated requires improvement.

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

Assessing risk, safety monitoring and management
At the last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12. The move to a computerised recording of care plans had improved staff access to information however specific care plans were missing and some information was incorrect.

- Not all people who lived with diabetes had a care plan and risk assessment in place to guide staff in providing safe care and management of their condition. This meant that there was a potential of unsafe care being delivered.
- One person had been refusing their medicine to manage their diabetes, and staff did not have the information to ensure their safety. For example, staff did not know what blood sugar level was normal for that person and were recording high blood sugars which could impact on the persons health.
- It had been recorded in their discharge from hospital that one person was at risk of low blood sugars and this had not been reflected in their risk assessments or care plans. There was no guidance of what symptoms to be alert to or what action staff should take if the person should be found unconscious.
- Respect forms and do not attempt cardiopulmonary resuscitation (DNACPR) forms for some people were not accurate. Staff were not able to explain the rationale for the decisions relating to people's best interests. They also confirmed that one person did have capacity to be involved in the decision making, but the form stated they did not. This could potentially impact on a safe decision in the event of a collapse.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection a new electronic care system had been introduced. This had improved the quality of care records and risk assessments. Specifically, wound care management.
- We saw some good examples of risk management that had been completed, such as risk of malnutrition. Staff reviewed risk assessments monthly and put actions in place to reduce these risks. For example, ensuring a person who was at risk of choking was provided with a pureed diet and modified texture fluids.
- One person told us, "I am only here for a little bit, but I feel that they look after me." Another person said, "I

had to come here to be safe and I am safe," and "I have no concerns about safety, but I don't like other residents keep walking in the bedroom, not unsafe but frustrating."
● There were detailed fire risk assessments, which covered all areas in the home. People had Personal Emergency Evacuation Plans (PEEPs) to ensure they were supported to leave the home safely in an emergency.
● Premises risk assessments and health and safety assessments continued to be reviewed on an annual basis, which included gas, electrical safety, legionella and fire equipment. The risk assessments also included contingency plans in the event of a major incident such as fire, power loss or flood.

Using medicines safely
At the last inspection medicines were not managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12. There had been an improvement in recording information on MAR charts however there were still issues with recording refusals, management of insulin and PRN medicines.

● There were people who had regularly refused their essential medicine. We were informed that the organisational policy for the refusal of medicines stated it should be offered three times if safe to do so. However, we could not evidence if the person received their medicine as there was no further documentation or evidence that it had been re-offered. Staff had not recorded medicines being re-offered.
● There was no evidence that the refusal of insulin had been discussed with the GP and diabetic nurse in a timely manner. This has now been rectified and the diabetic team will be visiting to discuss this issues with the resident and staff.
● Some people had been prescribed additional medicines on an 'as required' (PRN) basis. We identified again that not everyone had protocols in place to inform staff when these medicines were required and information about the safe administration of these medicines for the person concerned.
● There was no consistent approach to monitoring the effectiveness of the pain relief such as a pain chart. Some people did not have specific care plans or risk assessments for pain control. This included those people who had been prescribed Just in Case Medicines to be used at the end of their life. Staff were not monitoring the effectiveness of the pain relief for any resident and therefore could not use that important information to manage pain control safely and effectively.

The failure to ensure the proper and safe management of medicine was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

● There were aspects of the management of medicines that were adequately managed. For example, medicines were stored safely and in the main ordered in a timely way. Medicines were also disposed of safely. There was evidence that staff were aware of the stock levels. People had no worries about their medication. One person said, "I get my pills." Another said, "They let me know if my tablets are changed, "I have no concerns."
● All staff who administered medicines had, had the relevant training and competency checks that ensured medicines were handled safely.
● All emergency equipment was stored safely and ready for use.
● There was good practice regarding the application of creams. Body maps were in place and staff signed to say these had been applied.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to ensure that there were systems and processes established and operated effectively to prevent abuse of service users. This was a breach of regulation 13 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13. The service now investigated safeguarding issues including the handling of pressure sores and falls.

● Staff were aware of their responsibilities to safeguard people from abuse and any discrimination. Staff were knowledgeable of the signs of abuse and how to report safeguarding concerns. They were confident the manager would address any concerns and make the required referrals to the local authority.
● A staff member said, "We have had training and we discuss safeguarding procedures at team meetings," "If the management didn't do anything than I would go to LA or CQC."
● People told us they felt safe. One person said, "I am safe, I trust the staff, very kind." Another person said, "I do feel that I'm looked after, I'm looked after well here."
● There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority. Staff confirmed that they had read the policies as part of their induction and training.
● The registered manager kept on overview of all safeguarding's which were analysed and outcomes shared with staff.

Learning lessons when things go wrong
● Accidents and incidents were documented and recorded. We saw incidents/accidents were responded to by updating people's risk assessments. Any serious incidents resulting in harm to people were escalated to other organisations such as the Local Authority and CQC.
● Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. For example, one person had several falls. Staff looked at the circumstances and had tried various things to reduce risk such as sensor mats, and sensor beams.
● Learning from incidents and accidents took place. Specific details and follow up actions by staff to prevent a re-occurrence were clearly documented in most cases. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns.

Staffing and recruitment
● People received care and support in an unrushed personalised way. Comments from people included, "Plenty of staff to help me and always polite and never rush me." Another person said, "Usually very good, sometimes a delay when I ring for help, but they always answer and let me know."
● Rota's confirmed staffing levels were stable and the skill mix appropriate. For example, there was always two registered nurses on day duty, one registered nurse on night duty, supported by senior care staff and care staff. The clinical lead was supernumerary to the staffing numbers.
● The registered manager monitored call bells randomly and looked for trends or poor response to call bells. Action was taken when required, for example looking at staff deployment and skill mix. Calls bells were responded to promptly by staff during the inspection.
● There had been some turnover in staff over the past nine months, specifically registered nurses, which meant that the new team was still settling in. Staff recruitment was ongoing.
● New staff were safely recruited. All staff files included key documents such as a full employment history, at least two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or adults. This ensured only suitable people worked at the service.

● Registered nurses have a unique registration code called a PIN. This tells the provider that they are fit to practice as nurses. Before employment, checks were made to ensure the PIN was current with no restrictions.

Preventing and controlling infection

● We were assured that the provider was meeting shielding and social distancing rules. The rules themselves relating to safe distance was being complied with. The registered manager told us that social distancing and relatives and loved ones not being able to routinely visit was making some residents anxious. The service offered video links so residents could speak to and see their relatives. This went some way to relieving anxiety, but some people remained upset at the lack of visits.

● We were assured that the provider was preventing visitors from catching and spreading infections. Visitors had temperature taken on arrival, completed a health questionnaire were required to wear full PPE.

● We were assured that the provider was admitting people safely to the service. All new residents and those returning from hospital visits were required to isolate for 14 days.

● We were assured that the provider was using PPE effectively and safely. Training had been provided in infection prevention and control and there were plentiful supplies of PPE.

● We were assured that the provider was accessing testing for people using the service and staff. Both residents and staff were given weekly tests.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The premises were clean and we saw cleaning staff in all areas of the home.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The home was split into two wings both with a ground and first floor.

● We were assured that the provider's infection prevention and control policy was up to date. We were shown a recently updated policy document.

Good

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.

This is the first rated inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Most referrals to the service came from local hospitals. Pre-assessments were carried out by the registered manager or one of the management team. Demand on the service was sometimes high with several referrals being made each day. A professional told us, "Some assessments are carried out over the phone which can lead to only basic information being passed." Another professional said, "Although the care is very good, it's not always clear what roles staff have." Information gathered during pre-assessment was not always include in the care plans themselves.
- The service now used a newly designed proforma for pre-assessments which captured people's specific care and support needs for example, those living with diabetes or dementia. The information gathered formed the basis of the care plans for people.
- Some relatives were involved in the pre-assessment process. A relative told us, "I spoke to the manager and to adult social care, that formed part of the assessment." Other relatives told us they had not been consulted.
- As a step-down service people in most cases moved on after a few weeks. Some returned to their own homes with support from other professionals and some moved into residential or nursing care settings. The service was in the process of creating a specific role for a manager, responsible for discharge from the service.

Supporting people to eat and drink enough to maintain a balanced diet

- The catering staff were knowledgeable about people and their needs. A clear chart in the kitchen showed which people were diabetic and which people required food chopped up into small pieces. Everyone was given at least two options every mealtime. The menu followed a four-week rolling cycle.
- Care plans confirmed referral to speech and language teams (SALT) for support if there were concerns about a person's choking risks. People's weight and BMI were monitored and the service used the malnutrition universal screening tool (MUST), which is a simple way of calculating nutritional risks.
- People were generally positive about the food. One person said, "It's alright. I'm not that hungry because I'm not doing much. Adequate I'd say." A relative told us, "They love the food there." Most people were receiving their meals on trays in their rooms during the pandemic. Staff were seen to be wearing appropriate PPE when serving food.
- We were shown documentation confirming daily temperature checks were carried out in the kitchen and that all equipment was serviced regularly. The home had the highest food hygiene rating.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

● As a step-down service some people had mobility goals that needed to be achieved before leaving the service. It was not always clear how these needs were progressed or measured. The registered manager told us that they would liaise with ongoing services and provide information and support in some cases when needed.
● People were supported to access health and social care professionals. The service had established links with staff at local hospitals responsible for discharge processes. During the pandemic the majority of GP contact was done remotely through video calls. Some professionals still entered the service regularly for example, tissue viability nurses. The registered manager told us they had a good working relationship with the local pharmacy.

Staff support: induction, training, skills and experience
● The training manager ran induction courses for new staff. The length of induction depended on past experience and skills but usually was a weeklong. A staff member told us, "I didn't complete a full induction but I had plenty of opportunities to shadow." Another said, "I did a week. It was quite intense with a lot of online training courses."
● We were shown a training schedule that confirmed that staff were up to date with training in most areas for example, safeguarding, dementia and manual handling. The service had recently experienced some people who were end of life. There is no end of life training at the service but the training manager acknowledged that this needed to be addressed. Staff however were experienced in end of life care and were able to tell us the important aspects of care at this time. The nurses at the service had received end of life training as part of nursing training.
● We saw several staff files which confirmed details of induction and training that had been completed. Staff supervision meetings occurred every three months but staff told us they could approach managers at any time for support if needed.
● The number of people using the service at any one time varied a lot which presented challenges to ensuring the service had the right number of trained staff on duty for each shift. The registered manager told us that they always have more staff on duty than absolutely needed to cover when new admissions arrive. Staff rotas confirmed this and we saw that there was always a member of nursing staff on duty every shift.

Adapting service, design, decoration to meet people's needs
● The service is on two floors and is split into two wings, one providing nursing care. Each area has its own dining room and communal living spaces although at the time of the inspection the majority of people remained in their rooms following isolation guidelines. A central lift connected the two floors.
● The service had undergone some decoration and there was clear signage across the home. Although people spent only a few weeks at the service the bedrooms we saw were personalised with people having photographs and personal effects on display. Each room had its own television and radio and most were en-suite. Specialist equipment for example, mobility aids were safely placed across the service.
● The service did have a garden area that could be used by residents during warmer weather.

Ensuring consent to care and treatment in line with law and guidance
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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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 service 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.

- Most people using the service had capacity. Some had correctly had mental capacity assessments and these had been recorded as part of people's care plans. One DNACPR form did have incorrect information relating to capacity, (see our safe domain for more details.)
- No one at the service at the time of the inspection had a DoLS in place. We did see recorded on one capacity assessment, reference to a consideration to DoLS but this had not been deemed necessary at that time.
- Staff had been trained in the Mental Capacity Act and DoLS and showed a good understanding. One told us, "I will always speak to people and ask them about what they want. If a person sometimes lacks capacity, I'll only ever act in their best interests."
- Staff understood the importance of gaining consent from people. A staff member told us, "I always ask people and reassure them about what I want to do. I understand it's not all about verbal consent, people indicate 'no' in different ways."
- People were offered choice and this was seen in care plans. For example, people could choose whether to bathe or shower, what clothes they wanted to wear each day and what food from the menu.

Good

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.

This is the first rated inspection for this newly registered service. This key question has been rated good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us that they felt well cared for. Comments included, "The staff seem kind," and "I do feel looked after." Similarly, relatives told us that their loved ones were looked after well. One relative told us, "I'm more than happy. (relative) loves it there." Another relative said, "It's excellent, they are very supportive. I know they are in safe hands."
- We observed interactions between staff and people. Staff spoke in a calm and reassuring way. Staff spoke clearly to people whilst wearing face coverings, not by raising their voice but by taking their time and never rushing people.
- Professionals told us that staff and managers were caring. A professional said, "The care is very good, staff know people well." Another told us, "Staff know that some people will be anxious especially when they first move there but they do everything they can to help with this."
- Due to isolation practices several people would spend nearly all of their time in their rooms, including mealtimes. Staff made time to sit with people, observing social distancing guidelines and to talk to them. Those able to take their meals together did so in communal dining areas where they were able to socialise together.
- People's protected characteristics under the Equalities Act 2000 were respected. For example, people were able to observe religious practices if they chose and although no religious gatherings or visits were taking place the service offered video calls with faith representatives if desired.

Supporting people to express their views and be involved in making decisions about their care

- Care plans were person centred and since moving to a computerised system were easier for staff to navigate. Care plans had details of people's specific needs and what they needed to achieve before moving on. Likes, dislikes and preferences were recorded. A member of staff said, "Any special needs are picked up for example, diabetes, tissue viability or catheter care needs."
- Some relatives and loved ones were involved in care planning. A relative told us, "I spoke to the manager and adult social care (local authority) before they (relative) was admitted. I was able to tell them some specific information they might not have picked up."
- Staff were aware of the importance of giving people choice and encouraging them to make decisions. A member of staff said, "I'll always explain what I'm doing and ask if they have a preference."
- Confidentiality was respected and promoted with all sensitive documentation being stored in locked cupboards or within password protected computer systems. Handover meetings between shifts were held in separate areas where conversations could not be overheard.

Respecting and promoting people's privacy, dignity and independence

● Maintaining people's privacy was important to staff. Several people were isolating at the time of the inspection, but everyone had their own rooms where they were free to go at any time. A staff member explained, "Yes privacy is respected. We always knock on doors and only enter if invited or if we have concerns."

● Similarly, people's dignity was respected. We observed staff talking to people and engaging them in conversations, asking their views and what they would like to do next for example, after a meal had finished. A member of staff told us, "I ask them what they want or would like to do. I'll always place towels over them during personal care to protect their dignity." A manager said, "I love the way staff engage people here. They interact during personal care and really put people at their ease."

● Promoting and encouraging people's independence was an important aspect of care at the service as people prepared to move on to different settings, some returning to their homes with support and others moving to residential or nursing home settings. We observed people being supported in their mobility as they moved around safe areas of the home and others being supported to eat. A staff member said, "I always encourage people to be independent but will always reassure them and say, 'I'm just here if you need me.'"

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first rated inspection for this newly registered service. This key question has been rated requires improvement.

This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- We were shown a complaints policy that was generic to the provider. The policy was up to date but was not readily accessible to people or relatives. Neither people or relatives were aware of the policy.
- No complaints had been recorded. The registered manager told us that no complaints had been received however we were aware of some issues that had been raised that would meet the threshold of a complaint and there was no record of these issues being addressed. The registered manager was aware of these concerns but had not investigated further.
- A person told us about the absence of any investigation after a complaint was raised concerning a long delay in providing personal care. A relative was referred to the service complaints process following issues raised by their relative concerning poor décor and few drinks being provided. No record of either incident were found at the service.
- Similarly there was no record of minor incidents or concerns. The registered manager acknowledged this shortfall and undertook to put in place a system to record complaints and concerns.

We recommend the provider consider current guidance and that complaints are recorded in line with their service policy. The policy to be made accessible to people and relatives.

- Despite not being aware of the policy relatives told us that they had confidence in issues being addressed. A relative told us, "I've not raised any issues but I have every confidence that they would respond."

End of life care and support

- Although the service was a step-down home where people stayed for a few weeks before moving on to a more permanent placement there had been several deaths at the service. The nursing staff at the service had received end of life training as part of their general nursing training, the rest of the staff at the service had not received end of life training.
- We spoke to the training manager who acknowledged a need for all staff to be trained in end of life care and they told us that it was a training module that was planned for the near future.
- Despite this lack of training staff were able to tell us about the important aspects of caring for people towards the end of their lives. Most of the staff we spoke to had experienced being involved in looking after people at this time. A member of staff told us, "I make them as comfortable as possible, mouthcare is important. I'll listen to them and maybe turn the radio on if they want it." They went on to say, "I will sit with them safely and talk to them. We let visitors come to see them."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans had recently been transferred to a computerised system which was easier to access and update. Care plans were person centred and contained a section about personal preferences and daily routines. With the daily notes the system had clear pictorial symbols so staff could see at a glance whether a person had received for example, personal care or a meal and drinks.

● Staff knew people and their care and support needs well. A member of staff told us, "We do sit and chat with people, you get to know them and it helps when looking after them." Another said, "When people first arrive, we go through their likes and dislikes."

● A person told us, "I do feel looked after, I think the nurse seem a bit rushed." A relative said, "I have every confidence in the staff, they respond straight away to issues and know (relative) well."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Some people that stayed at the service were living with dementia or other forms of illness that affected their ability to communicate. Staff had completed dementia awareness training and were able to tell us how they effectively communicated with people. One staff member told us, "I will always reassure people and explain what I'm doing. The masks can be difficult for people who are hard of hearing, it's important we speak clearly and slowly and get as close as we can but keeping a safe distance."

● A relative told us that their loved one tended to say yes in answer to any question asked and that staff were aware of this. They said that this had formed part of the care planning for their relative and that staff looked at facial expressions to help determine the best options and outcomes for the person.

● The home was plainly decorated with some written and pictorial signs displayed to help people living with dementia to orientate themselves.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The pandemic has meant that regular activities have been stopped. Between the first two lockdown periods the service employed an activities co-ordinator who provided small group and one to one activities for people. This will be resumed as soon as it is safe to.

● Similarly visits from friends and relatives had not been possible. Between the lockdown periods garden visits were co-ordinated. Relatives can speak to their loved ones through social media for example, facetime and zoom meetings. Visits to people receiving end of life care took place but are time limited and strict rules around PPE were followed.

● People had access to radio and television in their rooms and staff made time to speak with people whilst observing social distancing. A person said, "I had to stay in my room but that's ok, I have a television." A staff member said, "We try and bring sunshine to their rooms. I sing with them sometimes."

● The service had a garden area that could be used by people during the summer months.

Requires Improvement

Is the service well-led?

Our findings

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

This is the first rated inspection for this newly registered service. This key question has been rated requires improvement.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the last inspection the provider had failed to ensure support plans covered specific areas of care and there was a lack of management oversight of auditing processes. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The move to a computerised system for recording and managing care plan details had improved the overall governance of care. However, this was a work in progress and care plans needed greater detail. Some key areas were either missing, for example diabetes and end of life care plans, or contained inaccuracies, for example, consent on DNACPR forms. These gaps had not been identified during auditing by the registered manager.
- Some care plans did not fully reflect people's current needs. As a step-down service several people had mobility needs and rehabilitation goals which needed to be achieved before leaving the service. These were not always reflected in care plans.
- We were shown care plans which showed daily amounts offered and daily amounts consumed. One showed 1100mls being offered one day and only 20mls another. On the same chart the amount consumed similarly varied with one day showing zero. Nothing indicated the reasons for these variations or any action taken as a result. This issue had not been identified by the registered manager during auditing.
- At the last inspection we highlighted that auditing processes were being completed by staff not in managerial roles and there was a lack of oversight from the registered manager. This had improved and we saw a clear scheduling of auditing processes. Clinical care, accidents and incidents, medication and infection prevention and control were audited weekly. However, despite the improvements in auditing processes there was a continued lack of management oversight as indicated by the failure to identify some aspects of care planning relating to diabetes and end of life.
- At the last inspection we saw accidents and incidents being reported but a lack of follow up and reviews particularly in relation to falls management. At this inspection this had improved but more needed to be done to identify the actual cause.

This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Accidents and incidents were followed through and we saw clear progress with falls management with systems in place to refer people experiencing more than a single fall to the falls management team. Care plans reflected this and provided clear guidance to staff.

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

● The registered manager had worked for Coast Care Homes for several years and had been the registered manager at Bexhill Care Centre since it opened in May 2020. The registered manager maintained a visible presence throughout the service in support of residents and staff. A staff member said, "There is always someone here, 7 days a week." Another told us, "I feel supported all of the time. They (managers) are around all of the time and there is always someone on call."

● There was a positive culture at the service and the registered manager showed a willingness and desire to continually improve the quality of care provision. We highlighted some issues for example, the lack of a minor incident log and inconsistencies in some care plans and these were immediately addressed. A relative told us, "I know that if I had any concerns or issues that the manager and the staff would sort things straight away."

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 registered manager knew their responsibilities under the duty of candour. Throughout the inspection the registered manager was open, honest and responded to issues that we raised. Registered managers have a legal obligation to inform CQC and other professionals for example, the local authority, about significant events that affect their service. This obligation had been fulfilled.

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

● The registered manager had not actively sought feedback from residents, staff, relatives or professionals in a way that could be collated and trends identified. The registered manager acknowledged this was an area requiring development.

● However, positive feedback was found on websites associated with care home quality. This feedback was mainly from relatives and former residents. Relatives told us that they were happy with the service provided one saying, "It's not just functional, you get the feeling it's a caring environment." A professional said, "It's a very supportive home."

● Restrictions during the pandemic had meant that large staff meetings had not been possible. We were told however by staff that smaller meetings for example, between the nursing staff, took place every few weeks. Staff told us of daily handover meetings between shifts where all issues and current risks were discussed. Staff also told us that the managers were available, approachable and listened to their concerns, one telling us, "I've made suggestions which they take on board."

● We were shown a folder containing letters and compliments from former residents and relatives. All were complimentary about staff and the care provided.

● Peoples equality characteristics had been considered. For example, people's faith and cultural needs were explored and recorded during the pre-assessment and any dietary requirements relevant to their beliefs noted. These considerations were recorded on care plans and were accessible to all staff.

Continuous learning and improving care

● The training manager ensured that training reflected the needs of people. The service had recently experienced residents who were end of life. Training was developed for staff so that they were equipped with the skills they needed to look after people towards the end of their lives for example, oral health care.
● The registered manager showed a willingness to improve and to learn. The service was being supported by the local authority and the clinical commissioning group (CCG) to help them develop their response to improving the service.
● The registered manager kept up to date with developments in adult social care relevant to their service by monitoring CQC and local authority websites and weekly news bulletins.

Working in partnership with others
● The service had established relationships with local hospitals from where most referrals were made. Similarly, a good working relationship had been formed with local GP services, social workers and pharmacies. A professional told us, "Senior staff are able to provide the updates and information I need."
● The service had recently appointed a member of staff to manage people's onward journey after leaving the service. As a result, the service was beginning to establish a network with other residential and nursing homes in the area and with local domiciliary care services.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to demonstrate safe care and treatment was always provided. The provider had failed to ensure that there were systems and processes established to robustly assess the risks relating to the health safety and welfare of people. Systems were not in place to demonstrate safe care and treatment was always provided. The provider had failed to ensure that there were systems and processes established to effectively manage medication and equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to demonstrate safe care and treatment was always provided. The provider had failed to ensure support plans covered specific areas of care and there was a lack of management oversight of auditing processes