Shaw Healthcare Limited

# Deerswood Lodge

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Deerswood Lodge is situated in Crawley, West Sussex and is one of a group of homes owned by a national provider, Shaw Healthcare Limited. It is a residential 'care home' for up to 90 people some of whom are living with dementia, physical disabilities, older age or frailty. At the time of the inspection there were 58 people living in the home.

People's experience of using this service and what we found
There were continued concerns about some people's safety. Risk to people's safety had not always been identified or lessened. Medicines management was not always safe, and people did not always receive their medicines according to the prescriber's instructions. Staffing levels, competence and the deployment of staff had not always been aligned to meet people's assessed needs. Lessons had not always been learned to help improve the care people received. The provider had not always assured themselves that staff were appropriately trained, experienced or competent. Competency checks to assure themselves of staff's skills had not been completed. New staff had not always completed inductions or training which the provider considered necessary to meet people's assessed needs. This increased the risk that people would receive unsafe or inappropriate care.

Insufficient improvements had been made since the last inspection to ensure people received high-quality and safe care. The provider had failed to continually improve and improvements that had been made were yet to be embedded and sustained in practice. There had been a turnover within the management team and systems and processes to support the running of the service were not always robust. Audits, to enable the management team and provider to have an oversight of the service, were not always completed. Shortfalls that have been found at this inspection, had not always been identified by the management team or provider. The provider was working with external health and social care professionals to help improve people's experiences.

People who were living with dementia, did not always receive respectful or dignified care. There was sometimes a lack of person-centred practices to ensure that people's needs, preferences and wishes were respected and met. The environment and information had not always been adapted to support people's understanding and orientation around the building. There was sometimes a lack of meaningful and stimulating pastimes or interactions with staff to occupy people's time. People were at risk of social isolation.

We recommended that the provider accessed guidance in relation to providing accessible information and stimulating, meaningful and appropriate environments for people who are living with dementia.

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. People's needs were not always fully identified and assessed to

enable staff to deliver care that met people's preferences or requirements. People had access to external health care professionals when they were unwell. People were complimentary about the food and told us they had choice and their preferences were respected.

Most interactions between staff and people demonstrated kind and compassionate care. People told us they were fond of the employed staff and found them caring and compassionate. One person told us, "Staff are good, I get on well with them, and they are kind and answer queries".

Rating at last inspection
The last rating for this home was Inadequate. (Supplementary report published 10 August 2019).
This is the second consecutive time that the home had been rated as Inadequate and in special measures.

Why we inspected
Although an inspection was planned based on the previous rating, a decision was made for us to inspect sooner and examine risks. The inspection was prompted in part due to a number of concerns received about people's safety, medicines management, the responsiveness of staff and the leadership and management of the home. We have found evidence that the provider needs to make improvements. Please see all the sections of this full report.

Enforcement
We have identified six breaches in relation to person-centred care, dignity and respect, consent to care, safe care and treatment, staffing and the leadership and management of the home. You can see what action we have asked the provider to take at the end of this full report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.
The overall rating for this home is 'Inadequate' and the home is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow-up
We will continue to monitor the intelligence we receive about this home. We will request an action plan from the provider and meet with them to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and the local authority to monitor progress. We plan to inspect in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

## 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 caring?**

The service was not always caring.

Details are in our caring findings below.

**Requires Improvement**

**Is the service responsive?**

The service was not always responsive.

Details are in our responsive findings below.

**Requires Improvement**

**Is the service well-led?**

The service was not well-led.

Details are in our well-led findings below.

**Inadequate**

# Deerswood Lodge

**Detailed findings**

## Background to this inspection

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

Inspection team
The first day of inspection was undertaken by three Inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned for the second day of inspection.

Service and service type
Deerswood Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The home did not have a manager who was registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The home had been without a registered manager for five months. There have been a number of interim managers providing oversight since this time. A new manager was in the process of being recruited.

Notice of inspection
The first day of inspection was unannounced. The second day of inspection was announced.

What we did before the inspection
We reviewed information and concerns we had received about the home since the last inspection. We liaised with health and social care professionals for their feedback. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
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 spoke with eight people and six relatives, 12 members of staff, the manager, an operations manager and the chief operations officer. We reviewed a range of records about people's care and how the service was managed. These included the individual care and medicine administration records for 17 people. We looked at 16 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the home, which included policies and procedures, were also reviewed.

After the inspection
We requested information and assurance from the provider that risks identified as part of the inspection had sufficiently lessened. We shared some of our concerns with health and social care professionals from the local authority and specialist teams.

Inadequate

# Is the service safe?

## Our findings

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

At our last inspection, this key question was rated as Inadequate. At this inspection this key question remained the same. This meant people were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely; Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection, the provider had failed to assess and mitigate 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. At this inspection, we found that not enough improvement had been made. Some improvements that had been made were not yet embedded and sustained in practice. The provider has been in breach of Regulation 12 at the last three consecutive inspections.

● Medicines management was not always safe. Three people were prescribed medicines to manage their blood pressure but had not always had these administered according to the prescribing guidance. Before the inspection, the provider had informed us that staff had incorrectly entered information onto the electronic medication system for one person. The person had recently been in hospital and had a heart condition and a history of having a transient ischemic attack (TIA). A TIA is a brief episode of neurological dysfunction caused by loss of blood flow to the brain, spinal cord or retina, without tissue death. TIAs have the same underlying mechanism as ischemic strokes. Staff had been giving the person half-doses of their blood pressure medicine for four months. When this was identified by staff, medical assistance was sought. The person's blood pressure was recorded as high and staff were advised to reinstate the person's medicines to the correct prescribed dose. At the inspection, records also showed that the person had not been administered this blood pressure medicine for ten days, as well as another blood pressure medicine for two days. Another person's blood pressure medicines had not been administered for a period of up to 12 days. Prescribing guidance advised that both people's medicines should not by stopped without consulting a doctor. There was a risk that people's health condition was not well-managed due to their medicines not being administered according to the prescriber's instructions. This placed them at risk of harm.
● One person was living with dementia and may not have been able to clearly communicate that they were experiencing pain. They were prescribed pain relief four times a day. Staff had not administered their first dose of medicine until seven and a half hours after the prescribed time as the person had been asleep. Staff had not ensured that further doses of the medicine was given within the prescribed timescale and this meant there was not enough time left in the day for the person to receive all their prescribed doses of medicine. This increased the risk that the person may have been experiencing pain and their pain was not well-managed.
● One person was prescribed medicines for their mental health. Records showed that they had not been administered their medicines on five occasions. This had not been identified by the provider and when this

was raised with them they were unable to explain why the person had not been given their medicines. This increased the risk that the person's mental health condition was not well-controlled.

● Some people were prescribed medicines that needed to be taken before eating. This either improved the effectiveness of the medicine or helped minimise potential side effects of others. Three people had consistently not been supported to have their medicines according to this prescribing guidance. One of these people was receiving treatment for a gastric condition. There was a risk that staff's failure to administer their medicines as prescribed might exacerbate the person's health condition. The provider had failed to identify that people were not being administered their medicines according to the prescribing guidance.

● Two people were living with epilepsy. One person had not always been supported in a safe way. Records advised staff to contact the emergency services if the person experienced seizures that lasted longer than five minutes or if they were to experience two seizures within one hour. Staff demonstrated a mixed understanding about this and records showed that the person had experienced two seizures, each lasting ten minutes. Despite this, staff had not contacted the emergency services to ensure the person received appropriate medical treatment.

● Before the inspection, the provider had notified us of four separate occasions when two people had left the home without staff support. Both people were living with dementia and required staff to support them if they left the home, to ensure their safety. Safety checks on one person's window found that the restrictor was faulty. We were told this had been removed whilst waiting for a new part. During this time the person had climbed through their bedroom window, injuring themselves and had been found in the nearby area. Another person had left the home on one occasion and had again been found in the nearby area. Despite this, the provider had not taken measures to further reduce the risk to the person. The person left the home twice more during a different day and was again found by staff in the nearby area. It had not been recognised that both people had left the home until staff had seen the people in the home's car park and nearby road. Failure to ensure both people's safety and whereabouts and reduce known risks, exposed them to the risk of harm.

● Two people were not supported to move and position in a safe manner. Two people used wheelchairs to mobilise. Both people were observed to be using wheelchairs without footplates. An agency member of staff supported one person in their wheelchair. As there were no foot plates on the wheelchair the person's feet were, at times, touching the ground. There was a risk that this could have caused an injury to the person's feet or ankles.

● There are a number of safeguarding enquiries being conducted by the local authority. Themes have been identified which include staffing levels and competency as well as unsafe medicines management. The provider had worked with the local authority but had not always used the outcomes of the safeguarding enquiries as opportunities to learn and make improvements. There are still concerns about staffing levels, staff's competence and medicines management. The provider had failed to improve outcomes for people.

● There have been re-occurring themes throughout the provider's other services within the Sussex area. These relate to unsafe medicines management and compliance with the Mental Capacity Act 2005. The provider had not learned from other inspections or taken sufficient action to ensure that improvements were made.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's ability to administer their own medicines was assessed. When people lacked understanding, staff had followed safe processes and liaised with external healthcare professionals to ensure people had their prescribed medicines.

● People's medicines were reviewed by GPs. This helped ensure that for people living with dementia, their behaviour was not inappropriately managed by medicines.
● Staff shared information about potential risks with external healthcare professionals when safeguarding enquiries were being conducted.
● Equipment was regularly checked to ensure it was safe to use. Plans ensured that people could safely evacuate the building in the event of an emergency.
● Following the inspection, due to the concerns found by CQC, the provider made further safeguarding referrals to the local authority for them to consider under their safeguarding guidance.
● When they had identified concerns about people's safety, the provider had worked with external health and social care professionals.
● People told us that they would speak to staff if they had concerns. Regular meetings enabled people to share feedback about their care.
● The provider had improved their practice and oversight in relation to other reoccurring themes across some of the provider's other services. For example, staff practice had improved and there was safer management of medicines for people who were living with Parkinson's disease. People who required a modified diet were now being supported to eat foods that were safe and appropriate for their needs.

Staffing and recruitment

At our last inspection, the provider had failed to ensure there were sufficient and suitably trained staff to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider sent us an action plan to inform us of what they would do and by when to ensure that improvements were made. At this inspection we found that not enough improvement had been made and the provider had not complied with their action plan. There is a continued breach of Regulation 18.

● Staffing levels, their skills mix, and the deployment of staff had not been appropriately considered alongside people's needs or the layout of the home. Since the last inspection, the occupancy of the home had decreased, and the provider had lowered the number of staff in response to this. The provider had not considered people's dependency levels or assessed needs when doing this. Staff rotas showed that staffing levels had, at times, been below the amount set by the provider. The provider's policy requires team leaders, who have received training in medicines administration, to administer medicines to people. On three occasions there had only been one team leader working during the night, with overall responsibility for medicines as well as staff who were caring for people over two floors. One person was prescribed a controlled drug (CD) that could be offered to the person if they displayed signs of anxiety or distress. The provider's policy stated that two members of staff, who had undertaken medicines training, should administer CDs to ensure these were managed safely. The National Institute for Health and Social Care Excellence (NICE) also states that the care home staff responsible for administering any controlled drug as well as a trained witness should sign the controlled drugs register. There was a risk that should the person have required their medicines, that staffing levels would not enable them to administer the medicines in accordance with the provider's policy or in accordance with NICE guidelines. When this was raised with the provider they explained that the on-call manager could visit the home so that the medicine could be administered. Although this would ensure they complied with their policy and NICE guidance, there would be a delay in the person receiving their medicine as they would need to wait for the manager to be present within the home before this could be administered.
● People did not always have access to a sufficient number of staff to meet their needs. The home has nine

units for up to ten people, which are spread over two floors. Staffing levels meant that some units were staffed by one support worker. One person was assessed as needing to be supported with their mobility needs by two members of staff. There was a risk that this person's needs would not be met in a timely manner as staff would need to request assistance from another member of staff working on a different unit, therefore leaving that unit unstaffed.

● One person was observed asking a member of staff for assistance to access the toilet facilities. A member of staff told the person they would have to wait for five minutes, as they were not allowed to leave the communal area unattended. After ten minutes, the person called for help again and was told that they would have to wait as the member of staff was the only member of staff on the unit. The person continued to call out and was then supported to access the toilet by the member of staff, 36 minutes after they had first asked. This left the unit without staff support within the communal areas, where other people were present, whilst the member of staff supported the person with their personal hygiene needs.

● Another person was heard telling a member of staff that they had been waiting to go the toilet. The person said, "I don't know where you all get to, I've been waiting, I'll be soaked through".

● Another person was overheard asking a member of staff if they could go outside. The member of staff explained that there was not enough staff available to accompany the person into the garden at that time. The person then spent their time alone and not engaged in any meaningful pastime.

● Most people and relatives told us they thought the home did not have sufficient staff. They told us that staff did meet their needs but that they were busy and task-focused. One person told us, "Staff are good but stretched all the time". People and relatives had provided feedback within an annual survey and had commented about staffing levels. Comments included, 'Employ more staff' and 'The staff do a wonderful job but need more help'.

The provider had not ensured that there were sufficient staff to meet people's needs. This increased the risk of people's needs not being met in a timely way and placed people at risk of harm. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff that were suitable to work within the health and social care sector. The provider had ensured that pre-employment checks were undertaken to ensure people's safety.

● New staff were allocated to work alongside more experienced staff to enable them to learn about people's needs.

Preventing and controlling infection

● People were protected from the spread of infection. The environment was clean, and people told us they were happy with the cleanliness of the home.

● The provider assured themselves that infection prevention and control was maintained by conducting audits and acting when needed.

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.

We did not inspect this key question at the focused inspection on 11 and 12 April 2019. At the last comprehensive inspection on 17 July 2018, this key question was rated as Requires Improvement. At this inspection this key question remained the same. 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

At the last inspection, the provider had failed to ensure there were suitably trained staff to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider sent us an action plan to inform us of what they would do and by when to ensure that improvements were made. At this inspection we found that not enough improvement had been made and the provider had not complied with their action plan. There is a continued breach of Regulation 18.

● Staff's skills and competencies had not been appropriately considered. Following the last comprehensive inspection, when concerns about the skills of agency staff were raised, the provider had introduced a competency check to help assure themselves that agency staff had the appropriate skills to support people with moving and positioning in a safe way. However, due to the turnover of management staff, the provider told us it had not been recognised that this had not been implemented in practice. We noted an example where on one night there were seven support workers, five of whom were agency staff. When the provider was asked how they were assured of staff's competence, they explained that a central fulfilment team ensured that agency staff held appropriate qualifications. The management team at the service were not aware of these details to assure themselves of staff's training, neither had they assessed staff's competence before they started to support people.
● People were not always supported to have their medicines administered by staff that had received training or who had been assessed as competent. On one afternoon and four nights during August 2019, the team leaders working were agency staff. The provider had not ensured that they were competent to use and administer medicines from the provider's electronic medication system. Records showed that three people had not had their pain medicines administered when agency staff were working during this period. Not ensuring staff's competence was of particular relevance due to the amount of medicines errors that had occurred and placed people at increased risk of harm.
● People who were living with dementia did not always receive support from staff who had undertaken training on how to support people appropriately. Four units in the home were for people living with dementia. Despite this, no agency staff and over 50 per cent of permanent employed staff, had not been trained to understand how to support people who lived with dementia appropriately. Observations of some

staff's practice raised concerns about their skills and understanding, and people were at times, not always supported in a respectful and dignified manner. We observed one member of staff not supporting a person who was living with dementia, in a dignified way. The member of staff had not undertaken learning about how to support a person living with dementia, a training course identified as essential by the provider.

● The provider had recruited new staff since the last inspection. Staff had not always been provided with the appropriate training to ensure they had the relevant skills to support people appropriately. Neither had they completed their induction training within the timescale stated in the provider's policy or before they were allocated to work. Staffing rotas showed that these members of staff had worked and supported people without an induction or suitable training. This was not in accordance with the provider's policy.

● Most staff had been provided with training which the provider considered essential for their roles. Issues found at this inspection raised concerns about the quality of the training or the sharing of learning from the provider's other homes to improve staff's skills. Although staff that were employed had undertaken medicines training, most competency checks had not been completed and some continuing medicine errors raised continued concerns about staff's understanding and competence and placed people at increased risk of harm.

● People and relatives told us they had concerns over the suitability, experience and skills of some agency staff. They felt that some agency staff lacked the appropriate skills to meet people's needs. One person told us, "The regular staff are skilled at what they do, it's not the same of agency staff. Agency staff don't know the home, or the residents and I would always like to have the regular staff transfer and move me". Another person told us, "Agency staff are certainly not trained as well as the regular ones and an example was an agency one did not put my night bag on correctly". Comments from people had also been shared with the provider as part of their annual survey. One person had commented, 'Not to have agency as carers, they never know what they have to do'. It was not evident how the provider had used this feedback to improve people's experiences.

The provider had not ensured that there were sufficient, suitably qualified, competent, skilled and experienced staff. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were told that due to the changes within the management team and the need to prioritise improvements that needed to be made, staff had not always received regular supervision to enable them to reflect on their practice and identify areas for learning and development. The management team were now working with staff to ensure these were completed in a timely way.

● Staff told us it had been a difficult time due to the amount and turnover of managers. They felt that although the managers had good ideas about how to make improvements, because they did not stay, staff were left confused as to what they were required to do. Staff told us that although it had been a period of change, they felt supported by certain members of the management team.

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 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.
● People with a condition that had the potential to affect their decision-making abilities, had not always had their capacity assessed before others made decisions on their behalf. One person was living with dementia. Their relative had been asked to sign a consent form for the person to have an influenza injection. Staff had not assessed the person's capacity to consent to this themselves, neither had they assured themselves that the relative giving consent on the person's behalf had the legal authority to do so. This has been a reoccurring theme at some of the provider's other services. The provider had not identified that the shared learning had not been implemented in practice.
● Some people who had a health condition that had the potential to affect their decision-making, had their capacity assessed in relation to specific decisions. Most assessments were not decision-specific and mental capacity assessments had been photocopied and used for all decisions related to the person's care. This was not in accordance with the requirements of the MCA which states that staff should not assume that people lack capacity and that when mental capacity assessments are completed they should be decision-specific.
● Some people had Lasting Powers of Attorneys (LPA) that enabled others to make decisions on their behalf. The provider had not always assured themselves that people had appropriate legal authority by obtaining copies of documents before liaising and sharing information or enabling these people to make decisions on people's behalves. For example, relatives were signing consent forms in relation to people's care and treatment, when they did not have the legal authority to do so.
● One person was living with dementia and required constant support and supervision from staff. The provider had not assessed the person's capacity to consent to this when their condition deteriorated and had not made a DoLS application to ensure that the restrictions placed on the person were lawful.

The provider had not ensured that care and treatment was provided to people with the consent of the relevant person. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were effective systems in place to ensure DoLS that had been authorised were monitored and managed appropriately.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Some people's physical, social and emotional needs had not always been sufficiently assessed or met. It had been identified before one person moved into the home, that they had mental health needs. The person had, at times, expressed that they wanted to harm themselves. Despite this, the provider had not identified or further assessed this risk to ensure that the person was supported appropriately and in accordance with best practice guidance or that staff knew how to support the person if they displayed this behaviour.
● Staff were not always provided with accessible information about people's assessed needs. People's care records were large and comprehensive and did not always provide information that enabled staff to provide person-centred care. An agency member of staff was asked about one person's basic care needs and their care plan. They were not aware of the person's assessed needs or where the records that could inform their practice might be accessed. The provider had identified this and was in the process of implementing a new care planning system. This was of particular relevance due to the use of agency and new staff who did not know people's needs. The provider had not prioritised people's needs when undertaking this task and were working through people's care plans when they were due to be reviewed. This meant that some people's needs were not always assessed in a timely manner.

The management team were aware of the shortfalls and were in the process of working with external health

and social care professionals to ensure that people's care needs were reassessed and reviewed as part of the change over to the new system.

● At the last inspection there were concerns about people's nutrition and hydration. At this inspection, improvements in the monitoring of people's hydration and nutrition had been made. The management team had recently introduced a monitoring tool for people's weights. When people required their weight to be monitored more closely, due to their weight-loss and risk of malnutrition, the management team had a better oversight of this so that they could identify risk and take appropriate action. One person had lost weight, this had been identified and the person's GP contacted who had prescribed supplements for the person. Additionally, staff were also fortifying the person's food to ensure their calorie intake increased.
● Staff were provided with guidance about people's nutrition and hydration. Staff had a good knowledge of people's assessed needs and people were receiving appropriate support to maintain their nutrition and hydration. Records which documented this were being monitored to ensure people received sufficient hydration and nutrition.
● People's physical needs had been assessed and people were provided with equipment to enable them to be treated equally with others. For example, when people had physical disabilities they had access to hoists or mobilising wheelchairs to support them to move and position.
● Technology was used so that people were able to call for staff's assistance by using call bells.

Supporting people to eat and drink enough to maintain a balanced diet; Adapting service, design, decoration to meet people's needs
● People had a mixed dining experience. Some staff did not interact with people and were task-focused.
● The environment did not help people to navigate their surroundings and people did not always have access to objects that were meaningful or provided stimulation or orientation. For example, four units of the home were for people who were living with dementia. There were minimal prompts to aid people's orientation in line with best practice guidance when supporting people who are living with dementia. People's bedroom doors were plain and communal hallways were bare and contained minimal signage. A board, to help people understand the days of the week, the weather and season was blank and had not been completed. White boards, that staff used to write menu options, were not always complete and those that were did not provide information in a way that would support a person living with dementia to understand.

We recommend the provider considers current guidance on providing stimulating, meaningful and appropriate environments for people who are living with dementia.

● People told us they were happy with the food that was provided. They told us they had choice and that staff accommodated their preferences and beliefs. One person told us, "The meals are okay but if I don't fancy something, they will do something else for me".
● People had adequate space to move around the home. People were observed mobilising independently with their mobility aids. One person told us, "The home is well designed and suits my needs".
● People had private rooms if they wished to spend time alone or receive visitors in privacy.
● Regular meetings enabled people to be involved in on-going discussions about the home.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff contacted external professionals if people were unwell.
● People and relatives provided mixed feedback about the timeliness of receiving support from external healthcare professionals. Two relatives felt that their loved ones had waited too long to receive support.

Most people told us staff would contact healthcare professionals promptly if their health changed. One person told us, "The Home will call out the doctor without question". Another person told us, "The doctor visits and will be called out if needed".

● People received a consistent service as staff liaised and worked alongside external healthcare professionals to coordinate people's care.

Requires Improvement

# Is the service caring?

## Our findings

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

We did not inspect this key question at the focused inspection on 11 and 12 April 2019. At the last comprehensive inspection on 17 July 2018, this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People who were living with dementia were not always treated with dignity or respect. One person, who was not displaying signs of anxiety or distress, asked a member of staff if they could assist them to use the toilet facilities. The member of staff did not respond to the person's needs in a timely way. This caused the person to have to wait and they had to ask for assistance several times. When the member of staff did support the person, they spoke to them abruptly. Once the person was seated in their armchair and the member of staff had walked away, the person began to cry. This interaction was undignified and did not take into consideration the impact having to ask for support might have on the person's self-esteem or dignity.
- One person was sitting at the dining room table and had finished their breakfast. A member of staff took off the person's apron and wiped their face. They did not interact with the person or explain their actions. This did not demonstrate dignified or respectful care.
- A member of staff was sitting in the dining area and was observed calling across the room to another member of staff. They were overheard saying, "I'll 'do' her", "I've only 'done' X", "As long as you're not going to say I'm a lazy cow", "Pads are in their wardrobe". The member of staff then called across the room to one person, and were heard saying, "X, I need to weigh you in a minute". The person was then later observed being weighed in a weighing chair in the middle of the dining room in front of other people. These interactions did not demonstrate respect and the person was not provided with dignified or respectful care.

People were not always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When these interactions were fed back to the management team they took immediate action to respond to the concerns raised.

- Most staff treated people in a kind and caring way. One member of staff was observed interacting with one person who was living with dementia. The person was holding a teddy bear and the member of staff took time to ask the person about the bear. The person was observed smiling and engaging in conversation. Another person had lost their wedding ring. Several members of staff took time to listen to the person and assist them to look for their ring, which was of sentimental value to the person.
- People were complimentary about the caring attitude that permanent staff demonstrated. One person

told us, "Staff are always there for me to go to if I'm in trouble. If I've been upset, someone has always come and sat with me". Another person told us, "The staff are very caring, and I would go to my care worker and then to the team leader if I had a problem and it usually gets sorted out. Staff take one's views into consideration and they do an absolutely wonderful job".

● People who were more independent and able to share their views, felt that staff treated them with dignity and maintained their privacy. One person told us, "Staff most definitely give me respect and dignity like if staff are called away when attending to me, they leave me covered up".

● People's independence was respected and encouraged. Some people accessed the local shops independently with the use of their mobility aids. People told us that staff encouraged their independence so they could continue to do as much as they could for themselves.

● People's religious and cultural needs were established when they first moved into the home and people were able to continue to practise their faith if they so wished.

● People's confidentiality was maintained. Handover meetings, where staff discussed people's care needs, were conducted in offices so that people's privacy was maintained.

● Information held about people was securely stored in locked cabinets and offices.

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

● People and their relatives had not always been involved in discussions about their care. Reviews of people's care were conducted by staff using their knowledge of the person's health condition. It was not evident how all people had contributed to on-going discussions or decisions about their care. The provider had introduced a new system to better evidence people's involvement. One person told us, "I do feel involved in decisions about my care and I put my views forward which are taken into account".

● There was mixed feedback from relatives about their involvement in people's care. One relative told us that they did not know who to ask if they had any queries about their loved one's care. They felt that the changes in management had led to a break-down in communication. Others were more positive about their experience. A relative told us, "Staff are open with us when we are here and are completely honest, good or bad. Any problem, they ring".

● Regular meetings helped ensure people were involved in discussions about the running of the home. They were able to share ideas and make suggestions.

Requires Improvement

# Is the service responsive?

## Our findings

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

We did not inspect this key question at the focused inspection on 11 and 12 April 2019. At the last comprehensive inspection on 17 July 2018, this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- People did not always receive person-centred care to reflect their assessed needs or preferences. One person's needs had been assessed before they moved into the home. They had informed staff they only wanted to be supported with their personal care needs by female members of staff. Records to document the person's care showed that they had been supported with their personal hygiene by male members of staff. The person told us they did not like this and this had started to happen more frequently. This was brought to the attention of the manager who spoke to the person and provided assurances that they would be supported according to their preferences.
- One person, who was living with dementia, had slept through the times when breakfast was being served. Staff had demonstrated good practice and respected their wishes and enabled the person to sleep. Once the person was awake, staff supported them to have a later breakfast. The person was sitting at the dining table finishing their breakfast. When they had finished, staff cleared and re-laid the table for lunch whilst the person was still sitting there. Without asking the person's preferences, staff provided their lunch 50 minutes after finishing their breakfast. Although the person ate their lunch, staff had not considered that the person might not have the understanding to remember that they had only just eaten their breakfast. Staff had not always adapted the care to meet the person's needs and had not asked the person if they wanted to eat their lunch later. This demonstrated a service-led approach to this person's care.
- People's social and emotional needs had not always been considered, assessed and met. Not all people had equal access to opportunities that were offered, and most people spent extended periods of time unoccupied. Staff had not always gathered information about people's life histories to provide a sense of who the person was and what they had enjoyed before moving into the home. Other people had information about their life, it was not evident how this had been used to provide meaningful and stimulating opportunities for people. A comment received from a relative in response to the provider's recent feedback survey stated, 'When activities staff go out with residents, the residents left in the building don't do anything.'
- People who spent time in their rooms, as well as those who were living with dementia and were therefore more reliant on staff to meet their needs, were at risk of social isolation. We observed that there were sometimes missed opportunities for staff to interact and engage with people. When a member of staff was asked about spending time with people, they told us that they tried to go and see people in their rooms each day and would talk to them when delivering care. There were no arrangements for people who spent time in their rooms, to have regular, stimulating contact with staff, other than when they provided support with their personal care or with meals. This meant there was a risk that people's social needs were not always met.

● One person used English as their second language. Staff told us the person did not speak or understand most of the English language and they had to rely on facial expressions and hand gestures to communicate with the person. An interpreter had spoken to the person and informed staff that they would like to access and read books in their own language. Although staff had recorded this information in the person's care plan, it was not evident what action had been taken to implement this. When asked, staff were not aware of this and did not know what was being done to meet the person's social needs.
● Reviews of people's care had not always been completed according to the provider's policy. The management team had been through a period of change and the updating and reviewing of care plans had not always been fully maintained during this time. Reviews that had been completed did not always identify changes in people's needs. For example, staff had not reviewed people's access to medicines when they reviewed their care plans and therefore had not identified that people, had at times, not been administered their prescribed medicines.

The provider had not always ensured that the care and treatment provided to people was appropriate, met their assessed needs or reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people enjoyed participating in the planned group activities. They were seen to be engaged in Bingo or petting horses that visited the home. People were seen smiling, laughing, and asking questions.
● People were able to maintain contact with their family and friends who were welcomed into the home.

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 were living with dementia. Information was not always provided in a way that supported them to understand and make choices. People were asked to choose their meals for the following day. Some people were able to make this choice and staff respected their right to change their mind on the day if they preferred an alternative option. This approach did not accommodate people who were living with dementia who might find it hard to remember what they had chosen the previous day. The Social Care Institute for Excellence states, 'As dementia progresses a person might have difficulty choosing and deciding on the food they want to eat. Calling out a list of options can be confusing and difficult for the person as they may not recognise what the food is from hearing the words alone'. The provider had not considered other types of communication that might enable people to understand the different food options available to them. We saw that people were sometimes confused as to what was being offered and what they had chosen to eat.
● Information had not been adapted to meet the needs of people living with dementia. Complaints procedures as well as an annual survey that was sent to people, had not been adapted to provide a more user-friendly way of enabling people to share their views.

We recommend the provider considers current guidance on providing accessible information for people who are living with dementia.

Improving care quality in response to complaints or concerns
● Complaints that had been raised to the provider had not always been responded to according to the provider's policy. Some complaints had not been responded to in a timely way. When the management team were asked about this they explained that this was due to the changes in the management team. Once

it had been identified that complaints had not been dealt with, appropriate action had been taken to address people's concerns.

● The provider had a complaints policy and people were made aware of how to raise a complaint within the information provided to them when they first moved into the home.

● People and their relatives told us they felt comfortable to raise any concerns.

End of life care and support

● People were able to plan for care at the end of their lives and dependent on their needs, were able to remain at the home until the end of their lives.

● Staff had worked with external healthcare professionals to ensure people had appropriate medicines so that their comfort was maintained.

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. At this inspection, although some improvements have been made in relation to medicines management for people who were living with Parkinson's disease and people who required a modified diet having access to appropriate food, this key question remained the same. This meant there were wide-spread and significant shortfalls in service leadership. Leaders and the culture they created did not always ensure 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 and CQC, due to ongoing concerns about their failure to address and improve reoccurring themes. Since the last inspection, the provider had acted to help improve the service people received. They had worked with external health and social care professionals and had employed dedicated quality improvement managers. These professionals had worked with the service to make changes and help ensure improvements to the wide-spread concerns found as part of the last inspection, were made. Despite this, we found that not enough improvement had been made and people were, at times, still receiving care that was not always safe. The provider had failed to continually improve and had yet to embed and sustain improvements that had been made. The home was rated as Requires Improvement on three consecutive inspections. The provider has been in breach of Regulation 17 at the last four consecutive inspections. They have now been rated as Inadequate and were entered into special measures at the last two consecutive inspections.
- Since the last inspection, there has been a turnover of managers. At the last inspection, the registered manager had left, and the home was being managed by the regional operations manager. An interim manager was recruited but has since left. A quality improvement manager then managed the home with the support of a deputy manager for a period of time. A registered manager and a deputy manager from two of the provider's other homes had been managing the home for three weeks prior to the inspection. After the inspection the registered manager moved back to their own service. The deputy manager then took on the role of manager with the support of a quality improvement manager two days per week. They planned to continue in their roles until a new manager was recruited. At the inspection, the management team consisted of the manager, a deputy manager and two unit-managers.
- The provider told us that due to the turnover within the management team, audits, that enabled the manager and provider to assess the quality of care people received and to ensure that systems and processes were effective, had not always been completed. At the last inspection, we took enforcement action against the provider. We imposed conditions on their registration and they were required to send us an analysis of their audits in relation to risk. This was to enable us to have oversight of the service people were receiving and the action that the provider was taking. As some audits were not being conducted by the management team it was not evident that all risks had been identified and were therefore made known to

us as part of the provider's conditions of registration. This was fed back to the provider who is taking action to ensure all required information is provided.

● Shortfalls found at this inspection had not always been identified by the management team or provider. For example, it had not been recognised that medicines management was unsafe and that people were not always receiving their prescribed medicines according to the prescriber's instructions. Neither had it been identified that people's assessed needs or risks relating to their care had not been adequately assessed and lessened.

● The provider had not learned from some concerns that had been raised at previous inspections at some of their other homes within the Sussex area. There have been reoccurring themes in relation to MCA and DoLS over the past two years in ten out of twelve of the provider's services within the Sussex area.

● There has been a number of safeguarding enquiries being conducted by the local authority. Themes have been identified which have included unsafe medicines management, falls management and staffing levels and competence. It is not evident how the provider has learnt from safeguarding outcomes as risks to people in relation to medicines management and staffing levels and competence are still ongoing.

● Following the last inspection, the provider sent us an action plan to inform us of what they would do and by when to make improvements to the staffing levels and competencies of staff. At this inspection, we found that the provider had not complied with this. There was a lack of oversight and the provider had lowered the staffing levels due to a decrease in occupancy within the home but had not always considered people's needs or aligned these with staffing levels. Audits that had been completed were not always accurate or fully analysed to help inform the provider of people's needs or the types of risks that people were exposed to. For example, after the last inspection the provider had introduced a falls tracker. We found this was not always completed accurately as not all falls had been identified and recorded. When falls had been recorded, the provider had not used the data that had been collected to analyse for all trends and themes. The falls tracker that had been completed in July showed that there were a number of falls occurring over the weekend. The provider had not fully taken this into consideration before lowering the staffing levels in August or when allocating staff. At the last inspection there had been a number of incidents in relation to unsafe moving and positioning and medicines errors involving agency staff. The provider had not used this learning to minimise risk. Staffing rotas throughout August showed that overnight and at weekends there was still a high use of agency staff. Additionally, the provider had not assured themselves of staff's abilities or skills before allocating work to them. Agency staff were working who had not received medication training or competency checks for medicines and moving and positioning.

● The provider had recruited new staff since the last inspection. There was a lack of oversight and they had not identified that staff had not completed their inductions or been provided with the appropriate training to ensure they had the relevant skills to support people in accordance with their needs. The provider had not worked in accordance with their policy or procedures.

● Improvements that had been made were yet to be fully sustained or embedded in practice. Due to the turnover of management staff, some systems had not been introduced until August 2019. For example, we were told that the system to monitor and have oversight of weight-loss had not been implemented until one of the managers had returned from leave. Before this, the provider did not have a system in place to ensure people were receiving appropriate care and treatment when they were at risk of malnutrition and weight-loss.

● The provider's progress to address some of their planned improvements, was slow. It had been identified that due to large, comprehensive care plans, both employed and agency staff found it difficult to access and find information and know how to provide care to meet people's assessed needs. Following the last inspection, the provider had introduced a new, more succinct care planning system. At this inspection the provider had to date completed 4 per cent of people's care plans. We found that staff continued to experience difficulties accessing information about people's needs. This increased the risk of people not receiving appropriate care to meet their assessed needs.

● Records, to document the care people had received were not always completed in their entirety or well-maintained. Some records contained inaccurate or conflicting guidance for staff. For example, guidance for one person provided conflicting information about the frequency in which they should be supported to reposition. Staff had not always ensured that they accurately recorded their actions and it was not evident if people had received appropriate care or if staff had failed to correctly document their actions. Records, to document the administration of topical creams or the support provided to people to reposition, were not always maintained.
● The concerns found as part of this inspection did not demonstrate that the provider's values of wellness, happiness and kindness were always demonstrated in practice.

The provider had not always assessed, monitored or improved the quality and safety of the service provided. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There have been on-going themes amongst the provider's other services within the Sussex area in relation to unsafe medicines management for people who are living with Parkinson's disease and people who require modified diets being given high-risk foods. The provider had acted to ensure lessons were learned and had implemented specific training to increase staff's awareness. Systems and processes had been introduced to minimise potential risks and were in the process of being embedded in practice.
● New audit processes had been introduced as it had been recognised that those previously used had not always identified concerns that were being found at inspections of the provider's other services. These were yet to be implemented.
● Despite the concerns found at the inspection, people and relatives' feedback was positive. One person told us, "I think things are getting better and they are trying and trying hard. Overall, the delivery of this service is very good, only minor issue is not having a manager to go to if necessary".
● Staff acknowledged that it had been a difficult time due to the turnover of managers, yet were complimentary about the support they had received from a member of the management team. They told us one of the managers made them feel "Supported" and "I can approach them and they provide advice and guidance".
● The provider was aware of their regulatory responsibilities and had notified us of incidents that had occurred to enable us to have oversight to ensure appropriate actions were taken.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives had been asked for their feedback and had completed surveys which the provider analysed in a bid to help provide assurance that people's preferences were being met. It was not always evident that people or relatives' feedback had been listened to or acted upon.
● The provider had worked in partnership with external health and social care professionals to help identify areas for improvement and implement changes.
● Staff were involved in discussions about the home. Staff meetings enabled staff to raise suggestions and ideas to the management team. They told us that they felt supported.

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 manager and provider had worked hard to change and improve. They now demonstrated a candid, open and transparent approach.
● People and their relatives told us that the management team and staff were open and honest with them. Records showed that they were kept informed of any changes in people's needs or if care had not gone

according to plan.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Regulation 9 (1) (a) (b) (c) (3) (a) (b) (d) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.<br><br>The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.<br><br>The registered person had not ensured that service users were treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Regulation 11(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.<br><br>The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the |

consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

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<br><br>Regulation 12 (1) (2) (a) (b) (c) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment.<br><br>The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users. |

**The enforcement action we took:**

We have served the provider with a Warning Notice for the breach of Regulation 12. They are required to become compliant with this by 31 October 2019.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 (1) (2) (a) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.<br><br>The registered person had not ensured that systems and processes were established and operated effectively to:<br><br>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).<br><br>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 served the provider with a Warning Notice for the breach of Regulation 17. They are required to become compliant with this by 31 December 2019.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.<br><br>The registered person had not ensured that there were:<br><br>Sufficient numbers of suitably qualified, competent, skilled and experienced people<br><br>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 served the provider with a Warning Notice for the breach of Regulation 18. They are required to become compliant by 31 October 2019.