Reed Care Homes Limited

# Nayland Lodge

## Inspection report

44 - 46 Nayland Road
Mile End
Colchester
Essex
CO4 5EN

Tel: 01206853070

Date of inspection visit:
14 December 2023

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11 March 2024

## Ratings

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

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Nayland Lodge is a residential care home for up to 8 people. The service provides care and support to people with a learning disability and/or mental health needs. At the time of our inspection there were 6 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People we spoke with were satisfied with the service.

The service was not well led. The provider did not have adequate oversight of the service and lacked a recognition and understanding of risks to people using the service. Not enough improvement had been made and breaches of regulation continued. Governance systems were not robust or used effectively and were failing to consistently assess, check and improve quality and safety of the service, and care delivered.

Right Support:
People did not receive the right support to maximise their choice and independence. There were not enough staff to meet people's assessed needs and commissioned support arrangements. This meant people did not lead fulfilling and meaningful everyday lives that promoted their wellbeing. Limited information was available about people's aspirations and goals and how staff could support them to achieve these. People did not receive an interactive and stimulating service that ensured they led inclusive and empowered lives.

Right Care: Care delivered to people was not consistently person-centred and tailored to their needs. People were at risk of avoidable harm because risks were not recognised and mitigated, staff were not sufficiently trained to support people when they were distressed and there was poor management of incidents.

Right Culture:
Whilst people said they liked living at Nayland Lodge and staff were caring, the ethos and values of the service did not ensure people led confident, inclusive, and empowered lives. People were not given

opportunities to explore and develop their interests and achieve their goals.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 22 June 2023). The provider completed an action plan after the inspection to show what they would do and by when to improve.

We carried out a targeted inspection on 6 July 2023 (published 12 October 2023) to check improvements made in response to warning notices issued to the provider. Although the provider was given added time we found they had not made enough improvement and remained in breach of regulation 12 (safe care and treatment) and 17 (Good governance), and the rating was unchanged.

Why we inspected
We undertook this focused inspection to confirm the provider now met legal requirements. This report only covers our findings in relation to the key questions of safe and well led which have those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service is still inadequate.

We found no evidence during this inspection that people had come to any harm. Please see the safe and well led sections of this full report.

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

Enforcement
We found continued breaches in relation to management, governance and oversight, risk management, staffing and staff training at this inspection.

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

Follow up
We will 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 check progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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|---|---|
| **Is the service safe?**<br>The service was not safe<br>Details are in our safe findings below | **Inadequate** |
| **Is the service well-led?**<br>The service was not well led.<br>Details are in our well-led findings below. | **Inadequate** |

# Nayland 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 Health and Social Care Act 2008.

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
Two inspectors carried out this inspection.

Service and service type
Nayland Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Nayland Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 14 December 2023 and ended on 18 December 2023. We visited the location's service on 14 December 2023.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service. We looked at records in relation to 2 people's care.
We also spoke with the director of the company, the manager and 1 staff member. We looked at records relating to staffing, recruitment, training and development of staff, management of the service and systems for checking the quality and safety of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.

At our last inspection the provider did not have effective systems to assess, monitor and mitigate risks relating to the health safety and welfare of people using the service. This was a breach of regulation 12(1) 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

- Risks to people's safety were not always assessed or mitigated. This placed people at risk of harm.
- Following an emergency admission to the service, the provider had failed to put in place robust short term risk management strategies to protect the safety of the individual, and others, until they had settled and the risk could be re-assessed.
- Where risk was known, support plans did not specify how staff were to support people consistently to reduce the risk and avoid situations where they were vulnerable or a risk to others. For example, hoarding, self-harming, and violent behaviour.
- The provider did not have a robust system in place to ensure effective oversight and analysis of incidents, accidents, and people's behaviours. The provider was unable to demonstrate robust review of safety incidents to find out what went wrong, and why, and learn lessons from them. This meant there was always a risk of incidents reoccurring.
- There was no policy in place to guide staff on how to manage escalating behaviour. Staff told us and incident records showed police were regularly called to manage aggressive behaviours. The use of the police is not always, and in itself an appropriate method to manage escalating behaviour.
- Fire safety arrangements remained inadequate. A fire risk assessment carried out on 19 November 2023 considered fire safety risks relating to the occupants such as smoking and hoarding, electrical equipment, kitchen, laundry and the potential for a fire to occur. However, this needed to be extended to include a full review of the premises and any existing fire safety measures to check whether they were still adequate or if more had to be done.
- The provider could not provide documentation to demonstrate regular fire drills were happening for day and night staff as no records could be found to demonstrate these were occurring. Regular fire drills increase staff competence in how to respond in a fire emergency.
- The fire evacuation emergency grab bag was secured to the wall by the front door by a combination lock. It took a staff member several minutes to unlock the padlock to remove the bag, potential to take longer in an emergency, and a delay to obtaining important information. We were told it was padlocked to protect personal information and alternative arrangements had not been considered.

● The grab bag did not hold essential equipment such as a first aid kit, high visual vests, foil blankets or torches to help manage a safe evacuation. Fire safety information about people using the service was out of date and included out of date information. This meant staff or emergency services may not have immediate access to information needed to support everyone safely in an evacuation.

The provider had failed to set up and implement effective systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Senior staff had received Fire Marshal training since our last inspection. A fire marshal is a responsible person who is appointed to oversee fire safety, fire prevention and fire evacuation procedure in the service.

Following the inspection, the provider told us they had addressed the emergency grab bag and booked a trained external consultant to carry out a fire safety inspection of the service.

Staffing and recruitment
At our last inspection we found there were insufficient numbers of skilled and competent 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

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 18.

● There were not enough staff with the right skills and competencies to supply the right level of person-centred care and this affected the quality of support people received.
● Staff had not received training that teaches them skills in how to breakaway, disengage and de-escalate situations of aggression and violence. This meant staff did not have the skills to safely manage/deflect distressed behaviours that posed a risk to themselves and others, in a positive way.
● Staffing numbers were not linked to people's individual assessments. Staff told us staffing levels had reduced due to reduced occupancy of people using the service. The provider could not demonstrate people had the level of support they needed, including where they had agreed 1 to 1 support. There was no consideration about how staffing was managed to demonstrate people were supported to promote their wellbeing and live their daily lives.
● Staff told us there was high reliance on agency staff. The provider did not require agency staff to have any experience, training or knowledge of working with people with autism, learning disabilities or long and enduring mental health conditions. The provider did not have any systems in place to assess the competency of agency staff.

Insufficient numbers of skilled and competent staff and the lack of training is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

Our previous inspection found a breach of regulation 19 (Fit and Proper Persons employed) 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 19.

● A director of the company takes people out; we were concerned at our last inspection the provider was

unable to evidence a Disclosure and Barring (DBS) check had been carried out for this purpose. DBS checks supply information including details about convictions and cautions held on the Police National Computer. A DBS check was available at this inspection.
● Recruitment checks had been carried out for staff to ensure they were suitable for the role.

Using medicines safely
● Administration of medicines was generally well managed. Staff had received training in administering medicines safely and their competency was assessed to ensure they understood and were competent to undertake this task safely.
● Improvement was needed to ensure people prescribed 'as and when needed' (PRN) medicines for the short-term relief of severe anxiety had informative plans in place. There were no detailed positive strategies to be used first and name at what point staff should resort to PRN medicine, amount and how often, to ensure they received it appropriately.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, right legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.

At our last inspection the provider lacked effective systems and processes to keep people safe from the risk of abuse. This was a breach of Regulation 13 (Safeguarding people from abuse and improper 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.

● Staff had completed eLearning in safeguarding adults. Staff understood what abuse looked like and knew the process of reporting to the local safeguarding team.
● The service had safeguarding and whistleblowing procedures for staff to follow.

Preventing and controlling infection

Our last inspection identified poor infection prevention and control (IPC) measures and practices; this inspection found improvement.

● The provider had, since our last inspection, employed a full time cleaner. Cleaning schedules including deep cleaning was completed to minimise the spread of infection.
● Staff had completed IPC training.

Visiting in care homes

- People were able to receive visitors to maintain contact with those important to them.

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 our last inspection we rated this key question inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

The provider had failed for the last 5 consecutive inspections to set up and effectively operate systems and processes to assess, monitor and improve the safety and quality of the service provided to people. This placed people at risk of harm. This was a breach of regulation 17(1) 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 rating stays the same inadequate.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care; 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

- There were widespread and significant shortfalls in the way the service is led. The overall quality and safety of the service was not addressed, and breaches continued.
- The service has not had a manager registered with the Care Quality Commission for nearly 6 years. There was a manager in post but their responsibilities were split over another home. The providers organisational structure did not include enough leadership and support roles to oversee, improve quality and achieve consistent management and leadership.
- Despite there being less people being care for the provider had not taken the opportunity to divert resources into making sustained improvement.
- Governance was poor. The provider was not sufficiently assessing the quality and safety of the service. They did not have a robust, workable, and sustainable plan to drive improvement. Their systems for finding, managing, and reviewing risk were either absent or ineffective with continued shortfalls in staffing, staff training and development, risk management and personalised care.
- There was a lack of openness and transparency by the provider; they did not show commitment to the inspection and regulatory process. They were unable to find relevant paperwork and documents upon request and they had not ensured legal requirements were met.
- There were no clear processes in place or a culture to learn lessons and improve practice.
- The provider was unable to show how they identified any trends or themes in incidents across the service, and where improvements were needed in order to minimise risks of similar incidents.
- The complexity of people's needs was not considered, and people were not receiving the care and support the provider was contracted and funded to deliver. This meant people's recovery, well-being and best

independence was not effectively promoted and sustained, and situations were not prevented from reaching crisis point.
● The provider was not robustly checking staffing levels were right, to assure themselves and other agencies they had enough staff, sufficiently supported, with the right skill mix to meet people's assessed needs and keep them safe.
● The provider had failed to ensure staff had the right training and knowledge they needed to support people safely in line with best practice, nor did staff have the information they needed to ensure the care and support they delivered was the right care, consistent and safe.

We found no evidence people had been harmed. However, the continued failure to have effective oversight and robust systems to proactively recognise and act on failings that affect the safety and quality of service provision is a breach of Regulation 17 (Good governance) of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Since our inspection the provider has told us they had sourced a consultant to support them to address governance at the service.

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

Our last inspection found the provider had failed to show how people's needs were being met in line with right care, right culture and right support. This was a breach of Regulation 9 (person centred care) 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 9.

● The provider did not lead by example and lacked a commitment to promote a positive person-centred culture. The service delivered failed to achieve good outcomes for people.
● People's support plans did not include clear strategies to enhance their independence and did not show any future planning or consideration of the longer-term aspirations of each person and how they could be supported to reach them. Goals and interests were not explored or developed.
● Staff were unable to deliver tailored and consistent support because there was not enough guidance in people's plans on how this was to be done.
● The provider did not support staff in their learning and development to enable them to respond to people's needs safely, effectively and in a personalised way.

Working in partnership with others
● The provider did not always work in partnership with others.
● There were no systems in place showing if/how the provider worked with external agencies or engaged in local and national forums or development groups to gather best practice knowledge in relation to mental health and learning disability to support service improvement. This would help to ensure care and support delivered was the right support, following best practice and drive continuous improvements for a quality, safe service.

The provider continued to fail to deliver personalised care and support in line with right care, right culture and right support. This was a breach of Regulation 9 (person centred care) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.