Bexhill Care Centre Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Bexhill Care Centre is located on the main road between Eastbourne and Bexhill. The original building has been extended and consists of two units with their own communal areas, with lifts to enable people to access all parts of the home. There are secure gardens to the front and rear which are accessible to people who use wheelchairs or who require assistance with their mobility.

The home has accommodation for up to 41 people with nursing and personal care needs. There were 25 people living at the home at the time of the inspection. Some people had complex needs and required continual nursing care and support, including end of life care. Others were living with dementia and because of physical frailty or medical conditions needed assistance with person care and moving around the home safely.

This inspection took place on the 17, 19 and 21 July 2017 and was unannounced.

The service had not had a registered manager since November 2016. The provider told us the last manager had recently left the service and they were interviewing prospective managers at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our comprehensive inspection in December 2015 we found the provider was not meeting the regulations with regard to safeguarding people from abuse and improper treatment, safe care and treatment, staffing, personal records and assessing and monitoring of the services provided. We received information of concern about staffing levels and carried a focused inspection in February 2016. We found improvements had not been made and we took enforcement action.

At our last inspection in December 2016 we found improvements had been made and the provider had met the regulations. After that inspection we received new information of concern in relation to the management of the home and staffing, which may impact on people's care and safety. As a result we carried out a comprehensive inspection on 17, 19 and 21 July 2017 and found the provider was not meeting the legal requirements with regard to safeguarding people from abuse, safe care and treatment, staffing, personalised care, personal records and assessing and monitoring the services. There were five repeated breaches of these regulations and one new breach and there were other areas where improvements were needed

The quality assurance and monitoring system had been reviewed and a number of audits had been completed. However, the system had not identified areas of concern that we found during this inspection and appropriate action had not been taken to ensure people's safety.

Safeguarding referrals had not been made to the local authority when staff were aware of concerns about people's safety. Although staff had attended training, they understood about abuse and explained what action they should take if they knew people were at risk of harm.

The management of medicines was not safe. Nurses employed at the home had not accepted responsibility for the ordering, receiving, checking and giving out medicines, which meant people were at risk of not receiving their prescribed medicine.

There were not enough permanent staff working in the home, staff allocation was not based on people's needs and there was a risk that people would not receive the support and care they needed. Staff said they had completed relevant training. Although there were no records to verify this staff demonstrated an understanding of people's needs and how they would meet them. One of the staff said they had had one to one supervision and, however this was not up to date and it was not clear how this would continue with the recent changes in management.

Assessments had been completed to identify areas where people may need specific care and support. However, these were not consistently effective, people were at risk of harm or injury and the service had not provided person centred care. Care plans did not contain sufficient information for nurses and staff to plan care to meet people's needs.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The management and staff had attended training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware of current guidance to ensure people were protected. Staff said DoLS application had been referred to the local authority and they were waiting for a response. However, mental capacity assessments had not been completed for two people living with dementia who had recently moved into the home.

Staff said people had access to health care professionals and there was evidence of the management of people's care between the staff and external professionals. Although one record stated a person had difficulty with swallowing, but this was not supported by records of visits from healthcare professionals. GPs visited the home as required and these were recorded in the care plans,

People said the food was good, choices were offered and staff assisted people with their meals. Any concerns with people's diet were referred to the GP and people were weighed regularly to ensure they had sufficient to eat.

People were encouraged to keep in touch with people who were important to them and relatives and friends said they could visit at any time and were made to feel welcome.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was a reliance on agency staff and there were not enough staff working in the home with the skills and understanding to meet people's needs.

Medicines were not managed safely, which meant people were at risk of not receiving their prescribed medicines.

Emergency equipment was not ready for use and evacuation procedures to assist people to leave the building in an emergency were not clear.

Staff had attended safeguarding training; but had not made referrals to the local authority in line with current guidance.

Records showed regular checks had been completed to ensure the environment was safe. However, staff were not confident these were correct and the checks had to be repeated.

Recruitment procedures were in place to ensure only suitable people were employed at the home.

Is the service effective?

Requires Improvement

The service was not effective.

Staff said they had attended relevant training, but this was difficult evidence. Supervision was not up to date and, there were no systems in place to observe staff practice to ensure they provided support and care people needed and wanted.

Staff said people have access to health and social care professionals when required, although records did not consistently evidence this.

Nutritious and appetising meals were provided; choices were offered and people chose where they wanted to have their meals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff encouraged people to be independent and make decision about the care provided.

Staff treated people with respect and responded promptly when they needed assistance.

People were supported to maintain relationships with relatives and friends, and they were able to visit at any time.

Is the service responsive?

Inadequate

The service was not responsive.

Pre-admission assessment had not been carried out effectively and support was not consistently person centred.

The care planning system was not robust. Care plans did not contain sufficient information and guidance to enable staff to plan and provide appropriate care and support.

A range of activities were provided for people to take part in if they wanted to.

People and visitors were given information about how to raise concerns or to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The quality assurance and monitoring systems were not effective and did not identify areas where improvements were needed.

The provider and manager had not informed CQC about incidents that might affect the provision of appropriate support and care.

People and relatives discussed any changes in need with staff and agreed these before the changes were made.

Staff said they worked well together as a team and were supported by the new management.

Bexhill Care Centre Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 17, 19 and 21 July 2017. It was undertaken by two inspectors. We went out of hours on the first day of the inspection because of concerns raised about the use of agency staff on nights.

Before our inspection we reviewed the information we held about the home. This included safeguarding alerts and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider was not asked to complete a Provider Information Return (PIR) as this inspection was carried out in response to concerns raised. We spoke with the local authority responsible for commissioning support from the home and the safeguarding team.

During the inspection we spoke with 8 people and four visiting relatives. We spoke with 14 members of staff, which included housekeeping staff, chef, care staff, registered nurses, the interim manager and the provider.

Some people who lived in the home were unable to verbally share with us their experience of life at the home, because they were living with dementia. We spent time with people in their own rooms and in the lounge and, 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 observed care and support in the communal areas, meals, medicines being given out and activities. We looked at a range of documents. These included risk assessments, four care plans, medicine records, recruitment and supervision records, accidents and incidents, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection in 21 December 2015 the provider was not meeting the legal requirements in relation to safeguarding people from abuse and safe care and treatment. These were breaches of Regulations 13 and 12 of Health and Social Care Act (RA) Regulations 2014. At our focused inspection on 5 February 2016 we found continued breaches of these Regulations and we took enforcement action. At our comprehensive inspection in December 2016 we found the provider was meeting the Regulations although there were still areas that needed improvement.

At this inspection we found the provider was again not meeting the legal requirements in relation to safe care and treatment and safeguarding people from abuse. These were repeated breaches of Regulations 12 and 13 and, there were other areas where improvements were needed.

People said they were comfortable and relatives said their family members were safe. One relative told us, "Yes, my mum is definitely safe here. They really know how to look after all of the residents." Another said, "I feel my husband is safe here." Staff said there were times when they were very busy and had to rely on agency staff. One member of staff told us, "We know how much support people need and we can keep them safe" and, "Most residents need two staff and assistance to move around safely, so we have all done the moving and handling training."

There were not enough staff with relevant skills and understanding to provide safe care and treatment. We started this inspection at 6.30am to look at staffing levels, the use of agency staff and how this might impact on the care and support provided. Three of the five care staff working the night shift were agency staff. Two had worked at the home before, one for three nights and one for one night and, they were working together in Poppy Unit. The third agency care staff had not worked at the home before and they were working on their own providing support for people in Lavender Unit. Permanent staff said they asked agency staff to support people who needed minimal assistance; they told them what their support needs were before they started and they checked on what they were doing, but there were no records to support this.

Agency staff were also employed on the day shift, two had not worked at the home before and one had worked for a weekend. Staff were allocated to the units by the clinical lead, but the actual work on each unit was allocated by the senior care staff on duty. We observed the senior talking to the new agency staff, pointing out the exits and discussing the needs of people living in the home. Agency staff who had not worked at the home before were asked to sit in Lavender lounge because, "Staff have to be in the lounges if residents are using them." However, inexperienced agency staff would not have a clear understanding of people's individual needs; they may provide support that was inappropriate or may not know when to do simple things like talk to people. We observed no interaction between agency staff and a person sitting in Lavender lounge. The person looked like they were asleep as they had their eyes closed. We had spoken with them before agency staff came in and they often closed their eyes as their sight was limited. Agency staff had not been told this, they did not know how to support the person and were prompted to sit next to the person and talk to them.

A relative said, "There is too much reliance on agency staff and this is not good for residents with dementia." They said the changes in staffing meant people were unable to get used to staff, with different faces each day and no consistency with regard to how support was provided or if it was appropriate. We found the atmosphere in the home varied depending on how many agency staff were working. We asked staff how they felt about this and one said, "It was really stressful the first day (of the inspection), just too many agency staff who needed to be told what to do and also supported, but much more relaxed by the second day with only one agency." During the inspection an allocation sheet was introduced, to record which staff worked in each unit. Staff said this was so it was clear who was working in each unit and, that agency staff worked with permanent staff rather than on their own. One member of staff said this was, "To ensure appropriate support and care was provided."

The previous manager had resigned at the end of June, three care staff had handed in their notice and another member of staff said they were handing in their notice during the inspection. They had advertised for nurses and care staff and a number of interviews had been arranged. However, until sufficient numbers of permanent staff are employed there would be a reliance on agency staff and as we observed this affects the support and care provided.

Risk assessments had been completed depending on people's specific needs. These included risk of falls, pressures damage, nutritional risk and risk of choking and, staff explained how they supported people to remain as independent as they could and take risks in a safe way. However, risk assessments did not consistently identify people's individual needs, which meant they were at risk of harm or injury. For example, one person was at high risk of falls and staff had placed an alarm mat in their room to alert staff if the person stood up. The person was able to walk around the mat or push it away and did so regularly. Staff were aware of this; had not reviewed the person's needs and, an alternative measure to ensure the person's safety had not been put in place.

The management of ordering, checking, storing and disposing of medicines was not effective and did not ensure people were given their prescribed medicines. We looked at the medicine administration records (MAR) and found multiple gaps in people's records. There was a risk that people might not have been given their prescribed medicines. One person had been given an extra dose of one of their medicines for a period of 12 days. The interim manager referred this to the local authority as a safeguarding during the inspection. As required medicines (PRN) such as paracetamol for pain relief, had been prescribed, but protocols and guidance for staff to follow to assess if these were needed were not available in two MAR. The front page of the MAR did not have sufficient information for staff to identify people. For example, there were no photographs on the front of three MAR to assist staff to identify people who were unable to respond verbally if asked for their name. The temperature of the fridge and the room where medicines were stored should be monitored daily to ensure medicines were safe to take. We found the temperature of the room in Poppy had not been checked daily. The room had no window, there was a vent, but no fresh air and staff said the room was hot at times. The interim manager introduced a checklist during the inspection for nurses to complete at the end of their shift, to ensure medicines were checked and given out as prescribed.

Accidents and incidents were recorded and staff said the records were usually slipped under the door of the manager's office if they were not available at the time. We looked at recent incidents. Two incidents had occurred on one day but only one was recorded and, these were not discussed during the nurse's handover meeting on the first day of the inspection. This meant nurses who had not worked over the weekend were not aware of the additional support a person needed to protect them and staff.

Personal emergency evacuation plans (PEEPs) had been completed. However, the information in three did not have clear guidance for staff to follow to ensure people could be helped to leave the building safely. For

example, one person was unable to walk, but their PEEP did not state what equipment was needed to support them, such as a wheelchair. This meant the provider could not be assured that people would be supported safely in an emergency situation.

Emergency equipment was in kept in the home, but was not ready for use. There was no checklist to show that a suction machine worked and no evidence of portable appliance testing (PAT) to ensure it was safe to use.

The provider had not ensured safe care and treatment for people. The above are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

Staff told us they had completed safeguarding training and were verbally clear about the action they should take if they had any concerns. Such as send the details of any concerns to the local authority and seek advice to keep people safe. However, there were instances when information should have been sent to the local authority and staff had not done this. Such as the accident in Poppy lounge and the medicine errors, in particular the failure to ensure medicines were available and given to people as prescribed. This meant people were at risk of injury or harm. The interim manager placed a memo on the notice boards for nurses to follow, with clear guidance about the action they should take if people were at risk. However, the referrals had not been made by the second day of the inspection and staff were asked to follow the providers safeguarding procedure and make these referrals.

The provider had not ensured that people were protected from harm or that people were safeguarded from improper treatment, staff had not made referrals to the local authority in line with Sussex Safeguarding Adult Policy and Procedure. This is a breach Regulation 13 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

There was evidence of on-going maintenance and records showed that relevant checks had been completed. However, the housekeeping manager said they were not sure how reliable the records were as some of the checks had not been completed by maintenance staff, although it was their responsibility to do these. They were not confident the records could be relied on so had arranged to repeat them; including checks on the electrical system and the fire alarms and preventive systems in the home. They told us they would inform us when these checks had been completed.

Staff had completed moving and handling training and we observed them supporting people using hoists and wheelchairs to assist them to transfer and move around the home safely.

Recruitment procedures were in place to ensure that only suitable staff were employed by the provider. There were relevant checks on prospective staff's suitability, including completed application forms, two references, evidence of their residence in the UK and interview records. A Disclosure and Barring System (Police) check, which identify if prospective staff had a criminal record or were barred from working with children or adults, had been completed for all staff. Systems were in place to check nurses were registered with the Nursing and Midwifery Council (NMC) and had the correct registration to provide nursing care.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection in December 2015 the provider was not meeting the legal requirements in relation to staff training the provider had not ensured there were sufficient suitably qualified, competent, skilled and experienced staff working in the home. This was a breach of Regulation 18 of the Health and Social Care Act (RA) Regulations 2014. At our inspection in December 2016 we found the provider was meeting the regulation in relation to staff training.

At this inspection we found there were not enough suitably qualified, competent, skilled and experienced staff to provide appropriate support and meet people's needs. This was a repeated breach of the Regulation 18

People said the staff were very nice. One person told us, "Yes they look after us." Another person said, "They are very good." A relative told us, "Yes I think things are good and they know how to look after the residents." People said the food was very good, they were offered choices and staff were available to assist them if needed. However, despite these positive comments there were areas where improvements were needed.

There were not enough staff working in the home that had a clear understanding of people's support needs and how these could be met. One member of staff said, "We always ask the agencies to send staff who have worked here before but, we don't know who is coming until they arrive and we don't always get the same staff." Staff also told us they expected the agencies to provide appropriate training for their staff. Senior care staff said they observed agency staff as they supported people and if they had any concerns about their practice they would tell the nurse, "So the agency knows not to send them again." Nurses did not work with the agency staff and relied on feedback from permanent care staff with regard to agency staff skills and understanding of people's needs. Care staff had not been trained to do this. The provider had induction training for agency staff, but this had not been used to assess their competency or identify if they needed support from more experienced staff. There was no system to ensure senior care staff had the skills to observe and assess inexperienced agency staff; or that the agency staff had a clear understanding of people's needs. For example, people who were unable to stand without support were at risk of falls. To mitigate this risk a member of staff was required to remain in the lounge to sit with people doing activities or chatting to reduce the risk of falls and keep people safe. A member of agency staff had been allocated to do this in Poppy lounge, but they left to answer a call bell and a person fell and injured their arm. Staff told us this was because where this staff member usually worked they were expected to answer call bells. Senior staff had not provided sufficient guidance for staff allocated to support people in the lounge. We observed four periods during the inspection when there were no staff in lounges in Poppy and Lavender. This placed people who were at risk of falls unsupported at times.

On the first day of the inspection there was very little interaction between people and staff unless staff were providing personal care, assisting people to move around the home or supporting people with meals. Staff said this was because of the high use of agency staff, which meant permanent staff had limited time to spend with people. One member of staff told us, "I know everyone very well, but when one of us is on holiday and we have other staff working here it affects how much time we can spend with residents" and, "This must

have some effect on care, we try to keep this as little as we can."

Permanent staff said they had completed relevant training. Four of the care staff had worked at the home for less than six months. They told us they had completed all the required training at the home where they had worked previously. This included moving and handling, infection control, safeguarding and fire training. However, there were no records to support this. Three of the staff said they chose not to support people living with dementia. One nurse said it was not within their area of expertise and had not attended relevant training. Two care staff preferred not to support people living with dementia, although they had supported people in Poppy unit when required. Appropriate support and care was not consistently provided for people living with dementia.

Supervision had not been provided for all staff and, staff were not supported to have a clear understanding of their roles and responsibilities. Of the six care staff we spoke to only one had had supervision, which had been on the first day they worked at the home. Nurses told us supervision was not up to date and there was no day to day observation of staff practice, to ensure they provided appropriate care and support and prevent poor practice. For example, agency staff assisted a person with their lunch in Poppy, they stood to the side of the person and there was no conversation until the person started to cough when they asked if they were alright. Another agency staff member sat next to people as they supported them with their meal, they chatted about the food, asked if they liked it, were they ready for some more and if they had had enough to eat.

The provider had not ensured that staff employed by the home were suitably qualified, competent, skilled and experienced to understand and meet people's needs. This is a breach Regulation 18 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

Staff said people had access to healthcare professionals including community mental health team, continence nurse, opticians and dentists. Although one record stated the person had difficulty swallowing, there was no evidence of support from health professionals and staff were not aware of any difficulties. Visits from health and social care professionals were recorded in people's care plans. GPs visited the home as required and there were directions for staff to follow if there had been any changes in how staff should support people to meet their needs.

Staff told us they liked working at Bexhill Care Centre. Their comments included, "I like working here, it is a nice home." "I enjoy working here the residents are lovely, each one is different and we plan the care around them" and, "I think we can provide the care residents need." One member of staff was studying a healthcare diploma at level 3; two were qualified nurses in their own countries and were employed as senior care staff and one had five years of experience supporting people living with dementia. They demonstrated a good understanding of people's care and support needs and spoke knowledgeably about people's preferences and choices and, we saw they offered appropriate support.

Staff said they had attended training in Mental Capacity Act (MCA) 2005 and they had an understanding of capacity and the implications of Deprivation of Liberty Safeguards (DoLS) for the people they supported. The purpose of DoLS, which is part of the MCA, is to ensure that someone, in this case living in a care home, is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them. Additional guidance had been sought for one person's care from an Independent Mental Capacity Assessor (IMCA) and there were on-going discussions to ensure their needs could be met. Staff said people living with dementia could make decisions about their day to day care. Staff told us one person, "Has dementia but can decide what they want to do, when they get up and what they want to eat." "They are all able to make some

decisions. As I have got to know them I can see that residents can make decisions about most things, even with dementia. We just need to learn how best to ask them." "We don't restrict anyone, unless they are at risk or falling and then we would try and distract them with an activity or talking to them" and, "We can support people to do what they want to, we are not here to restrict them and if we do it has been discussed and it is to keep them safe."

People and relatives said the food was good. People told us, "I can have what I like, but I need help as I can't see very much." "They ask us what we want to eat and we can decide." "It is very tasty." "It's lovely at meal times here" and, "Food is usually good, can't complain." The chef had a good understanding of people's individual needs and planned the menu on this basis. They spent Monday asking people to put forward suggestions for Tuesday's main meal, which was blank on the menu, and a different meal was made for that day depending on what people wanted. Meals were based on people's specific dietary needs and included soft and pureed diet, with staff providing assistance when required. People were asked by staff where they wanted to sit for their meals and they chose to sit at the dining tables, in the conservatory in Poppy unit or to remain in their armchairs in the lounges or their own rooms. The atmosphere was sociable and relaxed, cold drinks were offered and condiments and napkins were available. The chef told us, "Residents can have what they want, there are no restrictions on what I can make and I ask people all the time for any suggestions. One person has asked for rabbit pie so we are buying that and will be offering it to everyone." "I want to be sure they have what they want and they enjoy it" and, "I can add cream and cheese to increase the calories and am willing to listen to everyone and when residents move in staff give me a sheet with information about their diet." A summer fete was planned for the end of August and, the chef had arranged to make a cake and organise the party to celebrate a 60th wedding anniversary, "Other residents and staff will be able to join in if they want to, should be a good day."

People's weights were checked monthly and more often if people were at risk of losing or putting on weight. Referrals had been made to the GP if they had any concerns and the Speech and Language Team (SaLT) had visited the home to assess one person's needs with regard to their ability to swallow. The advice given was recorded in the person's care plan and staff knew the person should have pureed diet following the assessment. Care staff and the chef were aware that this person did not like the look of the pureed meals and they were continually reviewing the meals offered and looking at alternatives to ensure the person had a nutritious diet. Staff agreed that pureed meals were not as visually attractive as the usual diet and the chef had been researching new techniques to make pureed food more appetising. They told us, "There is a machine that produces food that looks very similar to usual diets, but it is expensive and we may have to look at other ways of making them look better." We discussed the possibility of staff sitting with people and having the same meal to encourage people to eat pureed meals. The chef said he would like people and staff to have their meals together; it was something he had talked about with senior staff and, one care staff sat with the person in the evening and ate part of the pureed meal with people.

Requires Improvement

Is the service caring?

Our findings

At our inspection in December 2016 we found the staff kind and caring, they enabled people to make choices about the care they received.

Comments from relatives varied. One relative said, "My relative has been here a long time and staff know her very well. I have no concerns." Another relative told us, "Staff seem to know residents well. I have seen them persuading my relative to eat something quietly and slowly, even when they refused at first." A third relative said, "Some are great; (names) are fantastic….others are not friendly and their approach is awful." A fourth relative told us, "Two star building but five star care." People said the staff looked after them very well. One person told us, "Yes, they are lovely and so nice." Staff said their role was to ensure people lived the best lives they could, with the restrictions they have, like poor mobility and ill health. One member of staff told us, "We look after the residents so they can do as much as they can themselves. We don't want to take away their independence and they should make decisions about what we do."

Despite the positive comments we found the reliance on agency staff had an impact on staff offering people choices and enabling them to make decisions about the care and support provided. We observed poor practice. Such as agency staff assisting a person with personal care with their bedroom door open and uncovered and, agency staff sitting in Poppy lounge with five people with no conversation or interaction on the first day of the inspection.

Some of the care was task orientated rather than personalised. For example, we started the inspection at 6.30am on the first day and found the home quiet. Staff had assisted people with personal care and we observed people were washed, dressed and lying on their beds. We were told later that the nurse on duty had asked care staff to do this as one of the day staff had called in sick and, they may not be able to get agency staff. People were comfortable and did not show any signs of distress or upset, however the expectation is that people should be supported to have a wash and get dressed when they want to, rather than when staff chose to do this.

The atmosphere in the home was relaxed and conversations between people, relatives and staff were friendly and on first name terms. People were comfortable with staff and responded positively to them as they chatted and joked together.

A member of staff sat next to a person in Poppy lounge and asked them how they felt and if they needed anything. They were facing the person so they could see their face and asked about their soft toys. The member of staff responded appropriately when the person held onto their blouse and slowly encouraged them to let go. The member of staff said the person often did this and she understood it was part of their illness. They said, "We need to know about this and how to respond, so that she doesn't miss out on time with us sitting and talking."

Staff were respectful and responded quickly when people needed assistance. Staff talked to people as they assisted them to transfer in the lounge from wheelchairs to armchairs using hoists. They asked people

where they would like to sit, although most had their favourite chair and, explained what was happening when they were lifted up and transferred into their chair. Staff asked if they were comfortable, had everything they needed or if they wanted a drink before they assisted other people. One member of staff told us, "We always check they have everything they need, as we usually have a number of residents to help before lunch. They like to be in the lounge or at the dining table by then."

Relatives said they visited when they wanted to and were made to feel welcome and people were encouraged to keep in contact with relatives and friends. We observed staff and relatives talking about the support provided and their family members care needs. Relative's comments varied. One told us, "They are very good, they know exactly what care (name) needs and how to look after her so she is comfortable." Another said, "The care is very good, and they let me know if (name) needs anything." Although a third relative told us, "Some staff are not as good as others. Some haven't liked me staying with (name) for as long as I have been." The relative was reassured by staff during the inspection that they could stay as long as they liked.

Inadequate

Is the service responsive?

Our findings

At our comprehensive inspection on 17 and 21 December 2015 the provider was not meeting the legal requirements in relation accurate and complete personal care records. This was breach of Regulations 17 of the Health and Social Care Act (RA) Regulations 2014. At our comprehensive inspection in December 2016 we found the provider was meeting the Regulation.

At this inspection we found care plans were not accurate and did not provide appropriate guidance for staff to ensure people had the care and support they needed. This is a repeated breach of Regulation17 and we found an additional breach.

Relatives said staff provided the support their family members needed and they had been involved in discussions about their care. Although they also said there were issues with the changes in staff and one relative was concerned about their family members care if staff did not understand their specific needs. Staff told us they had a good understanding of each person's individual needs and they planned support and care based on these. One member of staff said, "We know residents are all different, like us, and we have a good understanding of how to provide the support they want."

Nurses said each person had been assessed before they were offered a place at Bexhill Care Centre, to ensure their needs could be met. However, one nurse said supporting people living with dementia was not in their area of expertise and, pre-admission records for people who had most recently moved into the home had not been completed adequately. For example, one person's behaviour put staff and visitors at risk of harm. This information was recorded in the support plan provided by the local authority responsible for placing the person in the home, but had not been used as part of the assessment process. Staff had not been given the opportunity to discuss this person's individual needs and assess if they could be met, before they moved into the home. The care plan therefore was based on inadequate information; the changes in the person's behaviour had an impact on staff and consequently affected the care and support provided for this person. Senior care staff said only staff of the same sex would provide support.

We discussed the provision of personalised care with the interim manager and they agreed it would be difficult with current staffing to provide personalised care consistently.

The provider had failed to ensure the provision of personalised care and support for people that met their needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans had information about people's specific needs and there was evidence they had been reviewed when people's needs changes. However, information was missing, people's individual support needs had not been consistently recorded and the support plans contained conflicting information. For example, one care plan stated the person ate a normal diet and was a slow eater, but also that they had difficulty swallowing. Their nutritional assessment was blank and there was no evidence of a referral to SaLT to assess their needs and if they needed specific support.

A person's support needs with regard to their mobility was not clear. The identified need was that they had become weak and needed assistance to transfer, as 'unable weight bear' and at risk of falls. The goal was to minimise the risk of falls and the support plan stated they needed two staff to assist them to move around the home safely. The moving and handling risk assessment was not dated and, although the care plan stated they needed two people to transfer it also stated they were able to walk a few steps with one care staff.

People living with dementia were not consistently supported to be involved in developing their care plan. The personal life story in one care plan had not been completed and the comment added by staff was, 'declined to answer – dementia'.

One relative said they did not know what the care plan actually meant and were worried that their relative was not receiving the care they needed. They discussed their concerns with the clinical lead nurse, the care plan was explained to them and they said they felt more comfortable about how the staff were supporting their family member.

Nurses were responsible for a number of care plans each, but with the changes in staffing there would not be enough permanent nurses to do this, relevant information may not be recorded and guidance for care staff would not be up to date. Nurses said they were responsible for keeping the care plans up to date and relied on the care staff to inform them of any changes in people's needs. Two care staff said they had not read the care plans as the nurses were responsible for them and one care staff said they had read the care plans when they first started. They told us, "We don't usually write in the care plans, but if we have something to add we ask the nurse if they want us to add it or do they want to."

Permanent care staff discussed people's specific needs knowledgeably and explained how they involved people in decisions about the care and support provided. From our observations these staff knew people very well. However, the service relies on agency staff and the guidance for them to follow was not consistent and therefore people did not receive appropriate care and support.

The provider had failed to ensure personal records, and guidance for staff to follow when planning care, were accurate and complete. This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the beginning of each shift nurses had a handover from the nurse on the previous shift and, then there was a full handover with all staff. We sat with staff during two of these handovers and saw the discussion involved nurses and care staff. Any changes to people's needs were discussed and permanent staff were allocated to each unit depending on their skills. One of the nurses was allocated to 'work on the floor'; to provide personal care and support, as there were not enough care staff working in the unit. Staff told us the handover sessions at the beginning of each shift were very good and they relied on them to keep up to date with peoples' needs. One senior care staff told us, "I know everyone very well on this unit; we work with the same staff on the same shift each week so we get to know each other and how we work. I think it is very good and we can look after people." The interim manager had introduced an 'At a Glance' care plan sheet for the front of the daily record folders; which also contained food and fluid charts and positioning records, for staff to refer when planning care. The 'At a Glance' forms included information about the person's mobility, with falls risk and hoists if used, continence, communication, skin integrity and social. Staff said the forms were good and they were getting used to them.

A range of activities were available for people to participate in if they wished. Activity staff offered one to one sessions for people who chose to remain in their rooms and people in the lounges. Music was played in

Poppy lounge one afternoon, people tapped their feet and sang along, and clearly they enjoyed it. In Lavender lounge a group of people were supported by a relative to do some water colour painting, they chatted about colours and each other's paintings. Staff sat with people during the inspection talking, looking at magazines or playing games. Staff said people could stay up as long as they liked and two people liked to watch TV in the evening and were supported to do this.

There was a complaints procedure in place, this was displayed on the notice board and was included in the information given to people, and relatives, when they moved in to the home. Relatives said they knew how to raise concerns and had spoken to the manager if there had been any issues. A relative told us, "I have no complaints and I know how to approach the manager." Another relative said they had concerns about incontinence management and, "This was dealt with." Their needs had been re-assessed and a new routine had been introduced to support the person. The relative said, "Would give 75% to this home and there is more one to one here than before."

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection in December 2015 the provider was not meeting the legal requirements in relation to monitoring and assessing the services provided and informing the CQC about important events that occur in the home that affect the care and support provided. These were breaches of Regulation 17 of Health and Social Care Act (RA) Regulations 2014 and Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009). At our focused inspection in February 2016 we found a continued breach of Regulation 17, but Regulation 18 (Registration Regulations 2009) was met. At our comprehensive inspection in December 2016 we found the provider was meeting the Regulation 17, although additional time was needed for processes to be embedded into practice.

At this inspection the monitoring and assessing of the services provided was not effective, which meant people were not protected from inappropriate and unsafe care and support. The provider had not informed us of important events that occurred in the home. These were repeated breaches of Regulation 17 of Health and Social Care Act (RA) Regulations 2014 and Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009).

Comments from people, relatives and staff varied. People said they were comfortable and were happy with the support they received. One person told us, "I like the staff, they are all good." A relative thought things had got better in recent weeks but, another relative was upset and felt staff had not provided appropriate support for their family member. The staff changes were also an area of concern for people, relatives and staff.

The management processes in Bexhill Care Centre were ineffective. There had been no registered manager at Bexhill Care Centre since November 2016. A manager was appointed in November 2016 and they had been supported by an external consultant, whose role was to audit the services provided and identify areas for improvement. There had been no improvements since the last inspection; there were repeated breaches of Regulations and we identified additional areas where improvements were needed. These had not been identified through the provider's own quality assurance system, despite the additional support for the manager from an external consultant.

For example, the concerns about staffing levels have continued since the home was first inspected in December 2015. Discussions with management of the impact insufficient staffing levels have on meeting people's needs have been on going. We discussed our concerns in detail at our inspection in December 2016 when the manager told us they planned to open Lavender unit as soon as they could. At that inspection there were not enough care staff working in Poppy unit to meet people's needs consistently and, there were not enough nurses to manage people's nursing needs if both units were open. We were assured by the manager and the external consultant that people would not be admitted to Lavender unit until there were two separate teams of staff working in the home, including a nurse for each unit. Despite our concerns and the assurances we received, Lavender unit was opened in March 2017. People were transferred from Poppy and new admissions were admitted to the unit, before there were two separate teams of staff in place. At this inspection there were not enough nurses and care staff employed at the home to meet people's needs

and this put people at risk of harm or injury.

The previous manager had made changes with regard to the staff working in each unit and their responsibilities. Care staff had, prior to this inspection, given out medicines in Poppy, if there was only one nurse working in the home and the nurse was responsible for Lavender. We had been told about this before this inspection. At that time we discussed with the clinical lead nurse the nurse's professional responsibilities for medicines, in line with the requirements of their registration with the Nursing and Midwifery Council. The expectation was that this would be resolved and people's medicines would be managed safely. However, at this inspection we found that nurses were not aware of their roles and responsibilities, which meant people were at risk of harm or injury. For example, their responsibility to ensure prescribed medicines were available and given when needed. Medicines had not been ordered when stock was low and this affected people's health and wellbeing. In addition, relevant training with regard to giving out medicines had not been provided for care staff when they were responsible for medicines. This meant care staff did not have had a good understanding of the medicines they gave out and how they might affect people and what they should be looking out for. Such as observing people, if they had been prescribed new medicines, for a reaction to them or assessing if people should be given as required medicines (PRN), including people living with dementia who were unable to inform staff or their needs verbally. Senior care staff said they had given out medicines, but this had stopped. They told us, "The nurses do them now, don't know why."

Staff had attended MCA training and were knowledgeable about people's ability to make decisions about the care provided. However, mental capacity assessment had not been completed for all of the people whose care plans we looked at. For example, in one care plan the mental/cognition assessment was blank and an assessment had not been completed for the person whose behaviour was subject to changes.

Staff said they had attended relevant training and it was up to date, however records did not support this.

The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support. The above are a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and manager are required, by law, to inform us of any important events that occur in the home, which may affect people living in the home and the support provided. For example, they are required to inform the CQC if there are 'insufficient number of suitably qualified, skilled and experienced persons being employed for the purposes of carrying on the regulated activity'. We found at this inspection they had not informed us of the difficulties recruiting enough care staff and nurses and, they were unable to show that staff provided appropriate care and support for people living in the home.

This was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009).

People and relatives said staff talked to them about the support provided and if changes had been suggested they discussed and agreed these before they were made. One relative said their family member had moved rooms to one of their choice and they had brought in a lamp shade and curtains to make it more homely. They were very happy with the care provided.

Staff said they worked together really well as a team and felt supported by the new management at the home. One member of staff told us, "They are trying to deal with the staffing. I think a full time nurse starts soon and they have advertised for care staff and interviews have been arranged. I think when we get more

staff everything will settle down." Another member of staff said, "We all have the same aim, to provide the support people need, on their terms. We don't want to take away their independence, but make them more independent."

The interim manager has made a number of changes since the inspection. Including the closure of Lavender unit by transferring people living there to Poppy unit. They said this had been done only after consultation with the people concerned and their relatives. They told us, "We explained the situation. About staffing and how it was difficult to provide the support people needed in the two units. It may only be a temporary move and they can move back when the staffing levels have improved if they want to."

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not informed CQC about incidents that affected the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured safe care and treatment for people. There were not enough staff with a clear understanding of people's needs to provide the support they needed; risk assessments had not clearly identified people's needs to ensure their safety and the provider did not ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were protected from harm or that people were

safeguarded from improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain secure and accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff employed by the home were suitably qualified, competent, skilled and experienced to understand and meet people's needs safely.