DFB (Care) Limited

Palm Court Nursing Home

Inspection report

17 Prideaux Road
Eastbourne
East Sussex
BN21 2ND

Tel: 01323721911
Website: www.palmcourtnursinghome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Palm Court Nursing Home is a residential care home providing personal and nursing care to up to 53 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 34 people using the service. At the time of our inspection, only the ground floor was being used.

People's experience of using this service and what we found
We identified widespread failures around the governance of the service. Audit systems and processes failed to identify risks to people's safety and other aspects of the service that required improvement. Improvements in relation to the environment, oral hygiene and accurate record keeping had not been made since their last inspection. Additional concerns were identified during this inspection in relation to reporting of incidents and person-centred care. Records did not accurately reflect the care people received.

People were not always safe from environmental risks. The home was not always clean and hygienic, and some furniture and fixtures were broken. People were at risk of injury from bed rails being used inappropriately. Although risks around people's health conditions were being safely managed, people's risk assessments did not always reflect current risks. Unexplained injuries had not always been investigated appropriately to identify the cause and reduce the risk of injuries reoccurring. People's fluid intake was not being recorded consistently or effectively.

People were not always receiving person-centred care. Systems to keep people's care plans up to date were not effective and people's care plans were not always relevant. People were not being admitted to the service safely. Activities were not always person-centred and there were limited opportunities for interaction and engagement for people who spent time in their rooms. People were not being appropriately supported with oral hygiene.

Although the management of people's topical creams required improvement, other aspects of medicines were managed safely. Staff received training before supporting people with their medicines and medicine records were completed. There were enough staff to support people and staff were recruited safely.

Staff spoke to people with kindness and in accordance with people's communication needs. The registered manager responded appropriately to complaints and suggestions made to improve the service.

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

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 requires improvement (published 13 December 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections. This service has failed to achieve a good rating over the last ten consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 25 November 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements. We also looked at the responsive key question.

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 has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement
We have identified breaches in relation to safe care and treatment, person-centred care, good governance and reporting at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Palm Court Nursing Home

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
This inspection was carried out by two inspectors.

Service and service type
Palm Court Nursing Home 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. Palm Court Nursing Home is a care home with 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 5 December 2022 and ended on 13 December 2022. We visited the location's service on 5 December 2022 and 7 December 2022.

What we did before the inspection
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 the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time with people that lived at the home. We spoke to people throughout the inspection and received feedback on living at the home from 2 people. Some people were not able to tell us their views so we spent time observing interactions between people and staff. We spoke to 5 people's relatives and received feedback from 1 professional that regularly worked with the service. We spoke to 8 members of staff which included the registered manager, deputy manager, nurses, senior carers and carers. We looked at 6 people's care plans and multiple medicine records. We looked at documents relating to quality assurance and feedback the home had received from people and relatives.

Requires Improvement

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 requires improvement. At this inspection the rating for this key question has remained requires improvement.

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

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

At the last inspection the provider had failed to ensure risks to people were safely managed. This was a breach of regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Concerns were found in relation to people's identified risks such as choking, dehydration, unexplained injuries and wound care.

At this inspection we found not enough improvements had been made and the provider was still in breach of regulation 12. Risks to people continued not to be well managed. Additional concerns were found in relation to infection prevention and control and the safety of the environment.

● People were not always safe from environmental risks. We found several bedrooms where people's furniture such as cupboards and drawers were broken. We identified two broken plug sockets one which had cracked and one which was coming off the wall, both plug sockets were still in use during our inspection. Although one of the broken plug sockets was identified by staff two days before our inspection, the other had not. The plug socket that staff had identified as broken was still in use despite staff recording this as broken. We raised this with the registered manager who immediately ensured both plug sockets were turned off.
● The registered manager told us they were currently recruiting for a maintenance person. In the interim, an external company were being used, however they had been unable to attend the home recently due to illness.
● Some people had bed rails to prevent them from falling out the bed. People's bed rails were not always being used appropriately. We saw one person had their legs over their bed rails with a crash mat beside the bed. We alerted staff to come and support this person as they were at risk of falling from their bed or receiving an injury. The registered manager and the person's care plan confirmed that this person had not been assessed for the safe use of bedrails and the bed rails had been put up by mistake. This had not been identified by staff.
● Over the two days of our inspection we identified three people's bedrails did not have bumpers on them. Bumpers protect people from the risk of entrapment. For one person, staff told us they did not know where this person's bumpers were and thought they may be in the wash. For two people staff were unaware they did not have bumpers on their bed rails. Another person's bed rails had a broken slat. People were at risk of receiving injuries by not being protected from the risk of entrapment.

● Risk assessments did not always reflect people's current risks. For example, one person had a choking risk assessment completed in 2021 which stated they were not at risk of choking. This person had a care plan for dysphagia which is a condition meaning the person has swallowing difficulties. This person was not able to chew their food. Although we saw that this person had a modified texture diet to reduce the risk of choking, there was no corresponding guidance for this in the risk assessment to help ensure staff had consistent guidance.
● Some people had call bells they used to alert staff to if they needed support or in the event of an emergency. People's call bells did not correspond to people's current bedroom numbers. We saw that staff on two occasions were unable to locate call bells that had been pressed and were looking around bedrooms to try and find the person. This system would not have been safe in an emergency where staff would need to respond to a person quickly.
● Unexplained injuries had not always been investigated to identify possible causes. For example, one person was documented to have a bruise and skin tear on their arm in March 2022. Staff recorded for another person that they were found with a bruise to their hand and finger in April 2022. For both injuries, staff had recorded the cause as unknown and the section of the report for investigation had been left blank.
● People's food and fluid charts did not support staff to identify if someone had reached their fluid target. For one person who was assessed as at risk of dehydration, staff had recorded when they had given the person a drink, but there was no target fluid goal and total fluid amounts for each day had not been added up. The registered manager told us that the head of care regularly checked food and fluids, but this was not evidenced. One person's food and fluid charts showed that they had had between 300mls-750mls each day over four days. Records did not show whether this was an adequate amount for this person to drink or whether any action was needed by staff to support and encourage the person to drink more.

The provider had not ensured that risks to people's health and safety had been assessed and action had been taken to mitigate these risks. The provider had not ensured that the premises was safe for people to use. The provider had not ensured that equipment was being used safely. This was a continued breach of regulation 12 health and social care act 2008 (Regulated activities) regulations 2014.

● Following our inspection, we received confirmation that both broken plug sockets and the bed rail had been fixed. The registered manager told us they would review bed rails for people and remove bed rails from the beds if they were not required from the person to avoid staff members using these for people that had not been assessed to need them.
● Some improvements had been made since the last inspection. Fire safety measures had improved, fire exits were not blocked and regular fire drills were taking place.

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, appropriate legal authorisations were in place to deprive a person of their liberty.

Preventing and controlling infection

● The environment was not always clean or hygienic. We found multiple areas of the home that were not clean. Bathrooms had toilet brushes which were soaking in a liquid. Some toilet brushes had faeces on them. Toilet basins and some sinks had a build-up of limescale in them which had coloured some of the toilet bowls black. One person's shower room was missing a section of tiles. Another person had a sink plug which was connected to the sink by a frayed piece of string. These were infection control risks.

● Cleaning records in people's bedrooms were inconsistent. Some people's bedrooms and bathrooms were not clean. Some people's bedrooms smelled strongly of urine.

● Personal protective equipment (PPE) was not always stored appropriately. Aprons were stored in people's bathrooms hanging over toilet rails. This meant PPE could be exposed to human waste and was not hygienic. This had been identified at our last inspection as an area that required improvement. We found improvements had not been made. Bins to dispose of PPE were not always appropriate.

The provider had not ensured people were protected from the risk of infection. This was a breach of regulation 12 health and social care act 2008 (Regulated activities) regulations 2014.

People were able to have visitors to the home when they chose to. Visitors were asked to wear face masks during their visit which complied with current infection prevention and control guidance.

Using medicines safely

● People's topical creams needed to be reviewed. Creams had recently been moved into people's bedrooms. Some people's prescribed creams did not have opening dates on them which meant staff were unable to tell if the cream was past its recommended date of use.

● Other aspects of medicines were managed safely. There were safe arrangements for the storage, administration and disposal of medicines. People's medication administration records (MARs) had been accurately completed by staff.

● Some people were assessed as needing to receive their medicines without their consent or knowledge due to not having the capacity to make decisions around medicine administration. Appropriate authorisations were in place for this practice and mental capacity assessments and best interest decisions had been recorded in detail. Staff had received instructions from the person's GP and pharmacist to ensure their medicines were administered safely.

● Staff received training and competency checks before supporting people with their medicines. Staff who administered medicines during our inspection demonstrated good practice.

Staffing and recruitment

● The provider had recently recruited staff from oversees who were registered nurses in their home countries. While awaiting their registration for nursing in the UK, these staff were working as senior care assistants and were being supported by the nursing staff. New staff were inducted to the service safely, given the opportunity to get to know people and how to support them.

● There were enough staff to support people safely. However, the service supported a high number of people with complex nursing needs and the nursing staff told us at times they felt pressured when trying to ensure everyone was supported with their nursing needs. The registered manager told us that once the oversees staff had received their UK registrations, they intended to have two nurses on duty during the day.

● People's relatives felt there were enough staff. One relative told us, "Generally seems to be enough around. You ring the door and it Is always answered quickly."

● Staff were recruited safely. The provider carried out checks on new staff before they began employment. This included references from previous employers and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National

Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding concerns were logged and tracked by the registered manager. This log included the investigation date, what action had been taken such as a meeting with a person's social worker and family and when the safeguarding concern had been closed.

● We spoke to one safeguarding professional that had recently worked with the service. They were positive about how staff engaged with the safeguarding process and felt staff had supported the person in a person-centred way to try and get the best outcome for the person.

● People's relatives told us they felt their loved ones were safe. One relative told us, "[Person] is in safe hands, I'm really happy with them. I am used to not worrying about [person] now which a relief."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● At the last inspection that looked at the responsive key question, issues were identified around people's activities and engagement. At this inspection we found that improvements had not been made and further issues were identified in relation to care planning.

● People's care plans were not always person-centred and some contained generic information about people's health conditions rather than how their health conditions specifically affected the person. Although people and their relatives were involved in the creation of care plans prior to the person's admission to the home, reviews were not taking place regularly to gather people and their relative's views. One relative told us, "We've not been asked to contribute to the care plan and not seen it since [person] moved in."

● Systems in place to keep people's assessments and care plans up to date were not always responsive to people's changing needs. Care plans were being written by the deputy manager and head of care. Care staff informed the nursing staff of information relevant to people's care and support needs. Nursing staff passed their own and the care staff's information to the deputy manager to be added to care plans. This process was not always effective and care plans were not always up to date. For example, one person had a contracted hand which had caused a wound to the person's palm. Although staff told us about this person's wound, this information was not in the person's care plan.

● Language used in people's care plans was not always respectful. For example, one person's care plan said, 'I need feeding', another person's care plan said, 'I can be challenging'. This was not best practice and was fedback to the manager to be addressed.

● People were not always being admitted to the service safely. We met a person that had recently moved into the home into a temporary bedroom. This person's bedroom had a broken plug socket that was being used to power an airflow mattress the person needed. This person also did not have any toiletries in their bathroom and had been in this room for 3 days. It was not clear how this person had been supported with personal care and oral hygiene.

● We met another person that had moved into the home the evening before. Staff had not checked this person to see whether they had any marks, bruises or skin complaints upon moving into the home. Records for this person did not show that they had been supported with personal care until the morning after they had arrived. Although staff told us the person had been offered food and drink, there were no records to confirm this. The person was still wearing their hospital gown, hospital ID bracelet and had their belongings in their room in black bin liners. We asked staff to support this person with personal care, oral hygiene and to get changed. We returned later to see the person in their pyjamas. We checked the person's bathroom and found there were no toiletries and no items to support the person with brushing their teeth. We discussed this with staff and the registered manager, there was no explanation for this person's treatment

during their admission and the registered manager acknowledged that this person had not been supported appropriately.

● The provider's consultant told us they were planning to introduce an admission check list for when people moved into the home to ensure staff understood what needed to be in place when people moved in. However, there was currently no system to ensure this was being done safely.

● People were not being supported consistently with their oral hygiene. We found 5 people did not have toothbrushes or toothpaste in their rooms or bathrooms. Staff were not recording in people's daily notes that they had been supported with oral hygiene.

● People's bedrooms had not always been personalised with items from the person's home or their belongings. Several bedrooms had no distinctive features to suggest that someone lived in them. One person's bathroom did not have toilet roll, soap, hand towels or a toothbrush. The registered manager told us this was based on the person being at risk of flushing items down the toilet and removing items from their bathroom and bedroom. This information was not in the person's care plan. Another two people's bathrooms were also without any toiletries. There did not seem to be an explanation for this.

● People were not always being provided with activities that were engaging and relevant to the person. People had detailed information in their care plans, completed by their relatives, of people's interests, hobbies and life histories. People's records did not show they were being supported to engage in their preferred activities.

● Relatives we spoke with told us that activities needed to be improved. One person's relative told us, "[Person] needs some stimulation when they are sitting around, and staff don't do that. [Person] is usually just plonked in front of the tv. They used to do cooking with staff but haven't seen that for ages. They used to do chair exercises too, but they don't anymore."

● Some people were cared for in bed. Although staff recorded when they checked on people in their rooms, staff had not recorded whether they engaged and spoke to the person or provided the person with any stimulation. We saw several people were in bed on their own without anything to interact with such as music, TV or staff to spend time with.

● The service was currently recruiting for an activities co-ordinator. Until this position was filled, care staff were assigned to support people with activities. Care staff told us there was rarely enough time for them to consistently provide activities and engagement for people.

● We saw one person was frequently becoming agitated in the lounge. The person tried several times to get up from their chair and was repeatedly asked to sit back down by staff. This person was at high risk of falls. Despite staff telling us that this person needed support with engagement due to continually trying to stand without support, staff did not engage this person in any further conversation, engagement or activity so they continued to try and get up from their wheelchair.

The provider had not ensured that people's care and treatment was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, we received confirmation from the registered manager that they had completed an audit of people's bedrooms and bathrooms and ensured that people had sufficient toiletries.

● We saw some areas of good practice. When staff engaged with people, they spoke kindly to them and we saw staff made people smile. We saw some instances of people being engaged in activities. For example, one person was being supported to throw small bean bags at some bowling pins. A choir also attended the home and sang Christmas carols to people in the lounge. This had been arranged following feedback from a relative and inspectors saw that people, relatives and visitors enjoyed this event.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People had clear communication plans to inform staff how best to communicate with them. Where people required equipment to aid communication such as glasses or hearing aids, we saw that people were being supported to use these appropriately.

● People's relatives told us that staff understood people's communication needs. One relative told us, "[Person] can't communicate verbally but will often say to staff, 'I don't mind' and smile. I guess staff know [Person] really well and what they like and dislike. They will monitor [person's] facial expression and read each situation."

● Staff told us for one person whose first language was not English, they had created a list of basic phrases and words with a pronunciation guide for staff to use with the person in order to aid communication and connect with the person.

Improving care quality in response to complaints or concerns

● There was a clear complaints process in place and people's relatives told us they knew how to make a complaint. People's relatives told us they would feel comfortable to raise any concerns. One person's relative told us, "I've not needed to raise any but could definitely approach the registered manager and would if I had any worries.

● The registered manager kept a log of complaints and concerns received and recorded how each was addressed and actioned. Complaints were discussed in staff meetings.

End of life care and support

● People had end of life plans in place which took in to account people's wishes and religious needs. These had been discussed with people's relatives where appropriate.

● One person's relative told us about how staff supported a person through a bereavement when another person who used the person passed away. They told us, "Staff wanted to be there when we told [Person] their loved one had passed away. Staff were very sweet, supportive and they helped us break the news. Two staff also came to the funeral and left flowers for [person]. They were quite upset when [person] passed away. You can see that staff genuinely love people."

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 requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last inspection the provider had not ensured that there were effective systems to assess and quality assure the service and had failed to maintain accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had not been made and the provider remained in breach of Regulation 17.

- The provider had failed to sustain improvements over the last 10 inspections where a rating was given and had not achieved an overall rating of good during this time. The provider had not demonstrated learning from previous inspections where issues had been identified.
- Following the last inspection, the provider submitted an action plan to tell us how they would meet the regulations. At this inspection we found that the provider had not met the regulations and further issues were found.
- Quality assurance processes were not effective and did not identify risks to people's safety. The registered manager had developed a service improvement plan to identify and track issues and concerns at the service. Following the last inspection, issues identified at that inspection were added to the service improvement plan. This plan did not show that concerns had been actioned. For example, the service improvement plan recorded that food and fluid charts needed improvement and this was to be achieved by staff checking food and fluid charts at the end of each shift and counter signed. Staff were not following this practice.
- Other issues identified at the last inspection and the service improvement plan had not been addressed and the same issues were found at this inspection. This included issues with oral hygiene, the environment and accurate record keeping.
- The environmental risks to people had not been identified by the provider's audit systems. The last environmental audit was completed in October 2022 and did not find any of the issues found at this inspection. A health and safety audit was completed in November 2022 which also did not identify these concerns. The most recent infection prevention and control audit had been completed in October 2022 and had identified some concerns with staff practice but not of the cleanliness of the environment.
- Systems to monitor and measure whether care plans were effective and relevant to people's needs were

not robust. We found some care plans did not contain important information about the support people needed such as with wound care.

● People's records did not accurately reflect the support they received. Care staff were allocated people to support and complete daily care records for the duration of their shift. Staff told us if another member of staff supported that person, the allocated staff member would write the person's daily notes for them. This meant daily notes were not always being written by the staff member that supported the person and the allocated staff member was reliant on other staff to tell them how a person had been and what support they had received.

● Recording processes were not efficient or effective. One person had a protocol for receiving a medicine which relieved anxiety when they were upset and distressed. During our inspection we saw this person had received this medicine that morning. Although one staff member was able to tell us why this person required the medicine which was in accordance with the person's care plan, staff had not documented this in the person's daily notes or the person's behavioural chart to monitor and record anxious episodes. This was due to the person's allocated staff member not being aware of what had happened. This meant the person's episodes of anxiety could not be monitored to identify triggers and trends to try and alleviate this person's distress.

● People's records did not show that risks to people were being safely managed. One person living with epilepsy could have seizures triggered by constipation. The person's care plan stated that staff should contact the person's GP if they did not have a bowel movement for 2 days. This person's bowel chart showed they had not had a bowel movement for 7 days. We discussed this with the registered manager who told us staff had informed them the person had had more bowel movements than had been recorded. However, records did not reflect this. There were no systems or processes to monitor that documents were being completed accurately.

● Record keeping was disorganised and information about people was not always able to be found promptly. For example, we requested the seizure record for a person who had epilepsy over two days of our inspection. Staff told us they were completing this but were unable to find it. We requested admission information for a person recently admitted to the home. Staff were unable to find parts of this person's records.

The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each person. The provider did not have effective systems to assess, monitor and improve the quality and safety of the services provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recently hired a consultant to look at quality assurance processes with the registered manager and staff. The consultant had recently provided feedback to the service and was beginning to work with staff on how to address the issues they found.

● The provider is required to submit statutory notifications to CQC about events in the service. These had not always been appropriately submitted. Although the provider had notified us of people passing away, serious injuries and allegations of abuse, they had not always notified us when people's Deprivation of Liberty Safeguards had been approved. We identified 8 people with DoLS authorisations that CQC had not been notified of. We raised this with the registered manager who was not aware these needed to be submitted.

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

● People's relatives were positive about staff and how they supported people. One person's relative told us, "I am happy with staff. They seem very caring with [Person]. [Person] is quite happy when I visit which is often. They're very attentive. They know [person] and us well. Staff are very kind and know their quirks and all about [person]."
● People we spoke to were positive about living at the home. One person told us, "The staff are very nice, very polite. I have no complaints."
● When staff spoke to people, they were kind and respectful. We saw staff supporting people with their meals. Staff engaged people's attention, told people what they were eating and made conversations with people whilst supporting them.
● Relatives told us there had been periods of change with managers and staffing. One person's relative told us, "There have been different managers and lots of changes with each one. It's only started to improve since the current registered manager and deputy manager came. They seem to be the only ones with passion to change things. They listen, they get things done if things go wrong."
● The registered manager understood their responsibilities around duty of candour and the importance of being open and honest.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People were invited to attend regular resident meetings to give their views and opinions. Staff recorded how people had responded during these meetings and what people had said. People had recently been asked by staff whether they enjoyed the food at the home and people commented to say they did.
● Relatives were invited to complete surveys on the quality of the care provided to their loved ones. The last survey was March 2022. Relatives we spoke to confirmed they had not received an opportunity for formal feedback recently. However, relatives told us they were able to raise concerns and views directly with the staff when they visited.
● The registered manager had created a 'you said, we did' board which showed how staff had acted on suggestions and complaints. This showed that following a suggestion from a relative to have more fresh fruit and low-sugar yoghurts, staff brought in this food for people and ensured homemade sugar free biscuits were available to people who were diabetic.
● Staff meetings took place regularly to speak to staff about good practices and areas to be improved.
● Staff told us about various events they had held to encourage community engagement. This had included an event to raise money for Alzheimer's Society, celebrating World Autism Day and working with Eastbourne Blind Society.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured that people's care and treatment was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured people were protected from the risk of infection. The provider had not ensured that risks to people's health and safety had been assessed and action had been taken to mitigate these risks. The provider had not ensured that the premises was safe for people to use. The provider had not ensured that equipment was being used safely. This was a continued breach of regulation 12 health and social care act 2008 (Regulated activities) regulations 2014.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each person. The provider did not have effective systems to assess, monitor and improve the quality and safety of the services provided. This was a continued breach of Regulation 17 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice