Reed Care Homes Limited

Nayland Lodge

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Nayland Lodge is a residential care home supporting seven people who may be autistic people, people with a learning disability and or people with a mental illness. At the time of inspection three people were receiving the regulated activity of personal care out of seven people living in the home.

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

Right Support
People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice.

The home had been closed to visitors at the time of inspection for three weeks due to people and staff at the home having contracted Covid. At the time of inspection one person had Covid and was isolating in their bedroom.

Some blanket restrictions were in place, such as a locked front door, a blanket ban of alcohol in the home and cigarette regime. Individual risk assessments and capacity assessments had not been completed around restrictions in place.

Right Care:
Care plans were not routinely updated and had not been reviewed for six months. At times peoples risk assessments and care plans did not reflect the needs staff told us people had.

Staff had not always undergone safe recruitment in line with legal requirements. Staff informed the provider at staff meetings across a six-month period that they did not feel able to manage people in extreme distress who were presenting as a risk to others. Training had been requested, but not yet offered. Staff had not received all the training they needed to support people well.

Right Culture:
Staff were observed to speaking to people in a kind way. However, we identified a number of restrictions at the service and a lack of provider understanding around capacity and decision making. This left people at risk of being cared for in a closed culture.

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 9 March 2021). This service has deteriorated to Inadequate. This is the fourth consecutive inspection where the provider has failed to

achieve a good rating.

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.

Why we inspected
We received concerns in relation to staffing numbers, restrictive practices and poor governance and oversight. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 deteriorated from Requires Improvement and is now rated Inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

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

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

Enforcement
We have identified breaches in relation to fit and proper persons employed, safe care and treatment, staffing, mental capacity and good governance and oversight of the quality of the service provided by Nayland Lodge at this inspection.

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

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

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below	**Inadequate**

Nayland Lodge

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team was made up of an inspection manager and two inspectors.

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

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

At the time of our inspection there had not been a registered manager in post for five years. A new manager had been in post for some months but had not yet applied to register.

Notice of inspection
This inspection was unannounced.

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 also reviewed the previous action plans submitted to us from the providers last three inspections where they had been in breach of regulation. We used all this information to plan our inspection.

During the inspection
We spoke to the Provider of the services, the manager, six member of care staff, one health and social care student and three people living at the service.

We reviewed care plans and risk assessments for the three people receiving a regulated activity.
We carried out an infection prevention and control audit of the service, as well as looking at a variety of records, policies and procedures used by at the service.

We spoke to the quality manager and reviewed a number of quality audits as well as environmental risk audits of the home to ensure that it was safe for people.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has deteriorated and is now Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- Staff told us they understood how to report concerns about potential abuse of people living at the service and completed incident forms when people had been placed at risk. However, there was no evidence of these being reported to the appropriate safeguarding bodies and incident forms did not demonstrate how people could be safeguarded from future risks.
- Not all staff had completed safeguarding vulnerable adults training. One told us they hadn't undergone any training but there had been a discussion around their previous training with other care agencies.
- Staff told us of incidents when they had had to lock themselves in the office or medication room due to risks from people living at the service. That other people living at the service would go to their rooms due to fear.

Due to a lack of systems and processes to keep people safe from abuse, people were placed at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
- The provider had not carried out robust recruitment processes for new staff.
- We reviewed the two most recent staff files and found that the appropriate checks had not been undertaken to insure that people were recruited safely. One staff member only had one reference where two were needed and Disclosure and Barring Service (DBS) information was not recorded. Another staff member had two references, but neither were from a previous line manager and both were from colleagues that they worked with. We had previously made recommendations about poor recruitment practices in June 2018, but no lessons had been learnt.

People were at risk of receiving care for people without the necessary safety checks and training. This was a breach of regulation 19 (Fit and Proper Persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us; "There's not always enough time to get everything done on shift." This was reflected in the poor cleanliness of the environment on the first day of inspection. Staff told us, "Following this inspection we have been told we would now be getting a cleaner."
- Some people were funded for 1:1 time, however staff told us that they were not always able to facilitate this. One said, "There's not enough time to do what people want to do. With the cooking and the cleaning,

there's too much. We have told the provider but nothing's happened."
● People living at the home had contacted the Commission to inform us that there was insufficient staff to do things they wanted to do.
● The provider had decided not to use agency staff to fill in any staffing gaps. This was despite staff reporting to managers in meetings in June 2022 and September 2022 that there was not enough staff to do the cleaning and they also raised concerns that people's needs were high.

There was not always enough staff to meet the needs of the people living at the service, including maintaining the cleanliness of the environment. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Staff kept medicines in a locked room with a locked trolley. However, topical creams were not always stored safely. One cream had been opened and was in use, but no date of opening was on it.
● People had as required "PRN" protocols in place to monitor the use of medications. This was an improvement; however, the effects of PRN were only recorded in daily notes not kept with medicine records. This meant important information like the assessment of if the medicines used was effective was not always to hand for staff making decisions about whether PRN medication would be helpful, and oversight of those records were not taking place.
● Staff had not completed medication audits to ensure that medicines were being provided safely. Not all staff administering medications had received competency checks. One told us, "I haven't been observed." However, incident forms demonstrated some errors where people had been given someone else's medication. Whilst initial actions to safeguard people health were taken and recorded on the incident sheet, there was no evidence of learning.

Processes to ensure safe administration of medication were not robust. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Peoples risk assessments had not been reviewed since 2020 and actions for how staff should support people in distress were poor. For example, staff instructions to mitigate the risk of a person not taking their medicine was for the person to be compliant with medication.
● Staff had completed hospital passports for people who needed them. The information in one passport reviewed was inappropriate. A description for hospital staff on how to support a person with "challenging behaviour" detailed how the person was "challenging." Using words or phrases that label, belittle or depersonalise people can impact on how they are viewed.
● Care plans were out of date. Risk assessments and care plans indicated that one person was restricted from using the kitchen due to the risks they presented to themselves. However, staff had told us there were no restrictions to using the kitchen and the person was able to use it at any time.
● The manager told us that one person could cook their own meals, however the person's risk assessments and care plan documented that the person could not cook their meals safety.

Risk assessments and care plan interventions were not regularly reviewed and did not always inform staff how to care for people safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was supporting people living at the service to minimise the spread

of infection. The home in some areas needed a deep clean with door frames heavily soiled with dirt and people's rooms had areas that needed repairing.

● One person showed us their bedroom. Their en-suite was not kept in a clean condition and plug seals were needing repair. Paint was flaking in areas and this caused an infection control risk.

● The medicines room was cluttered and in places dirty. The door frame had not been cleaned for some time and dirt had built up in high touch areas. The desk, notice board, and floor were dusty and dirty. Staff said, "We don't clean in here often as it's not a place where service users come."

● Care staff were responsible for the care of people, the cooking, updating paperwork relating to peoples care notes and cleaning. Staff told us, "I know the cleaning needs to be better but, today we have a member of staff off sick."

● The service had a number of soap dispensers around the building for people, staff and visitors to use to mitigate the risk of infection, but we found two were empty.

● The manager carried out handwashing checks but had not identified that some staff were wearing long painted nails which was contrary to the providers infection prevention and control policy and guidance for health care workers.

● The provider and staff at the service had not considered a link between the recent Covid outbreaks in the home of people and staff and the cleanliness of the environment. Cleaning audits had been poorly kept and staff were unable to locate them. We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We announced the second day of inspection on the morning of the visit, two days after the first visit. On arrival the service was looking cleaner. However, a member of staff told us, "I was called in to clean when they knew you were coming back today." No cleaning had taken place following concerns raised on the first day of inspection.

Poor cleanliness of the environment meant people were at risk of catching infections. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

● The provider's approach to visiting did not align to government guidance. The home had experienced a Covid outbreak and they had closed the home to visitors

● The governance lead told us that the provider had acted to prevent distress to people living at the home, but no assessments had taken place to evidence that people had requested that no visitors be admitted whilst Covid was in the service. One person was upset that inspectors could visit during a Covid outbreak, but their relative could not. They told us, "Why can you come in when my (loved one) can't."

● This impacted on people's ability to see loved ones or have their named visitor. We have discussed this with the provider, and they have updated their visiting policy.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to Requires Improvement.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff were not always working within the principles of the MCA and if needed, appropriate legal authorisations were not always in place to deprive a person of their liberty.
- The service was locked at all times to prevent a person leaving who had their liberty deprived under a DoLS. This meant that people could only leave if staff let them out.
- Staff told us there were some people not under a DOLS that they felt would be unsafe leaving the home and they would persuade them to stay if they tried to leave. Staff told us, "(Name) wouldn't be safe leaving the home. Perhaps they should be on a DoLS."

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

- One person was restricted in how many cigarettes they could have during the day. No capacity assessment had been carried out and staff told us this had been done because of family and medical advice. The manager told us they would complete a review to ensure that consent and right to change their mind was documented.
- People were not allowed to bring alcohol or drink alcohol in the service, despite it being their home. Staff told us, "We do have people that like a drink and we will sometimes support them to the pub, but we can't have it in the home as some people would be at risk." They also told us, "We haven't been able to go out for a while as some people have had Covid and we haven't always got enough staff to take people." This meant

that some people's rights had been infringed.
● The provider had CCTV at the service for communal areas. They had not asked for peoples consent to be monitored on CCTV. The providers own policy detailed that consent must be undertaken in line with legal requirements, but the provider was not aware of their own policy content. They told us they would review this following inspection.

Staff and senior leaders lacked understanding around mental capacity and consent. This meant that people were at risk of inappropriate restrictions and deprivation of liberty. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● The staffing training matrix used to identify what training staff needed and when they had been trained, showed that all staff working at the home had significant gaps in mandatory training. The manager told us the training matrix was not correct and that staff had been trained and competency assessments carried out. However, despite requests, no evidence was available to demonstrate this.
● Staff told us that induction was not always robust. One said, "The biggest problem is having the time to do it, it's impossible if there's only a couple of members of staff and you." Another told us, "I was given log in details for online training and the Care Certificate. I haven't done it all, there's not enough time in the day."
● Staff meeting minutes documented that staff felt they were not equipped with the skills needed to support people who may present at a risk of harm to self and others. One member of staff told us, "We were promised it, but it never happened," and "We definitely feel unsafe," and "We did restraint training about 6 months ago, not sure what level it was but it wasn't good enough for the clients we have now."
● Staff expressed concerns that training needs were not addressed in a timely way. One said, "We have been asking for it since August, we always get the same answer – 'It will happen when we do the changeover.'

Staff had not undergone the appropriate induction and ongoing learning and development and competency checks. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff carried out most of the cooking and cleaning at the service. It was not clear how people were being supported to develop their independence, which was contrary to the provider statement of purpose which stated objectives of a placement at Nayland Lodge was to "Respect and encourage the rights of all service users," and to help service users to achieve "their optimum state of health and well-being." Staff told us they did not always have time to support people in activities.
● People had access to a range of drinks and snacks throughout the day. Only one meal choice was recorded on the menu in communal areas, but people told us, "If I don't want it staff will make me something else."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service had developed good relationships with the local GP practice and were able to access support from medical professionals when they needed it.
● Staff supported people to attend hospital and other health related appointments when they needed that support. For example, access to a dentist.
● The provider told us they had, had difficulties accessing support from community mental health and emergency services. We encouraged the provider to raise these concerns with providers of these services and the Care Quality Commission.

Adapting service, design, decoration to meet people's needs

● People receiving personal care did not want us to enter their bedrooms, however one person living at the service showed us their room. They had been able to personalise their bedroom to their taste.

● Communal areas had improved, and people told us they liked the decoration. One told us, "I decorated the Christmas tree, it's nice isn't it."

Inadequate

Is the service well-led?

Our findings

Our findings - Is the service well-led? = Inadequate

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.
How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;
● The provider had poor governance systems in place to identify where things had gone wrong and what actions taken. Records were kept in a chaotic manner that did not ensure that lessons were learnt, and incidents could be identified, managed and learning disseminated to staff teams in a timely way.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● The previous manager and responsible person had left the company in August 2022 and staff did not have access to their quality records and none had been completed since that time.
● The current manager told us, "It has been difficult to get on top of it (oversight of quality) but we have been filling in staff shifts."
● At the time of inspection there were no responsible registered persons at the service.
● The provider told the inspection team on the first day of inspection that the governance lead for the service carried out quality audits at the service. However, the governance lead told us that managers carried out quality audits. Quality audits had not taken place for some time and they were not easily found by the manager.
● Staff had not always completed audits and checks at the service to monitor the quality and safety of the service. The manager had not had oversight of these audits to identify they were not being completed, for example environmental and fire safety audits.
● There had been frequent management changes at the service who had been without a registered manager for five years. The provider had not taken appropriate actions to ensure that there was a registered manager at the service.
● Following inspection, the manager of six months applied to register. However, they were also managing another home and due to short staffing had been working care shifts, so the quality overview of the service had been poor.
● The provider was not displaying their ratings in the service and on any other platforms such as websites in accordance with their regulated responsibilities.
● Staff told us that the manager at the service listened to their concerns but was not always been able to address them.

● Some gave examples of when quality concerns had been raised around staffing, cleaning responsibilities and training needs that impacted on care people received but had not swiftly acted on. One said, "The manager is good, but the director has the last say."
● Statutory notifications had not been made to the commission since 2021, however incident forms demonstrated medication errors, near misses and episodes of distressed behaviour of some people using the service that placed others at risk.
● The provider had failed to implement action plans submitted to CQC from each of the three previous inspections that detailed how they would be compliant with the fundamental standards of care.

There was a significant lack of governance and oversight of the quality of the service provided to people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was a significant lack of progress in place to demonstrate that people's needs had been met. There was no process in place to ensure that risk assessments and care plans were reviewed in line with the providers action plan that they had submitted to the commission following three consecutive breaches of good governance.
● Staff did not record comprehensive records of how people's needs were being met and developed. Some daily handover notes and records lacked any information of meaningful and fulfilling activity.
● The provider had a poor understanding of Registering the Right Care, Right Culture, Right Support for people with a learning disability and autistic people. Whilst people living at the service had mental health conditions, a number also had a learning disability. More was needed to engage people with activities and opportunities outside the service.
● The Provider spoke of one person potentially moving to another of their services. When challenged about offering choice outside of the providers services, the Provider said they hoped that they had done enough to support the person to want to stay with their services. There was no evidence to demonstrate that choice and alternative opportunities had and would be been given.
● The environment did not always support people's diverse needs. One person told us, "I am dyslexic and cannot read these signs up." There had been no consideration of how to identify and manage peoples individual needs to ensure the best communication and engagement.
● The Provider had told us of working with the local councillor to improve interaction with people in the local community and people living at the service, however there was little information or evidence to identify how this had benefited people.

The provider had failed to demonstrate how people's needs were being met in line with right care right culture and right support. This was a breach of Regulation 9 Person Centred care.

Working in partnership with others
● The provider told us that they had difficulties accessing support from mental health services for people in distress and often had to manage this alone. We encouraged the provider to feedback concerns to the commission.
● The provider had good relationships with primary medical services when people required support from their GP.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to demonstrate how people's needs were being met in line with right care right culture and right support. This was a breach of Regulation 9 Person Centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff and senior leaders lacked understanding around mental capacity and consent. This meant that people were at risk of inappropriate restrictions and deprivation of liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not undertaken safe recruitment checks in line with employment law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the appropriate induction and training, and ongoing training and quality observations.