Shaw Healthcare Limited

The Martlets

Inspection report

Fairlands
East Preston
West Sussex
BN16 1HS

Tel: 01903788100
Website: www.shaw.co.uk

Date of inspection visit:
14 October 2019
15 October 2019

Date of publication:
19 December 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Martlets is situated in East Preston, West Sussex and is one of a group of homes owned by a national provider, Shaw Healthcare Limited. It is a residential 'care home' for up to 80 people some of whom are living with dementia, physical disabilities, older age or frailty and who require support with their nursing needs. At the time of the inspection there were 77 people living in the home.

People's experience of using this service and what we found
People's safety was not always maintained. Medicines were not always administered according to prescribing guidance or people's assessed needs. People who required a modified diet were sometimes provided with high-risk food that increased the potential risk of choking. Staffing levels were not always sufficient and people, relatives and staff provided consistent feedback that people often had to wait for support due to the levels of staffing. Lessons had not always been learned and improvements implemented when care had not gone according to plan. Infection control was maintained, and the home was clean.

People, relatives and staff were not complimentary about the provider's systems and processes. They told us they were inflexible, and people were not cared for in a person-centred way. The provider's aims and values were not always implemented in practice. Quality assurance processes were not always effective and had not always identified shortfalls that were found as part of the inspection. Learning from the reoccurring themes that have been found at some of the provider's other services within the Sussex area had not always been shared to ensure improvements were made. The provider was working in partnership with external health and social care professionals to help ensure improvements were made to the delivery of care. People, relatives, staff and an external health professional praised the practice of the registered manager and told us that they valued the efforts they had made to improve the care people received.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People were supported by staff that had not always had access to training that the provider considered essential for their roles and that would enable them to provide effective care to meet people's specific needs. For example, people who were living with dementia were not always supported in a way that met their needs or in accordance with best practice guidance. The provider's procedures when employing agency staff were not always demonstrated in practice and competency assessments had not always been completed before they started work. People had access to external health care professionals and were supported to maintain their health. People had access to enough food to ensure they received a balanced diet.

People's privacy and dignity were not always well-maintained, and they did not always receive respectful or person-centred care. People's needs had been assessed but the support provided had not always met their assessed needs. People did not always have access to meaningful occupation and interaction with staff. Some people spent extended periods of time without interaction or stimulation with others. People told us

that staff were kind and caring and they were complimentary about staffs' compassionate nature. Most observations showed staff were considerate and caring.

We have made a recommendation about providing appropriate and meaningful environments for people living with dementia.

Rating at last inspection and update
The last rating for this home was Requires Improvement. (published 18 October 2018). There was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, not enough improvement had been made and the provider was in continued breach of the regulation.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have found evidence that the provider needs to make further improvements. We have identified six breaches in relation to person-centred care, privacy and dignity, need for consent, safe care and treatment, staffing and the leadership and management of the home. You can see what action we have asked the provider to take at the end of this full report.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

The Martlets

Detailed findings

Background to this inspection

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

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

Service and service type
The Martlets is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The home had a manager who was registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We liaised with health and social care professionals for their feedback. We had not asked the provider to submit a provider information return (PIR) since the last inspection. A PIR is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection

We observed the care and support people received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 18 people and 10 relatives, nine members of staff, the deputy manager, the registered manager and the regional operations manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care and medicine administration records for 28 people. We looked at one employed staff and six agency staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the home, which included policies and procedures, were also reviewed.

After the inspection
We were contacted by an external healthcare professional who shared their experiences with us. We sought assurances from the registered manager and the provider in relation to staffing levels and people's care.

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, this key question was rated as Good. At this inspection this key question has deteriorated to 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; Using medicines safely

- Medicines management was not always safe. One person had stayed at the home for respite care and required medicines for their mental health. Staff had made an error when transferring information about the person's medicines into the electronic medicine system. The person had gone without their medicines for six days. Prescribing guidance for the medicine advised that it should not be stopped suddenly as this could increase the risk of the person experiencing an adverse effect.
- There was one member of staff responsible for administering medicines on each floor of up to 30 people. They told us they were busy and the morning doses of medicines would often not be completed for all people until lunchtime. This meant that some medicines were not always administered according to the prescribing guidance. Three people were living with dementia and had been prescribed medicines to help manage their condition. Prescribing guidance advised to take the medicine at the same time each day to ensure its effectiveness. Records showed that these people were sometimes receiving their medicines outside of the guidance.
- Two people were living with dementia and may not have been able to communicate that they were experiencing pain. They had been prescribed pain medicines four times a day. As staff had not administered their first dose of medicine until later than the prescribed time, there was not enough time left in the day for them to receive all doses of their medicine. Both people had not received their final dose of medicines as they were asleep before the medicines could be given.
- One person was living with diabetes and had been prescribed medicines to help manage their condition. They had not always received their medicines according to prescribing guidance which advised that it should be taken with food or shortly after. Records showed that the person had not always been supported to have their medicines when they had eaten as the guidance had advised, and this increased the risk that their health condition would not be well-managed.
- Before the inspection the provider had notified us of a safeguarding enquiry being conducted by the local authority. One person had been assessed by a Speech and Language Therapist (SALT) and required a modified diet and thickened fluids to reduce the risks of choking. During a review, the local authority had identified that the person had been given foods that were not in accordance with SALT guidance which placed the person at increased risk of choking. At this inspection, another person had been assessed by a SALT who had recommended a modified diet and thickened fluids. The person had been assessed as being at high risk of choking on certain foods. Records showed, and staff confirmed, that the person had been admitted to hospital with Aspiration Pneumonia, a breathing condition in which there is a swelling or infection of the lungs or large airways. This can occur when food, saliva, liquids or vomit is breathed into the lungs or airways. When the provider was asked for evidence of what the person had eaten prior to their hospital admission, to enable us to determine if they had themselves chosen to eat food that was not in

accordance with their assessed needs or if they had been provided with this by staff, the provider was unable to locate the records or provide assurances. Guidance provided by the SALT informed staff of different foods to avoid. This included jelly and ice-cream as the food could melt and become too thin and bread, all of which could increase the person's risk of choking. Despite the person having a hospital admission, for which the cause of the condition could not be ascertained by the provider, records showed that following this they had been provided with ice-cream and toast. This had not been identified by staff and placed the person at increased risk of harm.

● There was a lack of oversight to ensure some people were hydrated. Some people were not being supported to have enough fluids to help maintain their health. The provider used an assessment to determine the recommended daily fluid allowance that people should be supported to consume. This did not take into consideration people's individual condition or health needs and there were consistent times when three people were receiving a much lower quantity of fluid than their assessment advised. It was not always apparent that staff had identified this and when they had what action had been taken when people were consuming very low amounts of fluids.

There have been reoccurring themes within some of the provider's other services within the Sussex area, particularly in relation to unsafe medicines management and people who require modified diets being given high-risk foods. The provider had not ensured that this shared learning was implemented in practice. People were not always receiving safe care and treatment and were sometimes placed at increased risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home was large and accommodated up to 80 people. Most people had received safe care and treatment and told us that they felt safe and secure.

● People were supported by staff to safely move and position when they required assistance with their mobility or repositioning. The provider had worked with an external moving and positioning advisor and improvements had been made to the guidance available to staff. For example, photographs and clear instructions of the types of hoists and slings were provided.

● People at risk of malnutrition had received safe and appropriate support to maintain their weight and ensure they were provided with appropriate nutrition. The registered manager monitored people's weights to ensure people were appropriately supported if they experienced an unplanned weight loss. Food had been fortified with milk, cream and cheese to increase people's calorie intake and they had access to prescribed supplements to ensure they had sufficient nutrition.

● The provider had improved their practice and oversight in relation to other reoccurring themes across some of their other services. For example, people living with Parkinson's disease received their medicines according to the prescriber's instructions.

● People were involved in discussions and their right to take certain risks was respected. For example, people at risk of falls were able to continue to mobilise independently. The provider had ensured they had access to appropriate equipment and means of calling for help should they require assistance.

● Equipment was regularly checked to ensure it was safe to use. Plans ensured that people could safely evacuate the building in the event of an emergency.

Staffing and recruitment

● Staffing levels were not always sufficient to meet people's needs. People, relatives and staff told us that there were not enough staff. Some felt that there was enough staff to meet people's basic care needs but that people had to wait for support. When asked if there were enough staff one person told us, "No, you wait a long time for things - the toilet, you wait ages."

● Staffing levels were not always aligned to people's assessed level of need. The provider did not use a

dependency tool to determine people's needs and how much support they required from staff. The registered manager had made efforts to assess and consider people's needs to ensure that the available staffing levels were deployed to their best effect. Staffing levels on some occasions raised concerns about how people's assessed needs could be met in a timely way by staff. Staffing rotas at night showed that there were eight support workers deployed across eight units of up to ten people. These members of staff supported people with their personal care and moving and positioning needs. In addition, there were two team leaders and a registered nurse, who were responsible for supervising staff and overseeing up to three units of the home each. They supported people with their nursing needs and administered medicines. Some people had been assessed as needing two members of staff to support them with their mobility. This meant that if they required support a member of staff would have to leave their unit to support the other member of staff, therefore potentially leaving their unit without a member of staff to support other people who might need support with their mobility or personal hygiene needs. A relative told us, "There is not so many staff at night and some people need two so sometimes there is a long wait." A member of staff told us, "The night staff complain there is not enough staff at nights for people's needs." One person told us, "At bedtime they always seem to be short. It is noticeable that people are waiting to go to bed. Some people go to bed later than they would choose to. Some people wait quite a long time." People told us that staff did their best but that this did affect the timeliness of the support they received. One person, who was asked if there were enough staff told us, "No, there's not. There are times when I need hoisting and that needs two people. You get the message you have to wait a bit. It infuriates me that their record keeping takes priority over most things. Sometimes it's not possible to wait. I've got to go to the loo. It's a problem."

● People told us that the skills-mix of staff was not always well-considered. One person told us, "Some are good, but some aren't. Some are noticeably not. There's been some horrendous moments when there has been two inexperienced staff on the floor the whole time. They need to put an inexperienced one with an experienced one. If they're inexperienced you have to tell them what to do the whole time. I don't feel unsafe, but it's uncomfortable and bloody annoying."

● People and relatives told us that some staff were busy and task-focused and were unable to spend time with people to meet their individual, emotional and social needs and our observations confirmed this. Two people told us that they felt that they were not supported to retain the skills they had because of staffing levels. They explained that they required two members of staff to support them to walk and that they were not supported as staff were too busy.

● We observed that staff did not always have time to spend with people and although in the vicinity where people were, they were busy with tasks and completing documentation and there were missed opportunities for interacting with people. One person told us, "Staff don't have a lot of time. It's not their fault, there are too few of them. I have in the past been to the shop with one of them but when I asked last time they were too busy to go." Another person told us, "There is a shortage of staff, they say I've got to 'do' so and so as well as this and that." A third person told us, "I have had to wait from 08:30 until 11:40 for some toast and to have a wash. There are only two members of staff here at the moment for up to 15 people."

● Staff told us that they wanted to spend more time with people yet felt frustrated and unable to do this due to the staffing levels and the processes expected of them. One member of staff told us, "We like to sit and talk to people, but we don't always get as much time now, there is so much paper work."

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

● Following the inspection, concerns were raised with CQC that the provider had made the decision to reduce the staffing levels further. When this was raised with the provider they explained that staffing levels had been increased prior to the inspection to meet people's increased needs. The occupancy level had

recently reduced, and staffing levels had been lowered to reflect this. It was not always apparent how people's needs had been considered before this change had been made as some people still required two members of staff to support them with their needs and new levels of staffing meant that some units of up to 10 people were staffed by one support worker.

● The provider had assured themselves that staff were of good character and suitable for the role before they started work. Recruitment processes had been revised to help the provider to appoint staff who shared their values. A member of staff told us that this had improved the quality of staff that were being recruited as it enabled more insight into the staff member's values and caring nature.

Systems and processes to safeguard people from the risk of abuse;

● One person had not always been protected from the risk of abuse. The provider had not ensured that timely action was taken when one person had experienced unexplained bruising. One person who was living with dementia had sustained large, unexplained bruising to both their forearms. Staff had identified this and demonstrated good practice by documenting the injuries and passing on the information to senior staff who had not considered the unexplained injuries as part of their safeguarding guidance. Five days after staff had identified the injuries, an external healthcare professional identified the bruising and raised a safeguarding referral to the local authority for them to consider as part of their safeguarding duties.

● Despite this example, staff understood the signs and symptoms that could indicate that people were at risk of harm. The management team had shared other information with external health and social care professionals when they had identified concerns about people's safety and had worked alongside the local authority to assist them with their enquiries.

● People told us they would speak to staff if they had concerns and felt comfortable doing so.

Learning lessons when things go wrong

● The provider has not always ensured that any shared learning found as part of inspections of some of their other services within the Sussex area, have been implemented in practice. On-going and reoccurring themes have been found in relation to the understanding and implementation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), people who required modified diets having access to high-risk foods and unsafe medicines management.

● Before the inspection, the provider had notified us of a safeguarding referral they had made in relation to one person. The person had not been supported in a timely way by community nurses who had not always ensured that their wounds were treated according to their assessed needs. The provider had informed us that they had improved the systems in place to provide them with greater oversight so that they would be able to recognise when community nurses should be providing care and therefore take timely action if there were concerns, this was observed in practice.

Preventing and controlling infection

● People were protected from the spread of infection. Staff used protective equipment and disposed of waste appropriately. The environment was clean, and people told us they were happy with the cleanliness of the home.

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

● Staff responsible for preparing food had received appropriate food hygiene training.

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 the last inspection, this key question was rated as Good. At this inspection this key question had deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff's skills and competence had not always been appropriately considered. The provider had introduced moving and positioning and medicines competency assessments for agency staff. At this inspection, this had not always been implemented in practice and the provider had not assured themselves of agency staff's competence before they started to support people. During one night in October 2019, there were eight support workers working, five of whom were agency staff who had not had their competence assessed. The management team were in the process of ensuring that all agency staff had their competence assessed before they started work to help provide assurances that they could support people safely.
- The provider had not always assured themselves that staff had the appropriate knowledge and understanding to support people according to their needs. Records showed that training which the provider considered essential, had not always been provided to all appropriate staff. For example, three units of the home were for people living with dementia, according to the information supplied, 59% of staff had not undertaken training to help ensure they had the appropriate skills to support people effectively. Observations of some staff's practices raised concerns about their skills when supporting people living with dementia. A relative told us they had overheard a member of staff speaking to a person who was living with dementia in an inappropriate way, when the person was asking staff repeatedly where their slippers were, the member of staff was heard saying, "I've told you three times already – they are in the wash."
- There had been an increased focus by the provider, the local authority and clinical commissioning groups to improve the quality of care planning, to help ensure that people's needs were appropriately identified, assessed and planned for. The provider had identified a learning need for staff and had introduced a specific training course for understanding care planning. According to the information supplied, this had not been implemented and staff were yet to complete the training.

The provider had not always ensured that staff were suitably qualified, skilled and experienced to meet people's assessed needs. This contributed to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was mixed feedback from people and relatives about staff's skills. People told us that agency staff sometimes lacked the skills and knowledge to support them effectively and this had at times made them feel worried or not confident that their needs would be met safely or effectively. Four people told us that most staff were skilled and worked hard to meet their needs, but they felt that more could be done to ensure that less-experienced staff worked alongside staff who were more experienced to help ensure staff were supported to know their needs and gain appropriate skills.

● The management team informed us that training on how to support people effectively when they are living with dementia, was in the process of being improved as staff had previously completed on-line training. The provider had identified that the quality of training needed to improve to help staff's skills and was in the process of arranging face-to-face training to staff.
● The provider had worked with the local authority and had encouraged staff to undertake courses provided by them to further develop their skills. Shared learning had been encouraged and the provider had worked alongside the local authority and the clinical commissioning group to help improve staff's awareness of assessing people's needs and providing appropriate care.
● The registered manager had introduced champion roles which enabled staff to specialise in topics related to people's care needs and share this with other members of staff.
● Staff told us they felt well-supported by the management team and that they were able to approach them for support and guidance.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● There have been reoccurring themes in the provider's other services in the Sussex area in relation to their understanding and implementation of MCA and DoLS. At inspections of their other services, it had been identified that when people had a condition that had the potential to affect their decision-making abilities, staff had not always assessed their capacity to make specific decisions and had not always worked in accordance with MCA. This had included consent for bed rails and influenza injections.
● We found the provider had not always applied this learning. According to the information supplied, 36% of staff had not undertaken MCA and DoLS training. Two people were living with dementia and used bed rails to help ensure their safety. Staff had not assessed their capacity to consent to this themselves and instead a member of staff had decided on people's behalves. This was not in accordance with MCA.
● We were provided with a list of names that had been given to the GP to state who was required to have the influenza injection. Some people on the list were living with dementia and this might have affected their ability to fully understand and consent to the injection. Staff told us they had not assessed their capacity to consent to the injection and had instead spoken to people's relatives to establish if the person had received the injection throughout their lives and had then gained their consent. When staff were asked if these people had Lasting Powers of Attorney (LPA) for health and welfare, to enable them to have the legal authority to make decisions on people's behalves, a member of staff told us that sometimes they did not and that if this was the case a member of staff would make a best interests decision for the person. This was not in accordance with MCA as staff had not assessed people's capacity to consent to the injection themselves before making best interests decisions collectively with others involved in the person's care.
● Some people had conditions associated to their DoLS. It was not always evident that these were being met. One person's DoLS condition required staff to provide activities and interests that reflected the person's life history and preferences. The provider could not demonstrate how this condition was being met.

The provider had not always supported people appropriately to enable them to provide their consent. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection, there was improved oversight of DoLS and people who were unable to consent to receiving constant support and supervision, had an appropriate DoLS application made.

Adapting service, design, decoration to meet people's needs
● The environment did not always help people to navigate their surroundings and people did not always have access to objects that were meaningful or provided stimulation or orientation. For example, three units of the home were for people who were living with dementia. There were minimal prompts to aid people's orientation in line with best practice guidance when supporting people who are living with dementia. White boards, and printed menus which informed people of menu options, did not provide information in a way that would support some people living with dementia to understand and we observed that some people were confused as to the options available to them.

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

● People had adequate space to move around the home. People were observed mobilising independently with their mobility aids. One person told us, "I use a walker and I have got a wheelchair. I can get about the home in that no problem."
● People had private rooms if they wished to spend time alone or receive visitors in privacy. People had been encouraged to personalise their rooms with items that were important to them. This helped to create a more homely atmosphere.
● Regular meetings enabled people to be involved in on-going discussions about the home. People told us they had been consulted and involved in decisions. One person told us, "They put in a new carpet, they came in with a wallet of samples and I chose, which was nice." Another person told us, "They asked me what colour I'd like on my walls. I said I'd like the same colour I had at home. It's nice and bright and clean and looks bright on a dull day. They were very nice about it."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care
● People's needs were assessed according to best practice guidance. The provider had worked with external health and social care professionals to reassess and review people's needs to ensure there was a better focus and emphasis on people's care needs and preferences. This had helped ensure that people's needs were effectively assessed.
● The provider had recognised that staff were not always provided with accessible information about people's assessed needs. They were in the process of implementing a new care planning system and had identified that person-centred information was not always available to staff in an accessible format to enable them to provide person-centred care. This was of relevance due to the use of agency staff and new staff who did not yet know people's needs. Some people's care plans contained a brief overview of their needs to provide clear and accessible information to staff. Staff told us they found this useful as they could easily find information to inform their practice.
● People's physical needs had been assessed and people were provided with equipment to enable them to be treated equally with others. For example, when people had physical disabilities they had access to hoists or mobilising wheelchairs to support them to move and position.
● Technology was used so that people were able to call for staff's assistance by using call bells. For people

who were unable to use call bells, due to their level of understanding, sensor mats were used so that when people stepped on these, staff were alerted and were able to go to the person's aid.

Supporting people to live healthier lives, access healthcare services and support;
● People were supported to maintain their health. The management team had implemented systems to help ensure people's health was promoted and maintained. For example, there was an increased focus on people's nutrition.
● People told us they had access to external healthcare professionals to help maintain their health and to seek medical assistance if they were unwell.

Supporting people to eat and drink enough to maintain a balanced diet;
● People provided mixed feedback about food. Three people told us they disliked the food and there was limited flexibility and choice. A further three people told us they enjoyed the food and it was well-cooked.
● When people required a modified diet and had their meals softened or pureed, staff had ensured that these were presented in an appetising way. Each item of food had been pureed and presented as separate portions on the plate so that the person would be able to differentiate the types of food.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection, this key question was rated as Good. At this inspection this key question had deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Two people were not supported to have their medicine administered in a manner which respected their privacy and dignity. One person was living with dementia, they were sitting at the dining table with others when a member of staff pulled down the person's jumper to apply a topical cream, exposing their shoulder and upper chest. The member of staff did not ask the person if they would prefer to go to their room and had instead administered the cream in front of others without considering how this might impact on the person or those around them. Another person who was living with dementia, was sitting in the lounge watching a film with other people. The same member of staff administered eye drops to the person without asking them if they would prefer to have these administered elsewhere, away from others.
- People were in the dining room eating their lunch. One member of staff was overheard using a person's name and informing other staff that the person had opened their bowels. They had not considered the impact that this might have on the person concerned or on others who were eating their lunch. These actions did not demonstrate respectful care and did not maintain people's dignity or privacy.
- One person who was living with dementia, was showing signs of apparent anxiety. They were sometimes swearing and raising their voice. Two members of staff were sitting in the same room as the person completing documentation. They were observed laughing at the person and did not attempt to interact with them to offer reassurance or support. This was not respectful and did not demonstrate dignified care.
- Some relatives fed back that they noticed a difference in their loves one's appearance when they had been supported with their personal care needs by night staff. One relative told us how their relative's vest had been put on over one arm with the rest hanging around the person's neck, their blouse had then been placed on top. Another relative told us that when they have visited they have been upset to see their loved one's clothes inside out, their hair not brushed or that they had not been shaved.

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

These observations were fed back to the management team who informed us they would raise these with the members of staff concerned to help their understanding of the importance of respectful and dignified care.

- Most interactions and observations between people and staff were positive and respectful. The management team had focused on encouraging staff to demonstrate person-centred care. One person who

was living with dementia, sometimes used English as their second language. Some staff were observed using key words and speaking to the person in their preferred language. The person appeared to enjoy this interaction as they were observed smiling and interacting with staff.

● Most staff spoke to people in a kind and caring way, taking time to explain their actions and ensure people's comfort. People and relatives told us that staff were compassionate. One person told us, "The staff say, we love you." Another person told us, "It's all good, the staff are kind." A relative told us, "My relative is well-loved – they all love them."

● People's differences were considered, and support was adapted to ensure people received equal access to the care provided. Independence was respected and encouraged. People were observed mobilising independently around the building using their mobility aids. People who required adapted crockery and cutlery were provided with suitable equipment to enable them to remain independent when eating and drinking. One person told us, "I make my own bed, it takes time and I have to sit down but they let me get on with that."

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

● People were supported to have contact with their family and friends. Relatives told us they were always made to feel welcome and were able to share meals with their relatives or stay the night if their relative's health deteriorated. Some people had access to mobile telephones to enable them to maintain contact with family and friends without needing to be supported by staff.

● Handover meetings, where staff discussed people's care needs, were conducted in offices so that people's privacy was maintained. Information held about people was securely stored in locked cabinets and offices.

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

● People told us they were involved in day-to-day decisions that affected their care and our observations confirmed this. People were asked what drinks they would like or what they would like to wear. People were observed wearing clothes of their choice that reflected their individuality and preferences.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection, this key question was rated as Requires Improvement. This was because people spent large amounts of time with little to occupy their time. We recommended that the provider sought information and guidance from a reputable source to improve person-centred care and people's access to meaningful stimulation and engagement. At this inspection, this continued to be a concern and this key question has remained the same. 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; Meeting people's communication needs; 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

- One person who had stayed at the home for respite care, did not receive person-centred care to reflect their assessed needs or preferences. The person was living with dementia and due to this and other health conditions, was unable to verbally communicate their needs. Their relative had provided staff with a booklet about the person's life as well as a communication book so that these could be used to interact with the person. Staff had not been provided with this information and were unaware that these resources were available. Records completed by staff showed that they had at times struggled to communicate with the person.
- The same person was a vegetarian. This had been identified during discussions with the person's relative when they first moved into the home. This information had not been provided to staff verbally or within records that were easily accessible to them and one member of staff told us that despite the person staying at the home for a week they had only found out the previous day that they were a vegetarian. Daily records, to document the food that had been provided to the person, showed that on one occasion they had been supported to eat a beef burger. This was not in accordance with the person's expressed needs and preferences and did not demonstrate respect or person-centred care.
- One person, who was living with dementia, was not always cared for in a dignified manner that met their assessed needs. Guidance had been provided for staff which advised them that the person required support and prompting to maintain their personal hygiene. The person was observed to have very long, and visibly soiled nails and they were unshaven. Records to document the care the person had received stated that they had been supported with their personal hygiene, yet it was not apparent that care staff had identified that the person's nails were long and soiled or that the person had not shaved, neither was it apparent that the person had refused support. This did not demonstrate respectful or dignified care and was not in accordance with the person's assessed level of need. This was fed back to the registered manager who provided assurance that the importance of meeting people's assessed needs would be fed back to staff.
- One person who was living with dementia, had a health condition that affected their mobility and had been assessed as being at high-risk of falls. Guidance for the person advised that they should be supported to wear their glasses and use a walking frame to minimise risks. The person was observed not wearing their glasses and being supported by a member of staff to walk across the room whilst holding the member of staff's hand. When the person's relative asked the member of staff where the person's glasses were or where

their walking frame was, we observed the member of staff being dismissive and they explained that the person forgot to wear their glasses and walked better without their walking frame. Another member of staff heard this and asked the member of staff supporting the person to find their walking frame. On the second day of inspection the person was not wearing their glasses again. When this was raised with staff they stated that the person forgets to wear them. It was not apparent that staff had attempted to remind the person or retrieve their glasses for them so that they were available should they choose to wear them. The person was not being supported in a person-centred way that met their needs or helped to reduce known risks.

● People told us that although there were planned, group activities, for those that chose not to partake there was little to occupy their time. People told us that although staff were kind and caring they did not take time to interact or spend time with them. One person told us, "There is no time for them to sit and talk. If I initiate a conversation, they talk but I don't do that very often. I don't depend on staff for companionship." Observations showed that people spent large amounts of time unoccupied with little stimulation and interaction. Staff were busy and task-focused and there were missed opportunities to interact with people.

● People told us that apart from initial assessments related to their care, they were not always involved in discussions about their care to ensure they were happy with the support they received or if they required any changes to be made. Reviews of people's care had not always been completed in a timely way to ensure that any changes in people's needs were identified and staff were provided with current guidance. Reviews that had occurred had been conducted by members of staff and it was not apparent what involvement people and their relatives had in the process. One person who had stayed at the home for respite care told us they had not been asked if their needs were being met or if they were happy with the care that had been provided.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Some people were living with dementia. Information was not always provided in a way that supported them to understand and make choices. People were asked to choose their meals for the following day. Some people were able to make this choice and staff respected their right to change their mind on the day if they preferred an alternative option. This approach did not accommodate some people who were living with dementia who might find it hard to remember what they had chosen the previous day. The Social Care Institute for Excellence states, 'As dementia progresses a person might have difficulty choosing and deciding on the food they want to eat. Calling out a list of options can be confusing and difficult for the person as they may not recognise what the food is from hearing the words alone'. One person who was given their meal was heard saying, "I am not in favour of this." The person explained that they would have asked for something different if they had known what they were having. The person's meal was taken away uneaten and they were provided with a pudding instead.

● Information had not been adapted to meet the needs of some people living with dementia. Complaints procedures as well as an annual survey that were sent to people, had not been adapted to provide a more user-friendly way of enabling people to share their views.

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

● Work was ongoing to ensure that all people had equal access to sources of stimulation and interaction. The provider planned to work with social care professionals from the local authority to help enhance

stimulation for people to ensure they had meaningful, person-centred interactions with others.
● Observations showed people enjoyed watching films and having snacks. People told us about activities and events they had enjoyed. One person told us, "They did bring a sheep here. It had a nappy on!" Another person told us, "They took a group of people to the garden centre. We went to see the Christmas decorations and had a drink and a savoury. It is good to do things otherwise people fall into lethargy and sleep all the time." A relative told us that their loved one had been given a small game of golf which they had enjoyed playing as they used to play when they were younger, they had also been supported to have pub evenings which they had enjoyed. One person told us they had enjoyed playing darts. Other people felt that there needed to be more stimulation and events that were of interest to people. One person told us, "They do try but I haven't found any activities here I like. I'm surprised they don't have any connections with the community. You would think they would have connections with the church groups and someone could take you out."

Improving care quality in response to complaints or concerns
● The registered manager welcomed comments and issues of concern being brought to their attention. Records showed that when these had been received, these had been dealt with in an appropriate and timely way in accordance with the provider's policy.
● People and relatives told us that when issues of concern were raised with the management team that these were listened to and acted upon to make improvements.
● Surveys had been sent to people by the provider. These enabled people to comment on the quality of care they had received. The registered manager had analysed the responses and had written personally to people or relatives when issues were brought to her attention. This demonstrated that the registered manager cared about people's experiences and welcomed their input and suggestions for change.

End of life care and support
● People were able to plan for their end of life care. People and relatives told us they were supported during the end of their lives in a caring and compassionate way and our observations confirmed this. A member of staff told us, "We are compassionate and make sure they are not in pain. We also consider the relatives as this is a difficult time for them and they need support too. We are respectful and give privacy but they know we are here if they want us."
● Staff had worked with external healthcare professionals to ensure people had appropriate medicines so that their comfort was maintained.
● Compliment cards and letters had been received which thanked staff for their caring approach and attitude.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. This was because there were continued concerns about the provider's ability to maintain standards and to continually improve the quality of care. The home had been rated as Requires Improvement for a fourth consecutive time. At this inspection, we continued to have concerns and this key question has deteriorated 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

At our last inspection, the provider had not always assessed, monitored or improved the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we asked the provider to submit an action plan to tell us how they planned to improve. At this inspection, we found the provider had not complied with their action plan and not enough improvement had been made. We found new concerns and the quality of care people received had deteriorated. The provider was still in breach of this Regulation and has therefore been in breach of Regulation 17 at the last three consecutive inspections. The home has now been rated as Requires Improvement five consecutive times.

● There has been an increased focus on the provider's services within the Sussex area, by the provider, the local authority, the clinical commissioning group and CQC, due to ongoing concerns about their failure to address and improve reoccurring themes. Since the last inspection, the provider had acted to help make some improvements to the service people received. They had worked with external health and social care professionals and had employed dedicated quality improvement managers to help drive improvement. These professionals had worked with the provider to help make changes to ensure that the quality of care people received improved.
● The management team consisted of a registered manager and a deputy manager. The provider had tried to recruit a clinical lead to help ensure that the management team was sufficiently resourced and therefore able to effectively manage the home and the demands of managing a large service, but had not yet been successful. An operations manager regularly visited the home to offer support to the registered manager and to undertake quality assurance audits
● Following the last inspection, the provider had sent us an action plan to inform us of what they would do and by when to improve the quality of care people received and to continually improve the service provided. At this inspection, we found that the provider had not complied with their action plan and some aspects of the service had deteriorated further.
● The provider's values of wellness, happiness and kindness were not always demonstrated in practice.

Despite staff's motivation to provide person-centred care that promoted the values, we received feedback that these were not always implemented in practice. People, their relatives and staff consistently fed back that the provider's systems and processes were inflexible and at times decisions had been made that did not appear to have been made in people's best interests. One person told us, "There is an ethos of good caring, but some of them get overburdened by the demands made of them." People told us that the provider's procedures felt "Institutionalised" at times and that this led to them receiving inflexible care. One person told us that they sometimes liked to have bacon for breakfast. They explained that due to having to order their meals the day before they sometimes did not have this when they wanted it. Another person, who had a visual impairment, told us that the light bulb that had been provided was too dark for their room. When they raised this with staff they were told that there was a box of light bulbs that had been ordered by the provider and needed to be used first and that their bulb couldn't be changed until these were used. Another person told us they enjoyed salad but were often given the same salad several times per week. They explained that when they had asked if this could be varied they had been told that this is what had been pre-set by the suppliers. People told us they felt secondary and sometimes lost in the processes in place at the home. One person told us, "These little things niggle you. If I were in charge, to have people be warm, comfortable and well-fed would be my priorities."

●Due to improvements that had been made at one of their other services, the provider had implemented new systems and procedures in addition to the ones currently being used. It was not apparent what consideration had been made as to which were already working well and which needed to be replaced before another layer of procedures were introduced. Staff consistently fed back that they felt overwhelmed and unable to fulfil their roles because of the documentation they were required to complete before the new systems were even introduced. One member of staff told us, "It is no-longer person-centred, it's paper-focused, excessive, bureaucratic and unnecessary. It's company policy and it's getting worse. There is less time to give direct care, no time at all. My colleagues say, 'Shall I write it down or shall I help people to the toilet.'" Staff spoke of their frustrations when trying to provide a service that reflected people's needs and placed them at the centre of their care. One member of staff told us, "People are getting forgotten." Another member of staff told us, "The time we spend on paperwork is quality time we could be spending with people doing the little things that matter to them like a chat with a cup of tea or in their room talking about their photos."

● Staff told us that when they had fed back their concerns about the staffing levels and paperwork they had not felt listened to. One member of staff told us, "You don't say anything because you want to keep your jobs." Another member of staff told us, "I complained about the staffing levels but was told it was policy so there is nothing that can be done about it." Staff told us they often had to complete documentation during their breaks or come in during their days off to meet the demands of the role. When asked about the challenges of their role, one member of staff told us, "The paperwork and staffing. Too much paperwork and not enough staff."

● Shortfalls in the delivery of care found as part of this inspection, had not always been identified by the management team or the provider. For example, despite a new modified diet protocol being introduced to help minimise risk, it had not been identified that people who required a modified diet had sometimes been given high-risk foods or that people's medicines had not always been administered according to their needs or prescribing guidance. There was a lack of oversight and action taken when people were consuming low amounts of fluids.

●There has been a lack of oversight to ensure that reoccurring themes that have been identified at previous inspections of the home or within the provider's other services within the Sussex area, have been identified, learned from and improved. For example, there has been a reoccurring theme over the past two years in relation to MCA and DoLS. This is currently a concern in six out of 12 of the provider's services within the Sussex area. There has been a reoccurring theme relating to agency staff's competence and the provider's failure to assess this before staff start work to ensure they hold appropriate skills. This has now been identified within five out of six of the provider's services that have been inspected within the Sussex area this

year.
● It was not always evident why decisions or changes had been made by the provider and how these had always considered people's best interests. For example, concerns in relation to staffing levels and the impact these were having on staffs' abilities to support people and the timeliness of support people received, were fed back to the management team and provider at the inspection. A decision had been made however, to further lower staffing levels after the inspection. Although the occupancy of the home had slightly lowered since the inspection, it was not evident how the provider had considered all people's assessed needs alongside the newly aligned staffing levels. Concerns raised to CQC about staffing levels following the inspection raised further concerns about the provider's oversight and understanding about the impact their decisions had on people.
● Records, to document the care people had received were not always completed in their entirety or well-maintained. Some records contained inaccurate or conflicting guidance for staff. For example, guidance for one person provided conflicting information about the type of modified diet they should be provided with. Another person had photographs of the type of hoist sling that should be used when supporting them. Although this was good practice, the wrong hoist sling had been photographed and provided to staff.

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

● Some improvements had been made since the last inspection and staff had been provided with guidance about people's recommended daily fluid intake. Records to document staff's actions when supporting people to eat or drink had improved.
● There have been on-going themes amongst the provider's other services within the Sussex area in relation to unsafe medicines management for people who are living with Parkinson's disease. The provider had acted to ensure lessons were learned and had implemented specific training to increase staff's awareness. The registered manager monitored the administration of Parkinson's medicines to ensure these were administered according to prescribing guidance.
● Since the previous inspection, the management team had worked hard to change the culture of the home and to help increase the focus on person-centred care. People and relatives told us that they found the management team receptive and caring and that when issues were raised with them these were investigated and resolved. A healthcare professional told us, "Since she [registered manager] has been the manager of the Martlets I have seen vast improvements on the residential and dementia floor. The team leaders and senior carers are always welcoming, and I feel this is in part due to her welcoming nature. She appears to be very approachable for her staff, I feel the standard of care has improved, it remains a work in progress, but I applaud the changes they have implemented." A relative told us, "She's lovely. I spoke to her last week about something I was concerned about. She really put herself out, we talked, and she was concerned. The phone went when we were talking, and she let it ring."
● The provider was aware of their regulatory responsibilities and had notified us of incidents that had occurred to enable us to have oversight to ensure appropriate actions were taken.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had embraced all the support that had been provided by external health and social care professionals. They had taken on board some feedback to help improve the delivery of care and were working in partnership with professionals. This feedback and learning from partnership working needed to be further implemented and embedded in practice.

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 demonstrated a candid, open and transparent approach. They had informed CQC and other external health and social care professionals, when care had not gone according to plan.

● People and their relatives told us that the management team and staff were open and honest with them. Records also showed that they were kept informed of any changes in people's needs or if care had not gone according to plan.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c) (d) (e) (f) (g) (h) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect. The registered person had not ensured that service users were treated with dignity and respect.

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

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

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 (1) (2) (a) (b) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.

The enforcement action we took:

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

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	Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

The enforcement action we took:

We have served the provider with a Warning Notice for the breach of Regulation 17. They are required to become compliant with this by 31 January 2020.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) (a) (b) of the Health and

Treatment of disease, disorder or injury	Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed.

The enforcement action we took:

We have served the provider with a Warning Notice for the breach of Regulation 18. They are required to become compliant with this by 31 December 2019.