SHC Clemsfold Group Limited

# Beech Lodge

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service:
Beech Lodge provides nursing and personal care for up to 40 people living with physical disabilities, learning disability and a range of neurological conditions. At the time of our inspection, 27 people were living at the service. The service comprises of three separate building: Beech Lodge, Oak Lodge and Redwood House. At the time of this inspection Redwood House was being used as a day centre and did not form part of this inspection. This is because day centre services are not regulated by the Care Quality Commission (CQC). The service is located in a rural setting and is purpose built to accommodate the needs of people with complex disabilities.

Beech Lodge is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation, the investigation is on-going, and no conclusions have yet been reached.

Beech Lodge had been built and registered before the CQC policy for providers of learning disability or autism services 'Registering the Right Support' (RRS) had been published. The guidance and values included in the RRS policy advocate choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen.

Beech Lodge requires further development to be able to deliver support for people that is consistent with the values that underpin RRS. For example, further work was required to ensure activities were meaningful and people had sufficient access to the community.

People's experience of using this service and what we found:
Risks to people were not always assessed and mitigated. For example, risks associated with behaviours which challenge, choking and skin breakdown. Safeguarding policies and procedures were in place, however, improvements to practice were not always made following a safeguarding concern being raised.

Systems and processes to assess, monitor and improve the quality and safety of the service were not consistently operated effectively. Medicine audits failed to identify shortfalls and drive improvement. Accurate documentation was not consistently maintained. The delivery and planning of care was not consistently person centred and did not always promote good outcomes for people. Lessons were not always learnt or used to drive improvement following local authority reviews, safeguarding concerns or deprivation of liberty authorisations.

People and their relatives told us that they felt involved in their care. However, the care planning process failed to consistently demonstrate people's involvement. Care plans were not always presented in a way that people could easily understand.

People and their relatives told us that they felt safe at the service. Recruitment procedures ensured only suitable staff worked at the service. Staff supported people using appropriate equipment to ensure infection control procedures were followed. Staffing levels were sufficient in meeting people's care needs. Staff understood and recognised the signs of potential abuse.

Medicines were administered in a dignified and person-centred manner. The storage, disposal and ordering of medicines was safe. Environmental checks were in place and staff's competency to safely move and transfer people was assessed. A complaints policy was in place and people told us that they felt confident raising any concerns with the management team. A range of activities were available, and staff had built positive rapports with people.

Risks associated with percutaneous endoscopic gastrostomy (PEG) and moving, and handling were managed well. Staff knew people well and demonstrated warmth towards the people they supported. People and staff were involved in the running of the service and staff felt able to raise new ideas and discuss any concerns with the management team. Relatives spoke highly of the service and of the kind and caring interactions between staff and their loved ones.

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

Rating at last inspection:
The last rating for this service was Good (report published 4 February 2019)

Why we inspected:
The inspection was prompted in part due to concerns received about insufficient staffing levels and poor moving and handling. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the Key Questions of Safe, Responsive and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement.

Please see the Safe, Responsive and Well-Led sections of this 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 Beech Lodge on our website at www.cqc.org.uk.

Enforcement:
We imposed conditions on the provider's registration, due to repeated and significant concerns about the quality and safety of care at several services they operate. The conditions are therefore imposed at each service operated by the provider, including Beech Lodge.

The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and

monitor the provider's services and actions to improve, and to inform our inspections.

We have identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) in relation to Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance).

Follow up:
We will request an action plan for the provider to understand what they will do to improve the standards of quality. We will also 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 and care commissioners to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always Safe.

Details are in our Safe findings below.

**Is the service responsive?**

Requires Improvement

The service was not always Responsive.

Details are in our Responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always Well-Led.

Details are in our Well-Led findings below.

# Beech 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 Care Act 2014.

Inspection team
This inspection took place over two days on 17 and 18 October 2019.

On 17 October 2019 the inspection team consisted of two inspectors, an occupational therapist specialist advisor and an Expert 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.

On 18 October 2019 the inspection team consisted of two inspectors.

Service and service type
Beech Lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

The service did not have a manager registered with CQC. Registered managers are legally responsible, together with the provider, for how the service is run and for the quality and safety of the care provided. The service had an unregistered manager in post at the time of the inspection and had only been in post 10 days. They are referred to as 'the manager' throughout the report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection we reviewed information we held about the service. We considered the information

which had been shared with us by the provider as well as the local authority, other agencies and health and social care professionals. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people living at the service and two visiting relatives/friends. Not everyone was able to communicate with us, so we spent time observing care interactions in the communal lounge. We also 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 two registered nurses, the deputy manager, manager, regional director, safeguarding lead, four care staff, chef, activity assistant and head of clinical services. We reviewed a range of records. This included five care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Further information was emailed to the inspection team following the inspection. We also sought feedback from five relatives via telephone after the inspection.

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 the last inspection this key question was rated as Good. At this inspection this key question has now 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:

- Care and support was provided to people who could display behaviours which challenged. Guidance produced by the National Institute for Health and Care Excellence (NICE) explains that behaviours which challenge for people living with a learning disability may serve a purpose for that person.
- A number of people had positive behaviour support plans (PBS) or behaviour care plans in place. These provided guidance for staff on how to manage the behaviour and support the person. However, PBS plans were not consistently in place and functional assessments of people's behaviour had not consistently been completed. For example, one person's care plan referred to behaviours which challenged. However, a functional assessment of the behaviours had not been completed. There was no assessment of the factors which might have contributed towards their behaviour such as the environment, or specific triggers. This posed a potential risk to the person as staff did not have access to guidance on how to support the individual in a structured and consistent manner. We brought these concerns to the attention of the manager and regional director. Subsequent to the inspection, they advised that the provider's PBS and autism lead would be reviewing the person's care plan with the aim to undertake a functional assessment and implement a PBS care plan.
- Similar concerns have already been highlighted to the provider about the management of behaviour that may challenge at some of their other services. Learning from these findings had not been appropriately used to improve support people with behaviours that may challenge at Beech Lodge.
- Risks associated with pressure damage to people's skin was not consistently safe. Several people received care and support on an air mattress (an inflatable mattress which could protect people from the risk of pressure damage) and it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown.
- We identified that three people's air mattress setting was set to the incorrect setting. This placed them at further risk of skin breakdown. Systems were in place to check air mattress settings daily, but these systems were not consistently robust. For example, one person's air mattress setting was set to 70kg. Daily checks noted that it had been on this setting since January 2019. However, the person's weight was 48kg. The air mattress had been set to the incorrect setting. The person was not experiencing any skin breakdown at the time of the inspection. However, the systems in place to ensure the safe setting of air mattress was not effective or robust and the person was at risk of developing avoidable pressure areas.
- These concerns were discussed with the manager and regional director who reviewed the air mattresses on the inspection and subsequent to the inspection provided a revised copy of the shift planner which included reference to additional checks of air mattresses on each shift.
- Ongoing risks to people's safety were not consistently managed. For example, one person had a risk assessment in place due to a history of them eating objects not meant for consumption. A safeguarding

concern had been raised and, as part of the local authority safeguarding plan, it was agreed for staff to carry out 15-minute safety checks at night to help manage the risk.
● We reviewed this person's nightly checks and found that hourly checks were taking place instead of 15-minute checks. This meant that the safeguarding plan was not being followed and the measures to manage the risk were also not being adhered to. We also reviewed the choking risk assessment for this person. Whilst this risk assessment explored the risks associated with food consumption, it failed to identify that the person was at risk of choking due to eating objects not meant for consumption. We brought this to the attention of the manager and regional director.
● Care and support was provided to a number of people living with epilepsy. Epilepsy care plans were in place; however, the risks associated with managing and responding to seizures at night time required further work. For example, one person's seizure management care plan referenced the need for 15-minute checks at night. However, the risk of the person having a seizure in-between those 15-minute checks at night had not been identified and no plan of care or risk assessment was in place. Seizure monitoring charts reflected that the person last experienced a seizure in July 2019. They therefore remained at risk of having further seizures.

The failure to assess, monitor and mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Other risks were managed well. Care and support was provided to people who required enteral feeding and had a percutaneous endoscopic gastrostomy (PEG) feeding tube fitted. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and throat. Observations and documentation reflected that staff supported people to maintain their PEG site and staff supported people to advance and rotate their PEG when required. Systems were in place to record and monitor when people required their PEG tube to be replaced.
● Staff understood that for people with a PEG in situ they were at high risk of aspiration. One staff member told us, "Some people have to be in a 45-degree angle to reduce the risk of aspiration."
● Staff were knowledgeable about people's epilepsy and the risks associated with their care needs. One staff member told us how one person required the use of oxygen following a seizure and were able to explain the signs that the person might be about to experience a seizure.
● Epilepsy protocols were in place which included guidance on when to administer emergency medicines and when 999 was required to be contacted.
● Staff had received training on safe moving and handling and had their competencies assessed. Personalised moving and handling risk assessments were in place and each person had pictures available in their bedroom of the equipment and slings that were required to safely move and transfer them.
● We observed staff supporting two people to move and transfer. This was carried out in a dignified manner and staff followed the person's moving and handling guidance appropriately.
● Risks around the environment were safely managed. All moving and handling equipment was serviced every six months and staff demonstrated an awareness of checking safety clips on people's hoists to ensure they were safe and fit for purpose.
● People and their relatives told us they felt safe living at Beech Lodge. One relative told us, "I know they are safe. Staff make us feel that they are well looked after and cared for."

Using medicines safely:
● Systems were in place to order, receive and dispose of medicines safely. Regular stock count checks took place of medicines stored on the medicines trolley.
● However, for additional medicines stored in the medicine cupboard there was a lack of oversight on how much stock was available. The provider had no way of monitoring how much stock was available at any one

time to ensure people had the medicines they needed. We discussed these concerns with the manager and regional director. After the inspection, the manager advised that a weekly stock check had been implemented.

● People received their medicines on time and in a dignified manner. There was a person-centred approach to medicines. Nursing staff supported people to take their medicines in a manner that was individual to them and offered people different ways of taking their medicines. For example, one-person preferred yoghurt to take their medicines with and was offered yoghurt or tea to take their medicines.

● The storage of medicines was safe, and staff followed the guidance in place on managing 'when required' medicines for each person and documented the reasons why they had administered the medicines. There were instructions for staff about giving medicines that people could take as and when they were needed, which ensured people had prescribed access to pain relief with suitable spaced doses.

● Staff checked the temperatures of rooms where medicines were kept. Records demonstrated that temperatures of rooms and fridges were in a safe range.

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

● The provider employed a dedicated safeguarding lead who maintained oversight of the safeguarding concerns that were under investigation, when they were raised and the nature of the concern. The safeguarding lead advised that they met with home managers every month to review safeguarding recommendations.

● The provider also received visits from the Local Authority to review safeguarding concerns and check that safeguarding recommendations were being met. Whilst systems were in place to review safeguarding recommendations, we found that these systems were not consistently robust. For example, the safeguarding plan for one person was not consistently being followed.

● Staff had received training on safeguarding adults. Staff were aware of the different types of abuse and how to raise concerns. One staff member told us, "We've had to raise concerns when one person sustained a blister. We also have to be mindful of unexplained bruising and ensure that is reported."

● A range of policies and procedures were available on safeguarding which were accessible to staff.

● A safeguarding policy was also available in accessible format for people living at the service to access.

● Relatives spoke highly of communication from the service. One relative told us, "If anything happens, they are on the phone to me. They were once found with a bruise and they immediately told me and carried out an investigation. It's good to know that they look into these things."

Staffing and recruitment:

● Systems were in place to determine the number of care staff required on each shift. A dependency tool helped determine staffing levels. This considered people's level of care and the number of staff required to ensure people received safe care. This was reviewed on a regular basis and the manager also completed a safer staffing tool to ensure staffing levels were sufficient and safe.

● Observations of care demonstrated that people's basic care needs were met. For example, one person was observed asking a member of staff to support them with accessing the toilet. Staff were able to provide assistance immediately.

● People and their relatives felt staffing levels were safe. One visiting relative told us, "There are always staff about when I visit. I have no concerns about staffing levels."

● Staff members on the whole were positive about staffing levels. However, we received mixed feedback from staff on staffing levels at the weekend. Some staff felt staffing at the weekend was sufficient, whereas other felt improvements were needed to ensure activities could take place at the weekends. We fed-back these concerns to the manager and regional director during the inspection process.

● The service was currently using some agency staff to ensure shifts were covered while they recruited to staff vacancies. A comprehensive agency staff induction process was in place and before agency staff

completed their first shift at the service, the provider received a copy of their profile to ensure they had required skills and training to provide safe care. The profiles of agency nursing staff demonstrated that they received training on epilepsy awareness, PEG care and learning disability training. Wherever possible, the same agency staff were booked for continuity.

● Recruitment of staff had been undertaken using robust safety checks to ensure suitable staff worked at the service. Pre-employment checks had been completed that included references, identity checks and referrals to the Disclosure and Barring Service (DBS).

Preventing and controlling infection:

● Staff had access to personal protective equipment such as gloves, aprons and anti-bacterial hand gel and we observed these being used throughout the inspection.

● The service was clean and hygienic. The provider employed cleaning staff who carried out daily cleaning of all areas and equipment in use at the service. Infection control audits were carried out which considered hand hygiene, management of linen, environment and personal protective equipment.

● Staff were aware of how to keep people safe if there were infectious diseases or illnesses in the service.

Learning lessons when things go wrong:

● Incidents were used as a forum to drive improvement and promote positive outcomes for people. For example, following two incidents in July 2019 involving one person. Staff sought input from an occupational therapist and the wheelchair service. The person's level of mobility has now greatly increased and with the implementation of a new wheelchair, so had their level of independence.

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 Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences: Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them:

- The delivery and planning of care was not consistently person centred and did not always promote good outcomes for people.
- One person's care plan included correspondence from the community learning disability team which identified that the person was on the autism spectrum. This was not referenced in their care plan. The correspondence from the community learning disability team also outlined a brief sensory profile which detailed how the person's sensory needs should be met. This was not further explored in the person's care plan to ensure that their sensory needs were supported in a structured way.
- During the inspection, this person was observed sitting in an armchair self-stimulating by hitting their hand against their head and moving their head from side to side. This indicated that they were expressing an unmet sensory need. We reviewed the person's care plan which identified that they enjoyed sensory objects, but the care planning process failed to identify what sensory objects they enjoyed most and how staff could engage with the person using them in a structured way.
- Staff were later observed supporting the person to file their nails which they appeared to enjoy as staff were holding their hand and providing a sensory stimulation. Staff were also observed supporting the person to engage with sensory objects. However, this engagement was not structured, and the person later returned to self-stimulating. We discussed these concerns with the manager and regional director who confirmed during the inspection process that the provider's PBS and autism lead would be reviewing the person's care plan and providing support to staff to ensure the person's sensory needs were consistently met. Subsequent to the inspection, the manager advised that funding was being sought to provide more sensory items to personalise and enhance the person's bedroom.
- During the inspection, a range of activities were observed. Including puzzles, arts and crafts and pampering sessions. Activity coordinator staff were observed to engage well with people and it was clear that they knew people well. Yet, the positioning of people meant that they could not always engage in the activity. For example, during one activity session, staff supported people to access the lounge and sit round a table. However, there was not enough room for everyone to sit around the table and consequently people ended up sitting in rows behind one another in their wheelchairs. One person was observed sitting 20 metres from the table and was heard calling out. Staff asked if they wanted to move closer, but no action was taken to move them closer to the activity.
- Another activity session was also observed whereby an activity member of staff was engaging with people through a story book. Again, not everyone could access the table on which the storybook was laid out on, so their level of interaction was hindered. The activity member of staff then spent time individually with each person, but this meant that the other people were left without engagement or stimulation. Consideration

was not given on how to support everyone to engage with the activity.
● Observations demonstrated that staff were kind and caring. However, activities were not consistently tailored to the needs of people. For example, we observed an activity session whereby the staff member asked five people sitting round a table if they like to do a jigsaw puzzle. The puzzle was laid out on the table. However, people were unable to reach the puzzle. The staff member then went round each person encouraging them to engage and asking 'where do you think that piece goes.' The staff member later identified that it was a shame people could not reach the puzzle. Thirty minutes into the game, the staff member then placed pieces of the puzzle onto people's trays that were attached to their wheelchair. This enabled people to engage more fully in the activity. However, consideration was not given at the beginning of the activity on how to fully engage people.
● The provider employed dedicated activity staff who lead on group activities and devised the activity schedules. One activity assistant told us, "People have care passports in place which detail their likes and dislikes. We've taken that information to formulate the activities and review what people like to do." Whilst the planning of activities was based on people's likes and dislikes. The evaluation of activities was not in place to assess whether the activity was meaningful for the person, what the desired outcome was or what people were trying to achieve.

Improvements were needed at Beech Lodge in how people's sensory and occupational needs could be better met through a more person-centred approach to care planning and delivery. We have discussed this in further detail in the 'Well-Led' section of this report in relation to how improvements at Beech Lodge had not been proactively driven by the provider.

● People had individual care plans in place which considered their likes and dislikes and include information on their background and interests. Staff were knowledge about people's interests and what was important to them. For example, staff told us how one person enjoyed having their journal to hand and how it was an item of importance to them. This person also told us, "I like to have my journal to hand so I can write everything down."
● Staff had clearly built positive rapports with people and people responded to staff with smiles and laughter. One staff member was observed interacting and laughing with one person, commenting, 'you always make me laugh.' Another staff member was supporting someone to make a cup of tea and commented, 'I know how much you love tea, it always makes you smile.'
● We observed staff supporting people to make Halloween decorations. People told us that they enjoyed the activities. One person commented that they also enjoyed the pamper sessions and during the inspection proudly showed off their painted nails following a pamper session.
● The provider was working in partnership with an organisation to help people access the community alongside in-house activities and community trips organised by the service. Subsequent to the inspection, the manager advised that people had recently enjoyed a trip out bowling.
● Staff spoke highly about supporting people in a person-centred way and ensuring their needs were met. One staff member told us, "We want to ensure that they have a good quality of life." Activity staff told us how they tried new ideas for activities and how new activities had been introduced. They commented, "We do music and massaging but some people didn't want to listen to the music, so we did movie and massage and we were able to do one to one. We've introduced more gardening and cooking. We've also introduced more hanging things like ribbons tied to bathmat. We've tried to introduce a sensory garden which was working fine until the weather changed. We had lavender, rosemary, textural plants like heather and lambs ear."
● Staff worked in partnership with healthcare professionals to achieve person centred positive outcomes for one person. The manager told us how one person presented with self-injurious behaviours. Following the implementation of one to one care and a change in medicine, the person's self-injurious behaviours reduced and they presented calmer and their quality of life improved.

Meeting people's communication needs:
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.

- The provider had taken steps to provide information in an accessible format for people. The menu was displayed in pictorial format. Key policies such as complaints and safeguarding were available in an accessible format.
- People and their relatives told us that they felt involved in their care. However, this was not always reflected within the care planning process and care plans were not always presented in a way that people could easily understand. We have identified this as an area of practice that required improvement.

Improving care quality in response to complaints or concerns:

- A complaints policy was available, and people and their relatives told us that they felt confident in raising any concerns or complaints. One person told us, "I talk to the nurse if I'm worried about anything." At the time of the inspection, the provider had not received any formal complaints in a year.
- There was a log of all complaints and the actions taken by the management team. Complaints received had been reviewed, investigated and feedback provided within a dedicated time-period.

End of life care and support:

- There was nobody receiving end of life care at the time of the inspection.
- End of life care plans were in place, however, further work was required to make them person centred. The manager told us that they were in the process of gathering further information to enhance the care plans and make them personalised.

Requires Improvement

# 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 the registered manager in post at the time had not received regular and formal supervisions. The provider was also not meeting aspects of registering the right support and no formal plans were in place to re-develop the model of the service to reflect the registering the right support guidance. At this inspection, this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Continuous learning and improving care:

- Effective governance systems were not consistently in place to drive improvement and evaluate the quality of care provided. There was a failure to consistently learn and drive improvement at the service.
- One person had a Deprivation of Liberty Safeguard (DoLS) condition in place which identified the need for sensory room provision and implementing an activity plan including in-house and community-based activities. We asked staff if this person used the sensory room and they were unable to advise how often or how a structured approach was in place to ensure that when they did use the sensory room they would not become over stimulated. The DoLS condition also referenced the need for community-based activities. We reviewed the activity log for this person and found that in five months, they had accessed the community on seven different occasions. A local authority review of this person's care in 2015 also identified the need for more community-based activities. The care planning process failed to consider and assess whether the current provision for this person was sufficient in meeting their individual social and psychological needs.
- A safeguarding concern was raised in August 2019 for one person and the concern was raised around lack of access to the community. The safeguarding concern noted that in August this individual had only accessed the community on three occasions which was insufficient in meeting their needs. We reviewed this person's activity records for September 2019 and found that they had only been out once in September 2019. The regional director advised that this person did not receive funded one to one and this was something that they were raising with the local authority. Whilst the management team were having ongoing discussions with the local authority, the provision of activities had not been reviewed in light of the safeguarding concern to consider and assess whether the current programme and availability of community-based activities was meeting the person's needs.
- Similar concerns have already been highlighted to the provider about the evaluation of activities and community-based activities. Learning from these findings had not been appropriately used to improve the provision of activities at Beech Lodge.
- Learning was not consistently derived from safeguarding concerns, DoLS conditions or local authority reviews to drive and improve the quality of care provided.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

● A quality assurance framework system was in place which included a range of audits. The provider also had a condition imposed on their registration which required them to monitor the safety and provision of care provided at Beech Lodge. These audits were not consistent in identifying shortfalls and driving improvement.

● We identified a number of discrepancies within people's care records. For example, one person's care plan identified that they should not be sitting for more than 45 minutes. On the inspection, we observed this person sitting in the same position for over two hours. Staff told us that this individual did not like to regularly move from their chair. The care plan had been updated monthly but these monthly reviews failed to identify that staff were not following the guidance cited and consider if the guidance required review.

● Epilepsy questionnaire forms were in place and staff were required to complete a form following an individual having a seizure. These forms enabled staff to provide information on how the person presented during the seizure, before and after. We identified that staff were not consistently completing these forms every time a person had a seizure. The epilepsy monitoring chart for one person (this is a chart which recorded the dates on which a person had a seizure) reflected that they experienced seizures on the 9, 7, 5 and 1 October 2019 and 28 September 2019. However, no epilepsy questionnaire form had been completed. Whilst staff were recording on people's epilepsy monitoring charts when they had a seizure and the length of the seizure, further details about the seizures were not recorded. This meant that detailed information about each seizure was being missed. We discussed these concerns with the manager and regional director. Subsequent to the inspection, they sent the inspection team a devised shift planner which required staff to spot check epilepsy monitoring charts throughout the shifts to ensure that they were completed when required.

● In June 2019, the provider's quality team visited the service. As part of this visit, they identified that when people were not meeting their daily fluid intake target, there was no evidence of escalation. We identified similar concerns at our inspection. We found good evidence of where people were meeting their daily intake. Yet for one person, we identified five days in October 2019 whereby their daily fluid intake had not been met and there was no evidence of escalation. We discussed these concerns with the manager and regional director who advised that they would amend the shift planner to ensure fluid charts are checked throughout the day and action taken where required.

● One person's care plan identified that they were at risk of constipation and received daily medicine to support with the management of constipation. Staff told us that the person last experienced constipation over a year ago and currently experienced healthy bowel movements. Their care plan identified that they were prescribed medicine, however, no further information was available on the risk factors or the steps to take if the person did not experience a bowel movement for a couple of days. We discussed these concerns with a registered nurse, manager and regional director who advised that they would amend the care plan to include clear guidance on how to manage the risk.

● Weekly and monthly medicine audits were taking place. These were not always effective in driving improvement or identifying shortfalls. One person had a protocol in place for the use of emergency medicine in the event of a seizure. However, a MAR chart was not in place. Whilst the person had not required the administration of this medicine, we brought this to the attention of the registered nurse, who implemented a MAR chart on the inspection. Medicine audits failed to identify this shortfall. Due to the nature of this emergency medicine, staff would be required to administer this medicine rectally. Guidance was not in place on how to safely administer this medicine in the event of the person experiencing a seizure whilst in their wheelchair. Seizure records confirmed that this person had not experienced seizures in a number of years. Subsequent to the inspection, the regional director provided copies of the protocols that had been implemented to provide guidance to staff.

● One person's PRN protocol did not match the administration guidelines on their MAR charts and one person had a medicine in place to support with the management of constipation, but this medicine was not documented on their MAR chart. Action was taken during the inspection process to amend these shortfalls.

However, internal governance audits failed to identify these shortfalls. There was also a lack of proactive monitoring and oversight at the service. Similar concerns have been highlighted to the provider about governance and monitoring. Learning from these findings had not been appropriately used to improve the provision of care at Beech Lodge.

There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to maintain an accurate and cotemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others:

● At the time of the inspection, the manager had only been in post ten days. The previous registered manager left the service in July 2019. In the interim, the regional director and deputy managers had been supporting and running the service. Staff told us that they felt well supported during the period when a manager was not in post and continue to feel supported.

● The manager and regional director were aware of the duty of candour to be open and honest with people, or their families, when something goes wrong.

● The CQC's rating of the home, awarded at the last inspection, was on display at the service and on the provider's website.

● People and staff were involved in the running of the service. Staff meetings were held which provided staff with the forum to raise concerns and discuss ideas. 'Resident' meetings were also held and the minutes of these were available in easy read format.

● A survey had been sent out to people living at Beech Lodge and other services to gain their views on activities and what they enjoyed doing. The provider was in the process of reviewing the provision of activities, accessing the community and day centres.

● The provider employed a dedicated involvement and engagement lead. Staff told us how they were working in partnership with the lead to support one person with accessing the community more and promoting their wellbeing. One staff member told us, "We've been working really hard to support this person. When they first moved in they were very aggressive and challenging. However, with input from the GP and changing their medicine, they've become a different person. We are supporting them to promote their independence and engage in more activities."

● Relatives spoke highly of the staff team and the support that their loved one received. One relative told us, "I visited one day and one of the activity team told me that they had been involved in making arts and craft. I was really surprised and happy that they managed to engage them and then display their work within the service. They are always trying to get them to do things."

● People, staff and relatives generally spoke positively about the culture of the service. One staff member told us, "It's a good team here, I really enjoy supporting the people that live here." One person told us, "I like it here. I can see my friends and staff give me hand massages which I love."

● The manager had only been in post a short while but spoke about their visions for the future. They commented, "I'm still learning about the service but one thing I've noticed and would like to look at is the environment. We support people with autism and they can struggle with bright lights and patterns on the carpet."

●The provider had a mission statement and set of values in place which governed the day to day running of the service. The regional director told us that the provider was re-looking at the governing values and that steps were being taken to enable people to devise their own values which underpin the day to day running of Sussex Health Care. Staff had been involved in putting forward ideas about values which were important

to them.

● Staff were encouraged to come up with new ideas. A member of the staff team had devised an electronic system to record people's menu choices and visually display the menu options that were available on each given day. The staff member told us, "I'm continually working on the programme, but it enables us to have oversight of people's dietary requirement, any allergies and whether people need support to increase their weight. Each month, people's weights are added to the system and we can monitor if they are losing weight or putting on weight and then adjust any dietary requirements." The service had received positive feedback from healthcare professionals regarding the implementation of this system. One professional commented, 'the innovation of the staff to place the electronic menu screen adds a positive feedback as to how staff assess the individual needs of the people.'

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and Treatment was not provided in a safe way. Regulation 12 (1) (2) (a) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes were not in place to effectively ensure compliance with the requirements of the regulation. Regulation 17 (1) (2) (a) (b) (c). |