

Summerley Care Homes LLP

Summerley Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Summerley Care Home is a residential care home providing personal care for up to 21 people. The service provides support to older adults with a range of care needs, including frailty of old age, dementia and learning disabilities. At the time of our inspection there were 19 people using the service.

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

People, staff and relatives told us there was not always enough staff to deliver person centred care. Most of the feedback we received from people and relatives expressed concerns about staff availability to support people with meaningful activity. Staff confirmed they felt pressured to rush when supporting people.

People's medicines were not always managed safely, records of medicines were not always available or were in a disordered state, this increased the risk of medicines not being managed safely. People's associated health risks were not always appropriately assessed and planned for when discharged from hospital with additional health needs.

People who were living with dementia did not always receive support in line with current guidance. Incident records had identified potential shortfalls in staff practice supporting people when they were distressed. Monitoring audits had not always identified concerns about incident management, staffing levels, medicines or health risks.

Staff were recruited safely and received supervision where opportunities to develop and feedback about their practice were discussed. Their comments included, "I can't fault the [registered managers] support they have supported me with training."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People, their relatives and staff gave positive feedback about the leadership and management at the service. One relative said, "The registered manager is a credit you can see their passion they are treated like family."

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 12 January 2022) and there were breaches 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 we found the provider remained in breach of regulations.

Why we inspected

We carried out an unannounced focussed inspection of this service on 15 October 2021 breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve staffing and safe care and treatment.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective and well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing and good governance at this inspection.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not 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 well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Summerley Care Home

Detailed findings

Background to this inspection

The inspection

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

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

Inspection team

The inspection was undertaken by two inspectors

Service and service type

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

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with five people who used the service and four relatives about their experience of the care provided. 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 eight members of staff including the registered manager, senior carers and care workers.. We contacted three healthcare professionals who have regular contact with the service.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality assurance processes, training records, policies and procedures were reviewed.



Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

- Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess, record and mitigate the risks relating to the health safety and welfare of people and medicines were not always managed safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to submit their improvement plan to address shortfalls identified at last inspection. Some issues concerning medicines including the administration of topical creams and gaps in medicine records had been addressed, but we identified new areas of concern with medicines. The provider had implemented an online care management system to address shortfalls with risk assessment and review however we identified significant shortfalls in care and risk assessment at this inspection.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people's health had not always been fully assessed on admission or managed safely. One person had recently been discharged back to the service with a new health condition which would require staff to take appropriate action in the event of an emergency. Senior staff had not updated the persons care plan or sought guidance on what action to take in the event of an emergency. A relative told us they were worried staff would not know how to support the person.
- We spoke with staff who were unable to tell us whether the persons care plan had been updated to reflect this health condition. Staff were unaware of any guidance or hospital discharge advice. There was nothing recorded in the care plan.
- The services admission processes had not effectively assessed or managed the risks to this person and as a result this increased the potential risk of harm. The registered manager, who supported the inspection whilst on leave, was not aware this person had returned to the service and spoke of how they had planned for their discharge to be assessed and planned prior to their return.
- Risks to people from Covid-19 had not always been effectively managed. On our arrival staff did not request evidence we had completed a rapid lateral flow test and we saw a used positive test result and swab on the desk of the office. Staff shortfalls in Infection Prevention Control (IPC) processes resulted in an increased potential infection risk to people and staff.
- Staff had not always followed current COVID-19 guidance to safely manage the risks and had not always considered the need to encourage people who had tested positive for Covid-19 to self-isolate to minimise the risks to others. We saw a person who had tested positive on the day of our inspection in communal

areas of the home with other people. We informed the registered manager who took immediate action to encourage the person to self-isolate. Staff had not taken necessary actions to support people who lived with dementia, to minimise infection risks.

- At this inspection records relating to medicines were incomplete and in a disordered state. There was no Medication Administration Record (MAR) for one person's PRN medicines to confirm it was being administered in line with the prescriber's instruction. For one person staff had recorded the use of a medicine for agitation when it had been prescribed to aid restlessness. Another PRN medicine we were told had been discontinued. Staff could not be assured they were supporting a person to manage agitation safely and consistently.
- Medicine risks had not always been considered within PRN protocols to ensure people received their medicines safely. PRN protocols did not always guide staff as to when the medicine should be administered or the symptoms to look out for. Some people needed staff to monitor health risks and offer PRN medicines to maintain their health and wellbeing. The absence of written information increased the potential risks of people not being supported to take medicines when they were needed.
- Staff had not identified the need to return a large stock of discontinued medicines. We informed the registered manager who took immediate action to ensure action was taken to address this.

Risks to people had not been sufficiently assessed or mitigated to ensure care and treatment was provided in a safe way. Infection risks had not been mitigated. Medicines were not always managed safely. This placed people at the risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Activities) Regulations 2014.

We sought assurances from the registered manager who took immediate action to mitigate risks. This included ensuring staff increased their monitoring of one person's health and welfare and current health advice was updated in their care plan. Health professional's advice was sought to ensure staff had correct information to administer people's medicines safely. After the inspection the registered manager told us how they had responded to the concerns, they said, "[Concerns}are taken seriously and they are nearly all resolved or in the process of being action planned so robust solutions can be found not only to rectify any of the points but to plan a procedure to ensure that errors cannot happen as easily".

- Falls risks were accurately assessed, monitored and recorded. These were comprehensive and included consideration of people's medicines, hydration, medical state as well as mobility. The environment had been adapted to mitigate falls risks, examples included handrails and coloured toilet seats. Relatives told us they had been informed when there had been concerns, one told us, "I'm always kept in the loop. For example, if there's any falls they ask what I want to happen."
- Staff had ensured people who were at risk of malnutrition or choking were supported safely. Meals were fortified to increase calorific intake and regular weights were taken and monitored. Any concerns and choking risks were referred to health care professionals.
- Regular health safety and maintenance checks were completed to ensure equipment and the premises were safe to use. The service had assessed fire risks and equipment was available to support people to evacuate in the event of an emergency.
- People could take their medicines in private when appropriate and safe. We observed how a staff member administered medicines in a person-centred way. They were patient and gentle in their approach, explaining what the medicine was and giving the person time to understand and consent to taking their medicine.
- Only staff who had been trained and assessed as competent were able to administer medicines to people.
- We were assured that the provider was using PPE effectively and safely and were assured the provider was

accessing testing for people using the service and staff.

- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises and we were assured that the provider's infection prevention and control policy was up to date.

Visiting arrangements were aligned to current government guidance. Relatives told us, "We still do a rapid lateral flow test (LFT) before we go and all staff are wearing their face masks." And "I am able to come in and out whenever I like."

Staffing and recruitment; Learning lessons when things go wrong

- At our last inspection we found improvement was needed to ensure staffing levels were managed safely and we recommended the provider reviewed the staffing levels to ensure the delivery of person-centred care. Following the inspection, the provider had implemented a staffing dependency tool to assess the staffing levels based on the needs of people living in the service.
- At this inspection there were not always enough staff to meet people's needs. People and relatives told us there were not always enough staff. One person said, "Staff are lovely but not enough of them so can't do the things that I like to do such as walking".
- Relatives provided feedback regarding staffing levels. Their comments included, "I have some concerns around being short staffed." And, "Staff don't have the right skills to support them they need more time."
- Our observations identified potential staffing shortfalls examples included one person who was supported in bed had minimal contact from staff. Support was task orientated and included bringing them hot drinks which on one occasion were left out of the person's reach for at least 55 minutes. Another person who had been assessed as having a choking risk was not observed or supported at lunchtime by staff. Staff told us some people's dementia needs were complex and records relating to people's care evidenced this complexity and for some included the need for two staff to provide support safely.
- Staff provided mixed feedback on staffing levels and told us this impacted on having enough time to talk and listen to people. One told us, "We need more staff. I don't think there's enough to do things safely some staff are a bit fast [when they support people]." And another told us of their concerns with how staff had been deployed, "It's a lot of work for three staff and there's not enough staff on shift and work isn't always evenly shared."
- The registered manager had failed to consider staff deployment in relation to people's needs. For example, staff had reported increasing concerns supporting a person when they experienced distress. Staff deployment had not been considered to provide support or mitigate risk to people and staff.
- Following the inspection, the registered manager provided details of their process of considering staff health and safety risks. They had not provided details of how they had considered the implication of the risk assessment outcome or the potential implications on maintaining safe staffing levels.

The provider had failed to operate a systematic approach to staff deployment which met the needs of people and kept them safe at all times. Staffing levels had not been reviewed effectively when new residents had been admitted. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we fed back our concerns in relation to staff deployment to the registered manager. They took action to ensure staffing levels were considered to ensure people who had been identified as having increased health needs or were experiencing regular episodes of distress were supported by adequate levels of staff.

- People were protected by safe recruitment processes. New staff were appointed following pre-employment checks which ensured they were of good character to work with people who had care and

support needs. This included undertaking appropriate checks with the DBS and obtaining suitable references. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions

- Not all lessons had been consistently learned and embedded in to practice. Previous inspections had raised concerns around medicine processes, staff deployment and risk assessment processes. This inspection found continued concerns in these areas.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. The service worked with other agencies to do so. Managers and staff were able to demonstrate they understood abuse. Relatives' comments included, " [Person] is safe ... they're trying their best." And, "No worries at all and feel that they are safe and happy."
- Staff received training and were aware of their safeguarding responsibilities. Staff understood the different types of abuse and how to recognise and report concerns. One staff member told us how they had reported a concern to the registered manager who took action to ensure safeguarding processes were followed.
- The registered manager demonstrated their knowledge of safeguarding; we saw referrals had been escalated to the local authority appropriately. Safeguarding concerns were appropriately investigated, and plans were implemented where required.

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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

At our last inspection staff were not provided with sufficient support, training or supervision to enable them to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to submit their improvement plan to address shortfalls identified at last inspection. Issues concerning staff supervision had improved but we identified continued areas of concern with staff support and training.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- Staff induction and support remained insufficient. Some staff had not received the induction and training they needed this included experienced staff and those new to care. Staff provided mixed feedback about their experience of induction and their comments included, "I shadowed for two shifts." And "I had four shadow shifts. I needed more to understand people's needs and I did request not to do personal care alone as yet but was told we were short staffed." Some staff provided feedback which suggested induction had been rushed and they expressed a concern they needed more support and training to support people living with dementia effectively.
- People were supported by staff who had not received consistent guidance or training to support people living with dementia or when they experienced episodes of distress. One staff said, "It's opened up my eyes on dementia how individual they are, personally the online training is not that great". And "Because of the strong dementia there's lots of aggression that some staff aren't used to." Another staff member spoke of how senior staff provided additional support if needed but shared their concerns with how this might impact on staffing availability to others in the service.
- It was evident from training records some staff had not received recent training in these areas. Records relating to one staff member evidenced they had not received training in dementia or challenging behaviours. This staff member had recorded supporting a person during five incidents in July 2022 and records relating to these incidents evidenced shortfalls in knowledge and training. For example, the language they used suggested they had continued to attempt to provide support to the person despite the person demonstrating physical aggression towards them. Some staff told us they deployed distraction and withdrawal techniques when a person became upset. The shortfalls in training and guidance resulted in the risk of people receiving inconsistent support due to the various approaches staff had deployed.
- A health professional told us, "In terms of knowledge, there are areas that the staff would benefit further

training such as the wider issues related to Dementia care i.e. Communication skills and understanding causes of certain behaviours."

- Volunteers have not always had effective training. We saw up to 10 people being supported by one volunteer whilst staff supported people in their rooms. They had not undertaken any training and were seen to be supporting people with drinks as well as activities. Some people required drinks to be thickened to mitigate choking risks. The failure to ensure volunteers completed training pertinent to their role potentially increased the risks of people not receiving timely support with choking risks.
- The provider could not be assured new staff were receiving consistent induction or that they were shadowing good staff practice, and this increased the risk of people not receiving support in line with current best practice or their own policy.

Staff were not provided with sufficient induction or training to enable them to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns to the registered manager who increased the amount of staff support one person received whilst they worked with dementia specialists to identify further areas of improvement. They also spoke of their plan to arrange in-person dementia training to increase staff members level of skills and knowledge in dementia and managing behaviours that challenge.

- Staff completed training the provider had considered mandatory. This included training in areas such as, safeguarding, fire safety, first aid, moving and handling and food hygiene.
- Staff received regular supervision and opportunities to speak with senior staff and managers.

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

- People's needs were not always assessed before they started to receive support from the service, to ensure their needs could be met. Some people's care plans did not reflect information provided from hospital discharge or assessment. For example, one person's behavioural needs were not reflected in a timely manner on their care plan. This included the failure to consider guidance for staff to support this person consistently when they experienced episodes of distress.
- Pre-admission assessments were not always available or detailed. The registered manager told us more detailed information was developed once the person had moved in and staff had got to know them better. The lack of sufficient information at the point of assessment to understand whether needs could be met increased the likelihood risks were not fully assessed, planned for or mitigated. . At the time of inspection, the registered manager was working with health professionals to consider whether Summerley Care Home could continue to meet a person acute dementia needs and had updated the persons care plan to provide interim guidance to staff.
- The registered manager completed initial assessments with people and their relatives and during the inspection recognised the use of some jargon within these assessments increased the risk of staff, people and relatives not understanding important information relating to people's needs. Relatives in general spoke positively about the consistency of care people received. Comments included, "There were a couple of things added to care plan that I didn't understand which they explained to me." And, "They treat [loved one] with kindness and compassion and always respectful. They ensure their dignity is maintained at all times."
- A range of assessment tools were used to ensure people received care and support appropriate to their needs. The Waterlow tool was used to assess the risk for the development of pressure sores and Malnutrition Screening (MUST). People who were at risk of developing pressure ulcers had skin integrity care plans and appropriate action taken.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink enough. We observed people being offered a variety of snacks and drinks.
- People were offered choices from a structured menu. Staff told us that they spoke with people to gather ideas to bring new foods to the menu. The menu was varied and people were asked to suggest meals they enjoyed. For example, on the day of inspection there were meatballs for the first time. Staff sought feedback about meatballs as they were a new addition to the menu and people were unanimous about having them again as a regular menu feature. Comments included, "They were great" and "They were fabulous, very tasty."
- People enjoyed their meals. One person who had fishcakes said, "They were lovely, I ate one and a half which I did not expect to do, thank you." Another person took time to go into the kitchen and thank the chef, "That was a lovely dinner, I really enjoyed it, thank you."
- Staff knew about modified diets and prepared food to people's individual requirements and preferences. We observed food being pureed separately and presented nicely on the plate.

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

- The service had been developed to consider the needs of people living with dementia. The registered manager had completed an audit of the environment and had worked through actions to enhance orientation and communication. For example, one of the actions they had taken was to install various art works in the environment and install pictures on people's rooms which reflected an element of their life which was important to them. Adaptations had been made to meet the needs of people using wheelchairs and walking aids.
- People's preferences were used to enhance their bedrooms which were personalised and contained personal effects such as pictures, photos, equipment and items to support their hobbies and interests.
- Some people were involved in an activity to add further plants to the garden. One person spoke of how they were able to help in the garden and has also been able to help in the kitchen, washing up and putting things away, they wanted to feel useful and occupied.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Care records showed that people had access to routine and specialist health care appointments. Records were kept about health appointments people had attended and staff ensured that guidance provided by health care professionals was implemented.
- Staff liaised effectively with other organisations and teams and people received support from specialist health care professionals. Records showed that people had regular access to health care professionals, GPs and specialist nurses. During the inspection health care professionals visited the service to provide support to people and guidance to staff. We observed communication between a healthcare professional and staff. This was professional and informative and demonstrated how people's healthcare needs were reviewed to ensure they received appropriate medical treatment in a timely way.
- Health professionals carried out regular visits to the service. Records evidenced effective multi-disciplinary communication.
- People's oral health care needs were met and people accessed regular health screening such as dentist and diabetic eye clinics.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- MCA assessments and best interests' decisions were in place where required. DoLS authorisations had been applied for and approved for the appropriate people; the registered manager checked DoLS authorisations to ensure they remained valid. Where people's DoLS had been authorised with conditions these had not always been monitored to ensure the conditions were met.
- During the inspection we identified some conditions not been reviewed. The registered manager took action to arrange a medicines review to ensure people continued to receive the least restrictive support with medicines.
- Care plans included mental capacity assessments where people lacked mental capacity to make decisions about aspects of their needs. These included medicine, personal care and health.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's website describes Summerley Care Home as a 'Dementia specialist care home' with a 'Highly trained team of care staff'. This inspection has evidenced shortfalls in staff skills, support and knowledge around supporting people living with dementia which the providers systems had not identified or managed effectively. People were highly dependent on staff knowledge and skills.
- The provider's incident reporting process had not always identified or acted on potential concerns staff had recorded. For example, staff had reported an increasing number of incidents for one person where they were distressed and potentially aggressive to staff. The registered manager was keeping a record of incidents as part of their auditing processes to monitor for trends. The registered manager had not identified shortfalls in staff knowledge, ensured the person was supported in accordance with preferences stated within their care plan or reviewed staffing levels to ensure they minimised risks to staff and other people.
- The provider had failed to ensure there were adequate staff to meet people's needs in a person-centred manner. the registered manager could not provide assurance how they were effectively monitoring staffing levels. For example, at our previous inspection, completed October 2021, we reported on how staffing levels were planned for three or four carers in the day, at the time there were 18 people living in the service. During this inspection we were told the staffing was planned for three staff to support 19 people living at the service.
- Quality monitoring systems had failed to identify that care plans did not provide accurate and up to date information. We found examples across people's care plans where information was missing or not up to date. For example, the registered manager was unaware of a person being readmitted to the service from hospital and had failed to ensure staff had effective processes to manage or mitigate risks whilst they were on leave. Staff had failed to update the persons care plan despite there being changes to medicines and a significant health need which might require staff to take appropriate action in the event of an emergency. This presented a risk to this person's health and welfare.
- The provider's medicines audit for July 2022 two days before this inspection had not identified concerns regarding some unsafe practices relating to medicines Examples included a lack of MAR records relating to some PRN medicines, records relating to medicines in an unsafe disordered state and the failure to arrange for medicines to be returned when no longer required.
- Systems and processes failed to identify and assess risks to the health safety and welfare of people. For example, Systems had not identified shortfalls with staff knowledge to ensure they followed current

guidance to manage COVID-19 risks. This presented a risk to other people, staff and visitors.

- There had been a failure to consider confidentiality of personal information. The registered manager told us as they had been away from the service staff had left confidential documents on the desk for review. They had not provided assurances they had considered a suitable process to ensure private information relating to people and staff was managed effectively.

The provider had failed to establish adequate systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The registered manager took action to address shortfalls identified at this inspection and provided further assurances of staffing levels, medicines and updated support plans which ensured staff had suitable information to support people in the event of an emergency.

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 registered manager understood their responsibilities under the Duty of Candour and was open and transparent when people's care did not go according to plan. Following our feedback after the inspection they told us, "We will also work to ensure that audits and processes are robust to ensure any errors are found in a timely manner and corrected."

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

- The service was led by an experienced registered manager who actively supported the care staff in their roles. Staff generally felt supported and valued by the registered manager and had been given opportunities to develop a career in caring.
- Relatives were generally positive about how the service and the registered manager had engaged them in discussions and decisions. One said, "I just adore the place I wish the manager had been there sooner the communication is above and beyond." Another spoke of how staff respect person and treat them fairly and equally this has been their goal all his life.
- The registered manager was involved in different networks and updated their learning through different sources. They engaged with provider forums and registered manager network groups. Information was shared through team meetings.
- The registered manager demonstrated their understanding of Right Support, Right Care, Right Culture and was in the process of updating their statement of purpose with consideration of this guidance. They told us, "For me it's not about treating everyone the same but ensuring they are treated equally in an environment they can enjoy and proudly call home."
- A health professional told us how the registered manager had engaged with local networks and, "Worked tirelessly over the last three years to improve the service despite some very hard challenges. Throughout the pandemic they were an active member of the Bognor Regis Forums supporting the whole care home network that we have in Bognor to maintain the safety and care for residents."

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 Risks to people had not been sufficiently assessed or mitigated to ensure care and treatment was provided in a safe way. Infection risks had not been mitigated. Medicines were not always managed safely. |

The enforcement action we took:

see WN

| Regulated activity | Regulation |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish adequate systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. |

The enforcement action we took:

see WN

| Regulated activity | Regulation |
|--|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to operate a systematic approach to staff deployment which met the needs of people and kept them safe at all times. Staffing levels had not been reviewed effectively when new residents had been admitted. Staff were not provided with sufficient induction or training to enable them to carry out their duties. This |

The enforcement action we took:

see WN