Forward Care (Residential) Limited

Hill Farm

Inspection report

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Date of inspection visit:
18 April 2018
20 April 2018

Date of publication:
06 September 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 18 and 20 April 2018 and was unannounced.

Hill Farm is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides support for up to nine people with physical and learning disabilities. There were six people living at the service at the time of our inspection including people with sensory impairments, autism and behaviours which can challenge.

The service was run by a registered manager who was present at our visit. They were registered to manage this service and another small service in the local area which is registered with the same provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected on 3 August 2017 when the area of 'Well-led' was rated as 'Inadequate' and the overall rating was 'Requires Improvement'. At that time we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that there were sufficient numbers of staff to keep people safe and that they were suitably trained: Regulation 18. There was also a continuous breach of Regulation 17 in that the provider had failed to assess, monitor and improve the quality and safety of the service and to mitigate risks.

The provider sent us a plan of action on 30 October 2017 setting out how they would improve the service to meet the Regulations.

We also made recommendations regarding following guidance in relation to making best interest decisions and reviews staffing deployment to ensure people have access to transportation as required.

At this inspection, on 16 and 20 April 2018, we found continuous breaches of Regulation 17 and 18. Quality assurance systems remained ineffective in highlighting shortfalls in the service or where shortfalls had been identified; they had not been addressed consistently or in a timely manner. Staffing levels had been increased since the last inspection in August 2017, but this had not been maintained. Staffing levels were increased back to safe levels on 20 April, but only as a direct result of our inspection visit. There remained shortfalls in staff training and support. We also found additional breaches of regulation with regards to the management of risks and inconsistency in treating people with dignity and respect.

This is the fourth time the service has been rated Requires Improvement.

The overall rating for this service is 'Inadequate' and the service is therefore placed in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Staff had not always received the training or knowledge needed for their roles including how to support people with behaviours that challenged, with an epileptic seizure, to apply first aid and to move people safely. The registered manager booked a training day for staff on challenging behaviour and epilepsy after the inspection visit.

There was inconsistency in the assessment and management of risks which meant that guidance and practices were not always in place to minimise any risks identified to people. There were not effective systems in place to monitor accidents and incidents as some information which informed the provider had not been kept up to date.

Staff knew people well, had built positive relationships, understood their likes and dislikes and preferred methods of communication. One person had a staff team built around them which matched their cultural needs and had had a positive impact on them in the reduction in their behaviours. However, there were inconsistencies in staff practice in treating people with dignity and respect. Some staff spoke about people in their presence as though they were not there and there were occasions when staff did things for people rather than promoting their independence.

There were systems in place for the management, storage, disposal and administration of medicines. However, some people's pain medicine was out of date so it was not available should it be required. We have made a recommendation about the management of medicines.
It was difficult to assess if people took part in a range of meaningful activities as records had been completed inconsistently. We made a recommendation about the recording of activities. Staffing levels had a direct impact on if people were able to spend time out in the community. On the first day of the inspection people took part in music for health but not everyone was able to go dancing. On the second day of the inspection, when staffing levels had increased, everyone went on a trip and lunch out to the seaside.

Staff were recruited safely and had completed an induction programme. Most staff felt supported but formal planned supervision sessions had not taken place in line with the provider's policy. Three out of four night staff had not received a supervision or review of their competency for over a year and one of these staff's

probationary period had expired.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made to ensure that people were only deprived of their liberty, when it had been assessed as lawful to do so. All interested parties were invited to best interest meetings in line with the principles of the e Mental Capacity Act 2005. However, there was inconsistent practice in gaining people's consent before supporting people with their care. We have made a recommendation about this.

Staff knew about the signs and symptoms of abuse and how to raise a concern inside and outside the organisation.

Staff followed the provider's guidance to help minimise the spread of any infection.

People's health, social and physical needs were assessed and guidance was in place to ensure they were monitored and supported to access health care and advice as required. People were supported to have a variety of foods which met their health needs and cultural preferences.

People's care plans detailed people's needs and how they preferred to be supported. They included information about people's life history, likes and dislikes and who was important to them. They contained 'communication passports' and details about how people would let staff know if they were upset or in pain.

There were policies in place that identified that people would be listened to and treated fairly if they complained about the service.

There had been an improvement in staff morale as staff felt that as the service was being sold, a new provider would be more effective in making the necessary improvements.

We found two continued and two additional breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 at this inspection. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People had not been consistently supported by sufficient numbers of staff to meet their needs and keep them safe.

People could not be assured of their safety at all times as risk management processes were inconsistent.

Some people's pain medicines were not available should they be required.

Staff were recruited safely and understood how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always have the support, training or knowledge they needed to carry out their role.

People's consent was not always sought before supporting people with their care.

People were offered meals that met their preferences and cultural and dietary needs.

People's health care needs were monitored and they had access to health professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not consistently treated with dignity and respect.

People were supported by staff that they had built positive relationships with and who knew them well.

Staff understood how to communicate with people in a way they could understand.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's access to activities was dependent on staffing levels and records were not always detailed enough to make sure activities were meaningful for people.

People's care plans gave clear guidance to staff about how to support them in the way they preferred.

A complaints procedure was available should anyone wish to raise a concern or complaint.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance systems continued to be ineffective in highlighting areas were improvements were needed.

The provider had a reactive approach to managing risks.

There had been an overall improvement in staff morale. Staff worked towards the same vision but they did not feel this was always supported by the providers.

The registered manager was very experienced and sought out support from other professionals as needed. They agreed they would benefit from attending local manager forums.

Hill Farm

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 20 April 2018 and was unannounced. The inspection was carried out by two inspectors.

Prior to the inspection, we looked at previous inspection reports and notifications about important events that had taken place at the service.

People were not able to describe their experiences of living at the service so 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 also joined some people for lunch and spoke to two relatives and an external activities organiser. We also obtained feedback from a commissioning officer and two care managers from the local authority.

We spoke with the registered manager, administration and finance manager and one senior and three care staff. We looked at a selection of records including three care plans and daily records, two staff files, staff training programme, staff rota, medicines records, environment and health and safety records and quality assurance documents.

At the inspection we asked the provider to send us an updated training matrix and information on the management of epilepsy which we received in a timely manner. We also asked for an action plan to address the Fire Safety Order. We did not receive an action plan so we contacted the provider on 14 May and they sent the relevant information.

Inadequate

Is the service safe?

Our findings

People's body language and facial expressions indicated they felt safe. Some people sought staff's company and other people preferred to have their own space and staff respected people's wishes to help make them feel safe.

At the inspection on 3 August 2017 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure there were sufficient numbers of staff to keep people safe. This was because on occasions, people who received one to one support required two staff to support them and this was not accounted for in the staff numbers. Care staff were also required to undertake cleaning and laundry duties each day and also cooking duties at the weekend, which took them away from their care responsibilities. The registered manager took immediate action to address this shortfall after the inspection on 3 August 2017, but only after we had brought this to their attention.

The provider sent us an action plan on 30 October 2017 stating that they planned to continue this increase in staffing levels so people were supported safely and so that the staff team could respond in the event of an emergency. However, at this inspection on 18 April 2018, we found that contrary to the provider's action plan, staffing levels had been reduced. The registered manager told us there had been no change in people's needs and that the reduction in staff was for financial reasons. This resulted in one person not being able to go out to a planned activity, one person's review with the local authority being cancelled and a member of staff from another of the provider's services attending to carry out some cleaning in areas of the service. On the second day of our visit, the 20 April 2018, staffing levels had been increased and an additional agency staff member had been booked to support people until 6 May 2018. This benefited people as everyone went out for lunch and a trip to the seaside and ensured their safety. After the inspection, on 30 April, the registered manager sent us the staff rota up to the 20 May evidencing that extra staffing had been arranged until this date. This demonstrates that the provider had failed to consistently provide staffing levels which meet people's assessed needs and only made the necessary changes as a direct result of our inspection visits.

The provider had failed to ensure there was an effective system to ensure there were sufficient staff numbers to keep people safe at all times. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was an inconsistent approach to the assessment, monitoring and management of risks. One person had entered another person's room at night time and scratched them. The provider had alerted the local authority of the incident and held a best interest meeting. Action had been taken to minimise a repetition of the incident. However, another person had removed their clothes and entered the room of a member of the opposite sex at night time. The registered manager told us this behaviour had first presented the week of 9 April, but staff had recorded this in daily notes from 3 April. A referral had been made on 16 April to obtain a mat which would alert staff when the person got out of bed during the night. When asked what action was being taken in the meantime to reduce the risk of any reoccurrence, the registered manager told us once the

behaviour was brought to their attention a member of the night staff had been allocated to sit by the person's room at night time. However, there was no information in the person's care notes or handover notes to guide staff and make them aware of this new responsibility. The person continued to regularly enter the other person's room during the night. On 12 April there were three incidents; on 13 April there were four incidents; on 15 April there were five incidents; and on 19 April there was one incident. Assessments of risk in relation to the two people had not been reviewed and updated as a result of people's changed behaviour. We contacted the local authority to raise our concerns.

The provider had received a visit from a representative from the Fire and Rescue Service on 8 January 2017 and their report dated 9 January 2017 identified a number of deficiencies in fire safety. This included fire doors failing to close; lack of emergency lighting; that the fire resisting compartmentation was not adequate to protect against the fire and smoke; and that fire evacuation drills had not been undertaken at night time when fewer members of staff were available. We contacted the registered manager on 19 January and they assured us that action was being taken as a result of the report and that they would provide us with an action plan. However, we did not receive an action plan and none was available at the inspection visit. On 19th April works were completed with regards to ensuring fire doors closed and some work was undertaken in relation to the fire compartment. However, the other actions in relation to fire safety remained outstanding and we contacted the fire officer to inform them of our findings. We asked the provider to send as a fire action plan immediately after the inspection and reminded them to do so on 14 May as it had not been received.

A record was made of any accident or incident and these were passed to the registered manager to review. This was to make sure appropriate action had taken place such as seeking medical advice or that of the local authority. The registered manager said they looked for any patterns or trends and that monthly keyworker meetings gave useful insight. However, they were not aware that a number of people's monthly reviews had not taken place since January 2018. This meant that they may not have all the necessary information to assess if there were any patterns, trends or lessons to be learned from accidents and incidents.

The provider had failed to assess risks to people's health and safety and do all that was reasonably practical to mitigate them. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's medicines were stored securely and kept at the correct temperature to make sure they were safe to use. However, two people's 'as and when required' (PRN) medicines for pain had expired past their use by date of February 2018 and new stock had not been obtained. Therefore if these people required pain relief it was not available for them. Medication administration records (MAR) were clearly and accurately completed which meant that people received their medicines at the right time, as directed by their GP. An exception to this was that three people had gone out for the day without their lunchtime medicines which included medicines for epileptic seizures. A senior staff member stated they had sought medical advice previously when this had occurred and knew the appropriate action to take to ensure people's health and well-being. Body charts were in place to direct staff as to the correct part of a person's body to apply a prescribed cream. Medicines checks were carried out in line with the provider's policy to ensure there was a clear audit of all medicines entering and leaving the service. When staff gave people their medicines they gave people time and did not rush them and made sure people took their medicines with drinks of water and that they had swallowed them.

We recommend that the provider reviews the management of medicines to make sure people receive their medicines when they need them.

Staff knew about different types of abuse and their role and responsibilities in protecting people from abuse. This included awareness of which external agencies they should inform if there were any safeguarding concerns. Staff had received appropriate safeguarding training and had access to the provider's and local authority policy and procedure on safeguarding adults. Safeguarding incidents had been reported to the relevant agencies when they had occurred and the registered manager had taken appropriate action.

Behaviour support plans were in place which gave guidance for staff about how to support people who may present behaviours that could harm them or other people. The specific behaviours that the person may show were identified together with any triggers. Staff guidance detailed the most effective ways staff should respond such as activities to distract the person, ignoring the behaviour, holding the person's hand or giving them space. Staff gave examples of how they had followed this guidance in people's care plans to support people appropriately and safely.

Staff recruitment practices protected people from the risk of receiving care from unsuitable staff. Appropriate checks were carried out which included obtaining a person's work references, a full employment history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people who use care and support services.

Personal protective equipment was available for staff such as gloves and aprons and these were appropriately used during the inspection. Staff were responsible for keeping the service clean and a cleaning schedule was in place so that each area of the service were attended to on a regular basis. The service was clean and had no unpleasant odours on the days of the inspection. On the first day of the inspection the cleanliness of the service was maintained by a member of staff from another of the provider's locations undertaking this role. The washing machine and laundry area was situated in a separate room to minimise the risk of infection spreading, should it occur.

Requires Improvement

Is the service effective?

Our findings

People benefitted from mealtimes which were social occasions when people and staff came together to eat in the dining room. People were supported to eat at their own pace and people's facial expressions indicated that it was a positive experience.

At the inspection on 3 August 2017 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that staff had all the training and support they required to carry out their role. This was because staff had not received refresher training in how to support people using distraction, redirection and physical interventions as directed in people's care plans. After the inspection the registered manager sent evidence of training courses in positive behaviour support (PBS) which had been arranged within the next two months. PBS is used to support people who present behaviours that may challenge in the most appropriate way.

At this inspection on 18 and 20 April 2018, we found that there were shortfalls in staff training which had an impact on people's well-being and safety. Only five out of 12 care staff had received training in PBS or challenging behaviour and none of the agency staff who regularly supported people. The registered manager sent confirmation after the inspection that an additional date had been booked on 9 June for staff to attend a course in challenging behaviour. Guidance in one person's care plan was that all staff should have first aid training and know what to do if they choked. Only six out of 12 staff had undertaken first aid training. One staff member had been allocated first aid training to complete in January 18, but had not completed the training and in addition two other staff were allocated the training after the inspection on 25 April.

Three people were on prescribed medicines to control their epileptic seizures and one of these people had had a seizure in December 2016. Staff had not received training in epilepsy awareness nor was there any guidance in these people's care plans about how to recognise or respond to a seizure. We asked three care staff what they would do if a person had a seizure and two people knew how to keep the person safe. However, one staff member said that they would find an object and put it in their mouth to stop a person biting their tongue and were not aware of the potential dangers to themselves or others in doing so. After this inspection the registered manager updated people's care plans with the necessary information and guidance for staff and booked a training course on the management of epilepsy for 9 June 2018.

One person required staff to guide them to move around their home due to their poor vision. Their care plan guided staff that the person could walk short distances holding onto their arms. Staff told us that if they placed this person's hands on their shoulders that the person would walk behind them. It was observed that one member of staff following this guidance. However, we observed one member of staff holding the person's hands and walking backwards so that they could not see where they were going on two occasions which posed potential dangers. This person had not undertaken training in how to move people safely. Only five staff had undertaken training in moving and handling and two staff required their training in this area to be refreshed. After the inspection, on 25 April, three staff were allocated this training to complete, including the staff member who was carrying out unsafe practices.

The majority of staff said they felt supported through the management of the service and that the registered manager was approachable. In preparation for their annual appraisals, some staff had completed a piece of reflective practice, including their strengths and skills and how they could use these in their roles. The registered manager was aware that supervisions had not taken place as frequently as the provider's policy. Three out of the four night staff had not received a formal supervision for over a year. One of these staff had yet to have a probation meeting, due five months ago in November 2017, to assess if they were suitable and competent to continue in their role. The registered manager said that they met with night staff on occasions to check on their practice, but that they had not recorded these events. Therefore, it could not be assured that night staff had the support they required or the competencies necessary to carry out their roles.

The provider had not ensured that staff had all the training and support they required to carry out their role. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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

At the inspection on 3 August 2017 a recommendation was made to follow guidance in relation to making best interest decisions, as some interested parties had not been included in this process. At this inspection on 18 and 20 April 2018, we found that a record was made of which interested parties were invited to each meeting and if they had attended.

There was inconsistent practice in gaining people's consent before supporting them with their care and treatment. Staff checked if people agreed to take their medicines and people indicated their agreement by accepting and swallowing their tablets. Staff checked if it was alright with people before helping them throughout the day, such as escorting them to the toilet. However, there were exceptions to this practice. One staff member wiped a person's mouth on two occasions before first checking with the person. Another staff member removed a person's feet from the table on two occasions without first informing them of what they were about to do and the reason for their action.

We recommend the provider seeks guidance from a reputable source and reviews current practices in gaining people's consent when giving care and treatment.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. People's capacity had been assessed when needed and DoLS authorisations had been applied for to make sure that any imposed restrictions were authorised and lawful.

A staff induction programme was in place and staff said that it was effective in giving knowledge and practical experience of their roles and responsibilities. A checklist was in place to ensure the programme was implemented and this included shadowing experienced staff. Staff who were new to care completed the Care Certificate. The Care Certificate includes the standards people working in adult social care need to meet before they are assessed as being safe to work unsupervised. The majority of staff had completed a Diploma in health and social care level two or above. To achieve this award, staff must prove that they have the ability and competence to carry out their job to the required standard.

People's social, physical and mental health needs were assessed and developed into a care plan. Health needs included details of people's skin care, eye care, mobility and medicines. Guidance for staff about how to meet people's health and medical conditions was available. People received access to community health care professionals such as their doctor, chiropodist, optician and dentist and to attend appointments with consultants as necessary. On the first day of our visit once person was supported to attend a dentist appointment. People's weights were monitored and referrals had been made to the dietician where appropriate and any guidance was available to staff. A record was made of all health care appointments including the reason for the visit, the outcome and any recommendations. Each person had a "Hospital Passport" which was given to hospital staff if a person was admitted to hospital. This provided essential information to hospital staff in a single document about each person's communication, personal support, disability, medicines and medical history.

People were supported to eat and drink enough and to have a balanced diet. People's individual needs in relation to their diet were assessed. Some people had specific dietary needs and this information was available to staff who were responsible for cooking. There was no designated cook at the time of our visit, but one had been appointed. Staff took turns to cook and they were aware of people's dietary and cultural needs, likes and dislikes and these were catered for. For example, specific cultural dishes were on the menu each week and people were supported to visit restaurants which met these needs.

Requires Improvement

Is the service caring?

Our findings

People had developed good relationships with staff and responded positively to staff contact. A relative told us, "He likes living here. Staff know his likes and dislikes. We are welcome to visit at anytime". Most people benefitted from staff that showed concern for their well-being and responded in a caring and meaningful way. Staff praised people for their achievements such as joining in with activities and undertaking independent skills. For example, one person was responsible for putting away the condiments after lunch and staff encouraged them to carry out the task and praised them when they had done so. However, there were occasions when people were not treated in a way which respected their dignity.

Staff sometimes talked about people in their presence as though they were not there and did not include them in the conversation. Staff referred to people as 'they' rather than using their individual names. For example, one staff member said, "This one here likes to go out", referring to a person who was standing near them and the inspector. On another occasion a staff member said, "I think I smell something. I think he needs to go to the toilet". The staff member said this so that the person and those around them could hear what they were saying.

At lunchtime a staff member gave a person a serviette and they wiped their mouth and threw the serviette on the floor. The staff member knew that this was part of their routine and gave them another serviette to wipe their mouth. However, on two other occasions, they wiped the same person's mouth without letting them know what they were going to do and therefore did not give them the opportunity or respect to act for themselves. One person put their feet on the dining room table on a number of occasions. One staff member explained that they should not have their feet on the table and asked them to remove them which they did. Another staff member pushed this person's feet off the table without communicating what they were going to do.

The provider had failed to ensure that people were treated with dignity and respect at all times. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not able to express their views and needs verbally. Care plans contained detailed information to guide staff about how people communicated their needs through body language, facial expressions, and physical actions. For example, one person put their hand to their mouth to indicate that they wanted a cup of tea. Staff also used verbal and physical actions to communicate with people. In addition each person had a 'distress passport' which gave guidance about how to recognise when people were upset, anxious, unwell or happy and content. For example, one person's face dropped and they folded their arms when distressed and they sucked their tongue to indicate that they were content. Guidance also included the best ways to support the person if they were anxious or upset such as favourite activities and any situations which may have the adverse effect and so should be avoided. Staff described how they read these non-verbal signs in order to understand how a person was feeling. For example, one person tapped their wrist and staff explained that the person was saying that it was time to go home.

Care plans included information about things that were important to people such as their likes, dislikes and cultural needs. One person's care plan said that they liked to hold staff hands. When they went to hold a staff members hand, staff took their hand as requested to give them comfort and assurance. Another person had a dedicated team of staff who were of the same gender and cultural background and who could communicate with the person in their native language. This match was especially important to this person as they had developed a close relationship with their care staff and their specific understanding of their needs helped to calm them, which had resulted in a reduction in any behaviour that may challenge themselves or others.

People's bedrooms had been decorated to their own tastes and personalised with pictures, photographs and items of furniture that were important to them. Information was available about people and relationships that were important to them such as members of their family and friends. Special occasions were celebrated such as birthdays and seasonal events.

Requires Improvement

Is the service responsive?

Our findings

Staff were responsive to people's individual needs. Some people liked to have their own space and this was recorded in their care plan. At lunchtime these people eat with a staff member in a separate room, rather than in the dining room in accordance with their wishes and preferences. A relative said that staff knew people well including their interests, which helped to support them with things that they liked. They told us, "He really enjoys the dance session on a Wednesday".

At the inspection on 3 August 2017, a recommendation was made that the provider reviewed their staffing to ensure people had access to transportation as required. This was because some people required a private vehicle to go out due to risks relating to their behaviours and there was a limited number of staff who could drive.

At this inspection on 18 and 20 April 2018, we found that the daily shift planner identified a member of staff who could drive. However, some people were still not able to go out when they wanted to, due to the lack of staff available. On the first day of the inspection it was detailed in four people's activity planners that they would go out to a planned event to go dancing. However, there were only enough staff available to take three people. The person who could not go said, "And me" when staff talked about going out, indicating that they too wanted to go. On the second day of the inspection an additional staff member was on duty and everyone one was able to go out for the day.

Social care professionals raised concerns that people were not engaging in meaningful activities. They said they had contacted the provider about this as for example, one person who received one to one staff support had spent a lot of their time each week shopping for clothes. Daily log sheets gave an overview of what people had done each day and when people had gone for 'trips out'. It was not recorded what or where people had gone and this information was inconsistently recorded in people's individual daily notes. For example, for one person it had been recorded that they had gone out for 'a drive' six times in the last two weeks. Therefore, it was difficult to assess if people had been engaged in a variety of activities and in those activities identified in their activity planner. Most people engaged in a 'music for health' session on the first day of the inspection and other people spent time in the garden where a swing was available. There was also a sensory room with specialist lighting and sensory equipment for people to use.

We recommend that the provider reviews current practice and recording around daily activities to ensure they are appropriate and meaningful to people.

Care plans contained guidance for staff about the support people required in relation to their daily living, social and health needs. Care plans were personalised and each person's individual needs were identified, together with the level of staff support that was required to assist them. There was information with regards to people's personal histories such as where they were born, where they had lived and their family members. People's daily routines were detailed and included people's personal preferences, what people could do for themselves and when they required staff support. Staff were knowledgeable about people's preferences and followed this guidance. For example, staff were guided that one person could eat independently using a

spoon and they were encouraged to do so at lunchtime.

Each person had a one page profile which gave a summary of people's needs, background, likes and dislikes and essential care and support needs. This gave a clear summary to staff about what things it was important to know about a person in order to respond effectively to their individual needs. It included people's preferred name, their family contact, the number of staff they required to support them and how their disability affected them.

A relative told us that they would feel comfortable and confident in raising any issues that they may have with the service, but that they did not have any. The complaints procedure set out how to make a complaint about the service and what people could expect in relation to the provider investigating and responding to their complaint. The complaints information was available in an easy read format using pictures and symbols of people's emotions such as if they are of unhappy, frightened or angry, to help people understand its content. There had been no complaints since our last inspection visit in August 2017.

Inadequate

Is the service well-led?

Our findings

People communicated with the registered manager and were at ease in their company. The registered manager knew people well, including their individual needs and preferences. A relative told us that they knew the registered manager well and that they were approachable. Social care professionals raised concerns with us about the lack of meaningful activities on offer for people, occasions where there had been poor communication and limited support from the providers. The providers were selling the service and staff said this had resulted in a reduction in their actions to make improvements in the service.

At the inspection on 3 August 2017 we identified a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service and to mitigate risks. This was because service audits had not highlighted shortfalls found at the inspection and staff did not always feel supported by the registered manager or provider.

At this inspection on 18 and 20 April 2018, we found that quality monitoring systems for the service had failed to identify shortfalls or that where areas had been identified as requiring improvements that they had not been acted on. There were continuing shortfalls with regards to ensuring there were sufficient staff available and that staff had the necessary knowledge and support for their roles. We found new shortfalls in risk management and how some staff did not communicate with people in a respectful and appropriate way. The provider had a reactive rather than proactive approach to risk management. Staffing levels had been increased and staff training booked after these had been identified as areas for improvement at our last inspection in August 2017. However, despite assurances by the provider, staffing levels had not been maintained and not all staff had received the necessary training. We were told that this was for financial reasons and not a change in people's needs. When there had been a change in one person's behaviour staff guidance had not been put in place to minimise the risk and the local authority had not been informed. There was also inconsistent practice amongst the staff team in ensuring that people were treated with respect and included in conversations about them. Supervision sessions, which offer support, assurances and learning to help staff development, had not taken place within the timescales set by the provider. Three out of four night staff had not attended a supervision session for over a year. The registered manager and administration and finance manager had not attended supervision from the provider since September 2015 and an appraisal since November 2009.

The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service and to mitigate risks. This was a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager monitored staff absence in order to gauge staff morale. They had found that staff morale was good despite staff anxieties about the provider selling the service. Three care and one non-care staff had left since the last inspection. The registered manager said that the new staff employed had complimented the existing staff team and this had benefitted everyone. Most staff were positive about their role, the support they received and had a shared vision of the service. They were optimistic that a new

provider would make a positive difference to people's lives as the current provider did not always share the same vision and values.

The registered manager had worked at the service for 18 years and described her commitment to improving the service for the benefit of people. At the last inspection August 2017 she agreed she would benefit from attending local registered managers' forums to keep up to date with good practice. At this inspection in April 2018, the registered manager said she had been unsuccessful when enquiring about these events. After the inspection she was sent a copy of the Kent Registered Managers Newsletter for March 2018, which contained the relevant information. The registered manager had submitted notifications to the Commission about important incidents and events that had taken place at the service in a timely manner.

People's views were sought at keyworker meetings. A keyworker is a named member of staff who takes a lead role in communicating with the person and the staff team. Keyworker meetings were planned monthly although some people's had not taken place since January 2018. These meetings recorded activities people had participated in, their current health and any changes in their support needs. When suitable these reports could be shared with people's loved ones to keep them up to date. People's relatives and visiting professionals were also asked for their views and any ideas for improvement through the use of survey questionnaires. At the last inspection in August 2017 we found that the last survey results had been very positive. No additional surveys had been sent since this time.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had displayed their rating in the staff office, where visitors signed in. The inspection report and rating was displayed on their website via a link which is not deemed as conspicuous according to CQC guidance. The registered manager was directed to the relevant CQC guidance so that it could be followed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failure to ensure that people were treated with dignity and respect at all times. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess risks to people's health and safety and do all that was reasonably practical to mitigate them. Regulation 12 (1) (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there was an effective system to ensure there were sufficient staff numbers to keep people safe at all times. The provider had not ensured that staff had all the training and support they required to carry out their role. Regulation 18 (1) (2) (a) (b)

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 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service and to mitigate risks. Regulation 17 (1) (2) (a) (b) (f)

The enforcement action we took:

Impose a condition