Songbird Hearing Limited

Charing Court Residential Home

Inspection report

Charing Court
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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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 29 and 30 August 2017 and was unannounced.

Charing Court Residential Home is registered to provide personal care and accommodation for up to 33 older people. There were 32 people using the service during our inspection; some of whom were living with conditions such as dementia, diabetes or impaired mobility.

Charing Court Residential Home is a large detached property situated in the village of Charing, near Ashford, Kent. There was a communal lounge, a second quieter lounge and a dining room with a conservatory area. People's bedrooms were set over two floors; accessible by stairs or the passenger lifts.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected in September 2015 when it was rated as 'Good'. However, at this inspection we found that standards had not been sustained in some areas, which has resulted in a reduced rating of 'Requires Improvement' in every domain and overall.

Risks to people had not been properly assessed or minimised to keep them safe. This included risks associated with medicines, epilepsy and the spread of infection.

Not all recruitment checks were completed to the appropriate standard but most staff files contained adequate information to ensure that suitable applicants were employed.

Lighting in some areas of the service was poor and created a hazard for people, staff and visitors.

Care plans about health conditions did not contain sufficient detail to enable staff to care for people appropriately. Not all weight losses had been referred for professional input in a timely way to make sure people's well-being was protected.

Staff practice was in line with the principles of the Mental Capacity Act (MCA) 2005 but written assessments were not decision-specific in some cases. Further work was needed to ensure that Deprivation of Liberty Safeguards had been applied for appropriately.

Staff received a wide range of training but had not had guidance about epilepsy; even though some people using the service had this condition.

End of life care planning required improvement to make sure people's wishes were properly reflected. Some

people's personal care needed closer attention to preserve their dignity. There was insufficient stimulation for people during the inspection, although the activities staff was on holiday.

The complaints process in operation did not comply with the provider's own policy about documentation. However, people and relatives knew how to complain and felt listened to.

There had been insufficient oversight of the service by the provider to recognise that it had deteriorated since our last inspection. Audits and checks had been ineffective in highlighting shortfalls in the safety and quality of the service.

Assessments about risks to people from falls and skin breakdowns were detailed and gave sufficient guidance to staff to enable them to support people.

The premises had been reasonably well maintained and provided a comfortable environment for people to live in. People received nutritious meals which they appeared to enjoy and drinks were offered frequently throughout the day.

There were enough staff on duty to meet people's needs and staff were caring and gentle with people. Staff understood their responsibility to raise any concerns about people's safety or well-being with the relevant safeguarding authority. They told Inspectors that they enjoyed working in the service and that there was an open culture.

People and relatives said the registered manager was friendly, approachable and responsive to any concerns or needs they may have. Feedback about people's experiences was sought and acted upon.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all risks had been properly assessed and minimised; including those relating to the spread of infection.

Medicines were not consistently well-managed.

Recruitment processes needed further improvement to ensure only suitable staff were employed.

There were enough staff to meet people's needs safely and promptly.

People felt safe and staff knew how to recognise and report abuse. Accidents and incidents were documented and actions noted.

The premises and equipment were properly maintained.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some aspects of people's health care had not been adequately reflected in care plans; to ensure appropriate care and treatment.

Weight losses were not consistently referred for professional advice in a timely way.

The principles of the Mental Capacity Act (MCA) 2005 were not always followed but staff gave people choices and opportunities to make their own decisions.

Staff had received training to help them provide effective support in most areas, but epilepsy training had not been carried out until highlighted during the inspection.

Supervision sessions had generally been carried out regularly.

People had access to GPs, district nurses, podiatrists and

opticians.

People said they enjoyed the food and plenty of drinks were available.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The service was caring in most areas but required improvement in others.

Most people were well-presented but some others were not supported so well with their personal care; which impacted on their dignity.□

End of life care required more work to ensure that people's wishes were fully documented.

Staff delivered care with consideration and kindness.

People were treated with respect and staff encouraged people to be independent as far as possible.

Most people and relatives felt involved in care decisions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Organised activities were limited and some people and families felt more stimulation was needed.

Complaints were not documented in line with the provider's policy but people and relatives knew how to make complaints.

Care plan information was person-centred and staff knew people very well. Bedrooms were personalised with people's own possessions.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There had been a marked deterioration in the standards of care people received since our last inspection.

Auditing and oversight checks had been largely ineffective at identifying shortfalls in the safety and quality of the service.

Feedback had been sought from people, staff and relatives and was acted upon.

Staff said there was good teamwork in the service and that they felt valued.

The registered manager kept abreast of social care developments through a variety of sources and training.

Links had been forged with the local community.

Charing Court Residential Home

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 was planned to check 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 29 and 30 August 2017 and was unannounced. The inspection was carried out by two inspectors, an assistant inspector, and an expert by experience, who had cared for an older relative and had other experience of care services. Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with eighteen of the people who lived at Charing Court Residential Home and spoke with three people's relatives. We also spent time observing the support people received. We inspected the service, including the bathrooms and some people's bedrooms. We spoke with five of the care workers and the registered manager.

We 'pathway tracked' eight of the people living at the service. This is when we looked at people's care documentation in depth; obtained their views on how they found living in the service where possible, and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

All the people and relatives we spoke with felt that the service was safe. One person told us "Luckily I'm still quite healthy; I feel more relaxed living here than I did at home, knowing that if something did go wrong someone is at hand". Another person said "There are always plenty of people around if I did need help" and a relative commented "Staff are always busy but Mum never gets neglected".

However, not all known risks to people had been effectively minimised. For example, some people had been diagnosed with epilepsy and two people had experienced recent seizures. There were no care plans or risk assessments in place to provide guidance to staff about what to do if someone had a seizure. Staff gave us differing accounts of how they would support a person during and following a seizure and were unclear about the point at which they might need to call an ambulance. Staff had not received specific training about epilepsy; creating a risk that people might not receive appropriate care and support. Following the inspection, the registered manager contacted us to say that staff had now received training about epilepsy.

The lack of assessments to assess and minimise the risks to people is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.Risks associated with medicines had not been consistently addressed. During the inspection, at 10:10am, we observed that one person had a pot of various tablets in their room. This person told us that they were not feeling very well. The medicines administration record (MAR) had been signed by staff to say that all this person's medicines had been administered to them at 8am that morning. MAR should only be signed once the person has been observed swallowing their medicines. This was unsafe practice and it was not clear if the person was feeling unwell because they had not received their morning medication. The registered manager ensured this person received their medicines immediately once we made them aware of the issue. They also told us that the staff member responsible would be disciplined for breaching medicines safety protocols.

Some entries about people's prescribed medicines had been made on the MAR in handwriting. In these cases it is good practice for two staff to sign the handwritten entry to show that the dosage and identity details have been thoroughly checked. However, this had not happened and the MAR had not been checked by a second staff member to ensure its accuracy. There was a loose strip of tablets in a plastic tub inside the medicines trolley. There was no name, dosage instruction or information leaflet with these tablets. The registered manager said that these tablets were no longer in use and should have been returned to the pharmacy. Having unlabelled medicines in the trolley meant there was a risk they could be administered in error.

There were no detailed protocols about medicines people could take as and when they needed them (PRN). These are designed to prevent the risk of people being given too much of their medicine by documenting the maximum and minimum doses, time gaps between each dose and the limit to be taken in any 24 hour period. PRN protocols also help staff to monitor how often people need their PRN medicines, which might for example indicate they are experiencing pain more frequently.

Some liquid medicines had not been dated when they were first opened so that staff could ensure they were

disposed of in line with manufacturer's instructions. For example; one person had been prescribed eye drops on 15 July 2017 and these were still in use on 29 August, even though the directions on them stated they should be disposed of within four weeks of opening. There was a risk that the drops were less effective after the four week period had expired.

The temperature of the medicines room had been measured daily, but had risen above the recommended maximum level for many medicines (25 degrees) on six days in August 2017. No actions had been taken to remedy this and there was a risk that some medicines could deteriorate in such warm temperatures. The registered manager said they would investigate the possibility of a cooler unit for that room.

The failure to manage medicines safely is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service was generally clean and tidy but some infection risks remained. Used latex gloves were seen in open waste bins around the service. The registered manager confirmed that these should have been disposed of as clinical waste. One person had a barrier spray for their skin in their room and this had faecal matter on the bottle, which was unhygienic. Another person had a brown stain on their carpet and soiled underwear was found tucked down the side of their chair. The registered manager told us this must have only just happened and told us the carpet would be deep-cleaned straight away. There had been a recent small outbreak of diarrhoea and vomiting in the service so good hygiene practices were especially important to ensure that people stayed well. A catheter bag and tubing were found on the floor in another person's bedroom. Urinary catheters are used to drain urine from the bladder to a special bag outside the body. No cover had been placed over the end of the tube that would be joined to the part of the catheter which enters a person's body. We asked staff how they cleaned catheter tubing and surrounding areas. One senior staff member said they did not clean the tubing before attaching it and a second staff said they washed it with "Just warm water and a cloth". The provider had a catheter cleaning policy which said that the area around a catheter site should be washed daily with soap and water. People could be exposed to the risk of infection if good hygiene practices were not consistently followed.

The lack of consistent infection control processes is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some risk assessments about, for example falls or skin integrity, contained sufficient information for staff to understand the risk and take appropriate action to minimise it. Where people were prone to skin breakdowns, staff knew they should be supported to reposition regularly and had recorded when this was done.

When people refused their medicines they were monitored and the GP was informed. Medicines about which there are specific legal requirements were correctly stored and documented. Regular audits were undertaken of these medicines to check that stocks tallied and two staff signed records to confirm that the correct dose had been administered to the right person. Where certain medicines posed a risk if taken alongside other medicines, this was noted on the MAR in red to make it clearly visible to staff. Any known allergies were documented and the MAR contained photos of people to help staff ensure they administered medicines to the correct person.

Recruitment processes were generally robust, but one staff member's application form showed a gap in their employment history. It was important that a full history was obtained so that any gaps could be explained and the provider given a full picture of the applicant's background before employing them to work with people in the service. This is an area for improvement, but the registered manager showed us a

new checklist that had just been introduced to ensure that all employment gaps were explored and the reasons documented in future. References had been sought for new staff and any queries had been verbally followed up by the registered manager; and conversations were documented. Criminal records checks had been made and records of interviews showed that care had been taken to employ only suitable staff.

People lived in a safe environment overall, but some corridors were very dark during the inspection, with no lights having been switched on until we raised it with the registered manager. The dark corridors created a hazard for people, staff and visitors because it was difficult to see where to walk and some floors were uneven; which might cause people to trip or fall. This is an area for improvement. All other environmental safety checks had been regularly carried out. Fire equipment, emergency lighting and fire exits had been routinely serviced and people had individual evacuation plans in place in case of an emergency. Fire alarms were tested weekly and the registered manager carried out unannounced fire drills.

The premises were reasonably well-maintained and decorated and provided a comfortable environment for people. Equipment such as hoists and special baths had been serviced to ensure they remained safe for people to use. The gas, electricity and water supplies had been regularly checked by professional contractors on a rolling programme so that any issues were quickly identified and put right.

There were enough care staff deployed to meet people's needs. There was one senior staff and four care staff on duty throughout each day with three care staff working waking night shifts. Rotas showed that these staffing levels had been consistent in the weeks prior to our inspection. The registered manager told us that they did not use a formal dependency tool to determine how many staff were needed, but continuously assessed any changes in need and altered staffing numbers to meet these. They gave an example of when a person had reached the end of their life and extra staff were brought in to ensure that the person had one to one care and company at that time.

Although agency staff were not often used, it had been necessary to bring agency staff in during a recent sickness outbreak; which affected some staff as well as people. Our observations during the inspection showed that people received prompt attention and support from staff, with call bells being responded to within reasonable timescales. People and relatives all said there were enough staff. One person told us "Always a very good response, of course it depends on what they are doing. I don't have to wait more than five minutes though ". Another person said "At the weekend I had a bout of sickness the night staff were here as soon as I pressed the buzzer." A relative remarked "Mum's only recently moved in, but we always see plenty of staff about when we visit". Staff were visible in corridors during the inspection and there was one staff consistently in the lounge with people so that they could monitor people's safety and respond to requests for support.

Accidents and incidents had been properly recorded and actions taken to help prevent further incidents had been noted. For example; when a person had experienced a skin tear, a body map had been completed to clearly show the site of the injury and the district nurse had been called in to dress the wound. The local safeguarding authority had been notified of matters which required investigation by them and staff understood how to recognise and report any suspected abuse. All staff had received up to date training in safeguarding people and had access to contact details for the local safeguarding authority should these be needed.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that they had confidence in staff to support them appropriately. One person said "They do their job very well, I can no longer bend my knee, so they help me get out of bed by moving my legs together to the edge of the bed and then help me sit up. Then I hold unto my Zimmer frame as I put my feet to the floor". Another person told us "Staff are very observant and will always notice if I am not feeling well and stay with me until they make sure I am okay". A relative commented "Mum seems to interact well with the carers. They are very kind and supportive to her and us".

People's health was monitored and enhanced in a number of ways. The GP visited regularly and people had access to chiropodists, opticians and the district nurse. However, guidance for staff about people's conditions and care needs was not always detailed enough to provide the information needed to ensure people remained well. For example; some people lived with diabetes and there was general guidance about the condition on display in the staff area. Individual care plans about the condition were scant however, and did not include details about acceptable upper and lower blood sugar levels; or what action staff should take to address changes in these. There was a risk that staff would not recognise when people's diabetes became unstable or required further treatment.

Some people had urinary catheters in place. Again, care plan guidance about catheter care was limited and did not provide enough detail about how staff could recognise any issues. The provider had a catheter protocol which stated that each person should have an individual care regime designed to minimise the problems of blockage/encrustation. This had not happened and there were no care plan directions for staff to note for example, the colour and odour of urine to check for possible infection, or instructions for cleaning the catheter equipment and site. Where people self-managed their catheter, there was no information about how staff could support them to do so safely and effectively.

The care plan for a person who sometimes showed behaviours that challenged had been updated following a recent deterioration in their condition. However, records showed that a nurse practitioner had visited them in March 2017 and recommended that their intake of tea, coffee and dairy products should be limited. The registered manager informed us this was not being monitored, and there were no records to show that any action had been taken to follow this recommendation; which was designed to improve the person's health and well-being.

The lack of appropriate care designed to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some people had experienced significant weight losses and in most cases they had been referred to the GP for advice about this, and blood tests had been subsequently carried out. However, one person had lost 17lbs between May and July 2017 but was only referred to the GP about this during our inspection. People had only been weighed every two months, even when they were losing weight. This did not provide an opportunity to quickly identify any further losses which might warrant professional intervention. We spoke with the GP who confirmed that they had not been consulted about the weight loss previously. However,

they also told us that the person was not underweight; they were not especially concerned about the loss but would check if any blood tests were needed. Nonetheless, there was a risk that this person could have had an underlying medical condition causing their weight to decrease over a number of months, but staff had not sought timely medical advice despite the large losses.

The risks to people's health had not been properly assessed or mitigated; which is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had all received up to date training about the Mental Capacity Act (MCA); which is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. In practice staff were observed seeking people's consent for straightforward decisions and providing people with choices. One person told us, "In the mornings, the carer always opens the wardrobe door and together we choose what I will wear for the day". There was evidence of best interest meetings with appropriate professionals and families to help make the right decisions for some people who lacked capacity to make their own. However, written assessments about people's capacity were not always decision-specific and this is an area for improvement.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).The registered manager had made two applications for DoLS from the relevant authority. In conversation with the registered manager however, it became clear that DoLS applications may need to be considered for more people. This was because the registered manager said those people lacked capacity and would need to be prevented from leaving the service alone for their own safety; which is a restriction of their liberty.

The failure to consider capacity and apply for DoLS where warranted is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had received a range of training to support them in carrying out their roles. This included mandatory subjects such as moving and handling, MCA, safeguarding and fire safety. Staff were also trained in other areas such as equality and diversity, dementia awareness and end of life care. 13 staff were National Vocational Qualification (NVQ) qualified in social care. NVQ's are training courses designed to equip staff to carry out their jobs effectively in the field. However, staff had not received training about epilepsy even though two people had this condition and had experienced recent seizures. The registered manager arranged for training in epilepsy following our inspection and confirmed to us that it had been carried out.

A detailed induction was provided to new staff and we read evidence of the training and job shadowing which had taken place in this period. Staff had generally received regular supervision and appraisal from the registered manager, but there were some recent gaps in supervisions due to the registered manager's limited availability to carry them out. The registered manager had a deputy; but they had not conducted the supervisions in the registered manager's place; to ensure staff had the regular opportunity to discuss any concerns and talk about training needs or development. This is an area for improvement.

People received a choice of nutritious meals and plenty to drink. There was exceptionally hot weather on one day of our inspection and staff were observed giving people cold drinks throughout the day and encouraging them to drink as much as they could. Most people ate their meals in the dining room and conservatory; which had a sociable feel and people chatted and laughed together over lunch. Others had meals in their bedrooms and we observed staff supporting people to eat them by describing the food and offering gentle prompts with each mouthful.

Most people enjoyed the food on offer and said that their preferences were taken into account. One person told us, "To be honest we have a better variety of food here than we used to have at home". Another person said, "Chef always buys best quality food, I am fond of salad and the chef always does me a lovely one with lovely beetroot and boiled eggs". A relative remarked, "Mum didn't like the Spaghetti Bolognese so the chef quickly did a jacket potato for her". There were bowls of fresh fruit in communal areas of the service; which we observed people helping themselves to as they wished.

Requires Improvement

Is the service caring?

Our findings

We asked people and relatives about their experiences of the care received in the service. We heard only positive feedback about staff and the care given by them. One person told us, "Staff are lovely, they really care about you. Always say good morning and how are you. It doesn't make you feel so alone". Another person said, "All the staff are charming. All very caring, I never feel hurried and they're always asking 'are you okay'", and a further person commented, "Staff are very good and caring. This is the best home you can have". Three relatives spoke with us and said "Whenever we visit, there is a very happy and calm atmosphere and we are always made to feel very welcome", "We're very pleased with the home. It's not clinical but actually a home. We were able to personalise Mum's room with her own bed and bits and pieces" and "Staff all seem friendly, able to answers any of our queries".

Most people appeared well-groomed and wore clean and coordinated clothing. However, three people had very dirty fingernails or long toenails while others had painted and manicured nails; and some ladies had noticeable facial hair. Unclean nails can pose a risk of infection if people then put their hands to their mouths and long finger and toe nails can cause skin tears if not kept in check. Staff and the registered manager told us that some people were resistant to personal care such as having their nails cut or cleaned, but staff tried their best. Care plans for these people did not document any particular difficulties with personal care or explore any alternative ways to address them and this is therefore an area for improvement.

People told us they were treated with dignity and respect by staff who really cared about them. One person said "Even though my door is always open, staff knock before they come in." and another person said "Staff always ask me what I want to do. Always polite". A relative said "Staff always use Mum's name when saying good morning to her, which is respectful. They're particularly good about asking people if they want to use the toilet in a dignified way and not shouting it across the room". We observed that staff showed kindness and consideration when supporting people. For example, they showed vigilance in helping one person take off their cardigan without pulling up their shirt and were quick to assist another person with their dentures, to save them from any embarrassment. Care plans and other documentation were stored securely and people's confidentiality was maintained by staff.

There appeared to be an easy-going mutual bond between people and staff. Small gestures such as waving to people in their rooms as staff walked by made a difference to those we spoke with. One person said "All of the staff wave and chat to me so I see lots of people in the day; We share a joke or two and I see them as friends". A relative told us "Whenever we visit, there is a very happy and calm atmosphere and we are always made to feel very welcome". We observed an especially kind interaction when one person spotted an orange in the communal fruit bowl and told staff they could not remember how the fruit tasted. The staff member pulled up a stool next to the person and helped peel the orange together. Then staff supported the person to take small bites of the fruit while discussing the taste and flavour. The person was clearly delighted with the one to one attention and the taste of the fruit, and their face visibly lit up.

People were encouraged to be as independent as possible. One person told us, "Staff always ask what help I

need from them when I am washed; they give me a soapy flannel to do my face". Another person said, "I go for a walk around the grounds whenever I want to. Nobody stops me or interferes" and a further person added "Staff never try to stop me doing anything. I like to keep my own room clean and make my own bed". Staff had proactively found ways to support people to be both independent and also have a sense of self-worth. One person told us they had felt depressed when they were first admitted to the service but that "Staff knew I needed something to do and gave me a little job peeling the carrots. Now I help the chef with the sandwiches, it takes me out of this room, does me good". It was important to this person to feel like they were making a valuable contribution to life within the service and staff had recognised and successfully addressed that need.

We observed that people were encouraged to walk with equipment such as Zimmer frames and that staff made sure these were close to hand for them. Reassurances were given to people as they manoeuvred themselves to sit down, with staff clearly directing people to feel for the seat behind them and gently lower themselves.

The people and relatives we spoke with during the inspection said that they felt reasonably involved in decisions about their care. A recent questionnaire completed by people had highlighted that some people felt they did not know what staff were writing about them in records and would like to be more included. The registered manager said that they had responded by going through some people's care plans with them; but this was a work in progress.

There was no one receiving end of life care during our inspection. Care plans about people's end of life wishes and preferences were limited and require improvement to ensure they are person-centred and consider the aspects of care which might make people's last day's comfortable, pain free and compliant with their choices. Some staff had received training about bereavement, death and dying and we read thank you cards from the relatives of people who had passed away at the service. One of these read, "Mum loved it at Charing Court as you were all so lovely to her" and another said, "A big thank you for caring for Dad in such a lovely way. You made his last years happy, comfortable and dignified".

Requires Improvement

Is the service responsive?

Our findings

People did not always receive sufficient social stimulation. During our inspection there were two notice boards detailing activities on offer. The information on these boards differed, which could be confusing for people with memory loss or living with dementia. None of the advertised activities happened in any event and people mostly sat in front of the TV;(which had a system message showing on the screen throughout most of the day which made the programme very difficult to watch), read magazines or dozed. One person told us "There's not much to do honestly: I do get fed up with the same four walls". The registered manager told us that a member of care staff had recently changed role to become an activities coordinator in the service, but they were on holiday during the inspection. However, when we spoke with people and relatives about the activities coordinator they all said that there was none and that care staff sometimes played games "If they have time" or there were sometimes visits from external entertainers, such as singers or seated exercise classes.

One relative told us, "They could do with more stimulation: not a lot of activities" and another family said that the expected activities for the weekend prior to our inspection had not taken place, "Which is a real shame because I think Mum would've enjoyed them". In a recent survey of people using the service one person had commented that they became "Bored at times". We observed staff passing a bouncy ball between people which they seemed to enjoy. However, the main lounge was divided into two areas by the seating there, and all of staff efforts were concentrated on the people in the larger area; while the others in the smaller zone just looked on. There was a missed opportunity to include more people in the game and provide them with at least some stimulation.

The lack of adequate stimulation to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some people told us they preferred their own company and that staff checked on them regularly when they chose to stay in their room. One person told us "I generally colour in my adult colouring book, very occasionally go to activities; I like my own company and like watching the TV". Another person said "I like the exercise classes, its good fun".

The provider's complaints protocol was clearly displayed in the foyer of the service. However, complaints had not been documented in line with the provider's policy. The registered manager showed us an emailed complaint which had been printed off and was filed in a cabinet. There was no complaints file or log to illustrate when complaints were received and responded to, or to detail any investigations undertaken. The provider's complaints policy stated that all complaints and actions should be recorded in people's daily notes and in the 'Complaints book'. The registered manager confirmed that there was no such book in use. Although the registered manager had responded in full to the emailed complaint, there was no information available about how it had been investigated or any remedial actions taken. This was not an effective way of receiving and handling complaints.

The failure to operate a robust complaints process is a breach of Regulation 16 of the Health and Social Care

Act (Regulated Activities) Regulations 2014.

People and relatives said they would not hesitate to complain to the registered manager if they had any issues. Some people had made complaints and said they were satisfied with the registered manager's response and the outcomes.
Care planning was person-centred, in that people's individual preferences and wishes were taken into account. There was detailed information about people's lives before they moved to Charing Court and the people who were important to them; and staff knew people very well. We observed that staff called on their knowledge of people's pasts when they engaged with them and this seemed to provide pleasure and comfort to people.

Preferences about times to get up and go to bed, food and drink and various aspects of how people liked their care to be delivered had been documented. People and relatives told us that staff went out of their way to try to meet their choices. One person told us "I like a late tea so have mine in my room at about 7pm. Staff bring me milk and water in the morning and its kept in the fridge and with my kettle I can make myself a drink whenever I fancy". Another person said they liked to shower before bed and that staff happily facilitated this for them.

Staff were immediately responsive to changes in people's wishes. One person wanted to try to walk with a frame and staff supported them to do so by walking alongside them and offering encouragement. Staff told us that this person usually preferred to use a wheelchair but was able to mobilise with a Zimmer when they chose to. Staff reacted quickly to ensure that this person was provided with the opportunity to walk with support, because it was their choice to do so. A relative told us, "[Name] has always been very independent. She hadn't walk for two months before coming here but staff have given her the confidence to walk again using the Zimmer frame".

People's rooms were personalised with their own possessions and photos to give them a homely feel. Bedroom doors were individualised by photos or pictures of items that held a meaning for people. One person's had a picture of a motorcycle on it and staff told us how this person had a passion for motorbikes. One person told us "I love my room. All my things are with me, it's warm and comfortable and just how I like it".

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2015, Charing Court was rated as good in all areas. At this inspection, there had been a marked deterioration in a number of areas across the service; which impacted on people's health, safety and well-being and led to several breaches of Regulation. These included: medicines not being managed safely, infection risks emerging, and other known risks going unaddressed.

The registered manager told us they had "Taken my finger off the button" in the previous four months. We spoke briefly with the provider during the inspection: they did not have robust oversight of what had been happening in the service. There were no specific audits carried out by the provider to check how the service was running. We told the provider about some of the issues we had discovered and that the service was no longer good.

Quality assurance checks and auditing had been largely ineffective in highlighting the shortfalls we identified at this inspection. Although a raft of detailed audits were carried out by the registered manager, these were often pitched at a high level and did not successfully address basic quality in care issues. For example, one audit commented that 'The home is easy to find and a map is available'. Another audit checked that there was a formal recruitment policy in place but did not prompt the registered manager to ensure that individual recruitment files contained proper details. An audit about medicines management had scored 100% on 2 August 2017 and yet we found numerous problems in this area just less than four weeks later. The auditing tools were not helpful in determining where any lapses in quality or safety had occurred, so that these could be put right. The registered manager said that the provider did not carry out their own checks or audits to ensure that they maintained good oversight of the service. This meant that the provider had not picked up on the failings which were happening until these were identified by Inspectors.

The lack of effective audit processes is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Registered persons are obliged to notify the CQC about certain incidences and events. These include the authorisation of DoLS. The registered manager had not submitted statutory notifications about DoLS authorisations to the CQC. They told us that they had not understood their responsibility to do so.

This is a breach of Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Statutory notifications about other incidences had been made to the CQC in a timely manner.

Feedback had been sought from people and their relatives about their experiences of the service. There was some evidence to show that the registered manager had taken actions in response to issues raised in survey returns. For example; some people had commented that certain night staff could be rude on occasion. The registered manager told us they had met with the staff concerned and reminded them of the need to remain courteous at all times. The registered manager added that the staff member was actually very caring in their view, but their communication was sometimes perceived as abrupt.

People and relatives told us that the registered manager operated an open door policy, was approachable and easy to talk to. They said that the registered manager was visible in the service and often walked around, stopping and speaking to people in their rooms and observing mealtimes in the dining room. One person told us, "[The registered manager] is always prepared to stop what she's doing and give you time when you want to tell or ask her something". Another person added "The manager is always around in the dining room when we are eating, she stands and chats with people and always asks how we are and what we think of the food". A further person told us, "It is really easy to talk to the manager; she is always prepared to listen. She always asks me how my leg is healing and is there anything else they can help me with". A relative commented, "She is very interested in auntie's care and is very informative about her illness" and another said "We rang around a lot of other homes to arrange a visit. This was the only home where we were told to come whenever we wanted and this demonstrated to us that the home had an open culture".

The registered manager kept abreast of developments in the social care arena through CQC news updates and membership of Kent Care Homes Association. They also ensured they received patient safety alerts about medicines and had undertaken training to NVQ level five, with a registered manager's award.

Links with the local community had been forged so that people benefited from visits from a local choir and church ministers.

There was a friendly atmosphere and staff seemed relaxed and comfortable when speaking with us. Staff said they enjoyed working in the service and that the registered manager and deputy were good to work with. Staff reported a strong team ethic and said that they worked effectively together to make sure people's needs were met. One staff member said "This is my second home and family; of course I want to do my best for them always".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not always met appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Some people's liberty was restricted with no DoLS authorisation in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been properly assessed or mitigated. Medicines were not safely managed. Infection control was lacking in some areas.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider's complaints policy was not being followed in practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was insufficient oversight of the quality

and safety of the service.