Sira Care Home Limited

Garlinge Lodge Residential Home

Inspection report

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Date of inspection visit:
11 June 2019
17 June 2019

Date of publication:
26 July 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Garlinge Lodge Residential Home is a small residential care home providing personal care to eight older people. The service can support up to 14 people.

People's experience of using this service and what we found
Relatives we spoke with felt staff knew people well and understood their care and support needs. People appeared happy and content. They smiled and interacted well with staff and each other. People had formed friendships and saw the service as their home.

Risks to people's health and welfare had not been assessed. People were at risk or harm because the provider had not adequately maintained the building to ensure it was fit for purpose. The fire alarm system, emergency lights, the lift, electrical equipment and gas equipment had not been serviced and monitored. The lift was faulty which increased the risks to people and staff. People were at risk of developing Legionnaires disease because the systems and processes in place to reduce the risks were not suitable.

Systems in place to check the quality of the service were not robust. The provider had not identified the concerns we raised in relation to risk management, the environment, mental capacity assessments, dignity and respect and providing care and treatment to meet people's needs and preferences.

Not all accidents and incidents were recorded. Processes and systems to analyse incidents and accidents for trends or lessons learned had not been developed.

People liked the staff. Staff knew people well and treated them with kindness, dignity and respect. The provider had not always treated people with dignity and respect as they had failed to improve the service.

People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible; however, the policies and systems in the service did not always support this practice. Mental capacity assessments were inconsistent and did not always follow the Mental Capacity Act 2005. Assessments made were not decision specific.

Although care plans were in place to describe the care and support people needed, they did not always include some important information individual to the person and failed to provide guidance to staff on how to meet their emotional needs. Activities offered to people were minimal; activities took place for one hour four days a week.

There were not enough staff deployed on shift at all times to ensure people's care needs were met. Staff had not always received appropriate training, induction and supervision. No new staff had been recruited since our last inspection.

Infection control practice within the service required improvement. We made a recommendation about this.

Medicines were stored, managed and administered safely. PRN (as and when required medicines) protocols were not in place to detail how people communicated pain, why they needed the medicine and what the maximum dosages were. This is an area for improvement.

Assessments were in people's care records for various areas such as medicine, dependency, and nutrition. However, the provider was unable to tell us how assessments had translated to the care provided. This was an area for improvement.

People were not always given information in a way they could understand. We made a recommendation about this. People told us that they did not feel confident to raise concerns. A complaints policy was in place which was displayed in the service. The policy was not displayed at a height where it would be visible, and it was not in an accessible format.

Staff and the registered manager understood their responsibility to protect people from abuse. Staff spoken with could explain how any suspected abuse would be reported.

People received access to healthcare professionals.

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

Rating at last inspection and update
The last rating for this service was requires improvement at a comprehensive inspection which was carried out on 20 November 2018 (published 31 January 2019). The service received a focused, shorter, inspection on 20 February 2019 (published 19 March 2019) which showed there had been an improvement to the Safe domain but the overall rating remained as requires improvement.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. They told us they would make the improvements by 21 May 2019.

At this inspection we found improvements had not been made, the service had deteriorated and the provider was still in breach of multiple regulations. This service has not reached a rating of good for the last five consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about people's safety because of the staffing levels at the service and training provided to staff. A decision was made for us to inspect and examine those risks.

We found evidence that the provider needs to make improvements to the whole service. You can see what action we have asked the provider to take at the end of this full report. The overall rating for the service has deteriorated to Inadequate. This is based on the findings at this inspection.

Enforcement
At this inspection we have identified seven breaches in relation to; person centred care, dignity and respect, need for consent, safe care and treatment, premises and equipment, good governance and staffing.

Please see the action we have told the provider to take at the end 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.

Follow up
We planned to meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We also planned to work with the local authority to monitor progress and return to visit as per our re-inspection programme. However, the provider has closed the service and applied to cancel their registration.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our safe findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our caring findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our caring findings below.

Requires Improvement

Garlinge Lodge Residential Home

Detailed findings

Background to this inspection

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

Inspection team:
The first day of the inspection was carried out by two inspectors. The second day of the inspection was carried out by an inspection manager and one inspector.

Service and service type:
Garlinge Lodge Residential Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also the provider of the service.

Notice of inspection:
The first day of the inspection was unannounced. We told the registered manager we would be returning for the second day.

What we did:
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed the information we held about the service including previous inspection reports. We also looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

We spent time with each person living at the service. We received feedback from four people. We spoke with six people's relatives. Some people were not able to verbally express their experiences of living at the service. We observed staff interactions with people and observed care and support in communal areas.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. We received feedback from the local authority commissioners. The local authority told us there had been some telephone contact with the provider in the last year. The provider had advised the local authority that they had closed one floor of the service due to staff recruitment and retention difficulties.

We spoke with nine staff including; the cook, the housekeeper, care staff, senior care staff and the registered manager.

We looked at four people's personal records, care plans and people's medicines charts, risk assessments, staff rotas, policies and procedures and other management records including audits.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with contractors to check the information we had been supplied was accurate. We asked the registered manager to send us additional information after the inspection. We asked for copies of the staff training matrix, telephone numbers and servicing records. These were not received in a timely manner.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk assessments did not have all the information staff needed to keep people safe.
- Each person had a Personal Emergency Evacuation Plan (PEEP). A PEEP should detail the level of assistance and the type of equipment required so people can reach a place of safety in the event of an emergency.
- PEEPS were not detailed and did not contain all the relevant information to guide staff to support people in an emergency evacuation. For example, one person had very poor eyesight but there was no mention of this in their evacuation assessment. Several PEEPS said, 'Make use of evacuation chair if needed'. Staff told us they had not received any training to use this piece of equipment and could not tell us how they would use it safely. One staff member said, "I would have to read the instructions", another staff member said, "I have not done the training, but could not use it anyway."
- There was a folder located by the front door containing PEEPs and floor plans of the service to be used in an emergency. Several PEEPS referred to people who no longer lived at the service.
- A document called 'Fire procedures for residents' was contained within peoples care files. It stated, 'When the alarm sounds all the doors will be kept closed this is a safety measure to protect you from the fire. Each door will be safe for half an hour. When you hear the alarm you should get up and put on your slippers and dressing gown until someone comes to fetch you. Do not open door as this might increase the danger, if the fire is a long way from your room then it may be a little while before someone comes to assist you as we will be attending to people closest to the fire first. Remember the door is keeping you safe so long as it remains shut. Someone will come to help you as soon as they can.' We found that doors were not fire resisting doors so the information supplied to people put them at greater risk.
- We found most fire doors, which should automatically close in the event of a fire, were propped open with door wedges on the first day of our inspection and not all fire doors could fully close.
- The building had not been suitably maintained. The last fire system service had been carried out on 06 June 2018. The registered manager told us that the fire alarm system had been serviced but they were not able to provide evidence so we were not assured that the information supplied was true and accurate. British Standard (BS) 5839 recommends that a fire alarm system should be inspected by a competent person at least every 6 months and the government recommends following this standard. We reported our concerns to Kent Fire and Rescue Service and the local authority.
- There was an increased risk to fire safety in the service because other essential maintenance had not taken place. Gas Safety checks had not been carried out since 26 May 2018. The registered manager told us that the gas checks were out of date and they had called the engineer, but this had not occurred at the time of this inspection. Portable appliance testing had not been carried out on electrical appliances since 11 May 2018. This increased the risk of fire.
- The last lift service had been carried out on 20 March 2018. The registered manager told us repeatedly

during the inspection that it had been serviced regularly and it was up to date. However, they were unable to provide the documentation to evidence this. The kitchen lift had broken down several months ago and the staff were bringing hot food and drinks up to the ground floor using the passenger lift. Staff told us that the lift dropped daily and that they had been shown by the registered manager how to override the hydraulics to pump the lift back up so the level of the floor of the lift met the level of the floor. Staff told us that this happened daily and the lift was known to drop by approximately a foot. This was a serious danger to people, visitors and staff using the lift. The Health and Safety Executive (HSE) guidance 'Thorough examination and testing of lifts' states that all lifts provided for use are thoroughly examined by a competent person every six months or sooner if the lift is faulty. This had not happened which has put people, staff and visitors at risk of harm. We reported our concerns to the HSE.

● There was a legionella risk assessment in place which had been completed by the registered manager on 20 April 2016 and reviewed annually up to and including 22 March 2018. HSE guidance regarding Legionnaires disease states that the person carrying out legionella risk assessments must be competent to do so. The registered manager was not competent to do so. The legionella risk assessment had not been updated and amended and additional practice put in place when rooms within the service became vacant. There was no evidence to show that the provider was running the water in empty rooms to flush out any stagnant water that may be in the pipes to decrease the risk of legionella and no shower head cleaning had taken place.

● The provider had systems in place to record and monitor accidents and incidents. However, it was not clear how they learnt lessons from these to reduce the risks of issues occurring again.

● One person had fallen and injured themselves two weeks before we inspected the service while mobilising in the lower ground floor to access a room used by the hairdresser. There was no evidence to show that the provider had discussed with staff the risks of people mobilising in this area of the service with no staff support. Risk assessments had not been put in place. A staff member told us, "I haven't been informed about escorting people down there." Another staff member said, "It has been said that staff should escort people to the lower ground floor in wheelchairs." This meant that staff had inconsistent information which put people at risk of harm.

● Incidents had not always been recorded. We observed that one person had cuts from a razor on their face and neck. We checked the accident and incident book and found that there was no incident form to detail when this had happened and who had been supporting the person with their personal care needs. We checked with staff who told us that the registered manager had assisted the person to shave when the injuries occurred. The injuries had not been adequately reported.

The failure to manage risks to people's health and welfare was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the concerns found during the inspection. Relatives told us that they felt their loved ones were safe. Comments included, "They walk behind him when he's walking with his frame" and "I wouldn't leave her there if I wasn't happy with the care and thought she wasn't well cared for."

Staffing and recruitment

● No new staff had been employed since we last inspected the service; we did not check any recruitment records.

● There were not enough staff to meet people's assessed needs. The staffing rota showed that there had been occasions when only one member of care staff had been deployed on shift to meet people's needs. The registered manager told us that this was not the case, however following additional questioning they admitted to, "Testing out", staffing levels and having one staff member on at night and at times during the day.

● Relatives we spoke with reported that there had been occasions when they had found one staff member on shift and their loved one had not had their needs met. One relative said, "I never know how many staff are meant to be on at the time. Mum would like to be somewhere else, we don't know what is going to happen here."

Registered persons had failed to deploy sufficient staff to meet people's assessed needs this was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Most people were in receipt of as and when required (PRN) medicines. PRN protocols were not in place for people to detail how they communicated pain, why they needed the medicine and what the maximum dosages were. This meant that staff working with people (including those administering these medicines) may not have all the information they need to identify why each person takes that particular medicine and how they communicate the need for it. The provider's medicines policy which had been reviewed in May 2019 stated that anyone having PRN medicines should have protocol in place. This is an area for improvement.

● Medicines were securely stored and kept at the correct temperature to ensure their effectiveness.

● Medicine administration records (MARS) were complete and accurate and people received their medicines as prescribed.

● Medicines were given by staff who had received medicines administration training. We observed good practice at medicines rounds.

Preventing and controlling infection

● Staff told us they followed good infection control practices and used personal protective equipment (PPE) to help prevent the spread of healthcare related infections where necessary.

● The service smelt fresh and looked tidy on the first day of the inspection. On the second day of inspection there were strong smells of urine in the lower ground of the service. We spoke with the registered manager about this. They told us the room was not in use and required cleaning.

● Some rooms required additional cleaning. We observed one person's bedroom had a thick layer of dust on hard surfaces. One person told us that the housekeeper was unable to clean under the bed because of the layout of the room and because the vacuum cleaner did not have a pipe that would reach. We observed that the toilet in one bathroom was very soiled and dirty. One person told us, "I will not use communal bathroom as the toilet its filthy there is often wee all round the seat and on the floor and one night I went to go in there and there was a turd on the floor. It was disgusting."

● Relatives told us, "The rooms are always clean" and "It's homely, I call it shabby chic."

We recommend that the provider seek advice and guidance from a reputable source on how to improve infection control practice within the service.

Systems and processes to safeguard people from the risk of abuse

● The provider had effective safeguarding systems in place to protect people from the risk of abuse.

● Staff continued to know how to spot signs of abuse and mistreatment. Staff had received safeguarding training.

● Staff had confidence in the provider to appropriately deal with concerns if they reported them.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- The provider told us they had made one DoLS application and was waiting for authorisation from the local authority. The provider said they could not find the application to show us. In the persons care file a previous authorisation request had been made in February 2017 which had not been granted and there was no information to show this had been followed up with the local authority. The provider told us they received confirmation that the person's DoLS had been granted on the second day of our inspection.
- The provider did not have a good understanding of the principles of the MCA. One person had a capacity assessment which was completed in April 2018. Under the section which asked, 'Decision requiring test of mental capacity (please provide details)' they had recorded, 'Has a history of mental illness with psychotic episodes'. It was not clear what specific area the assessment was in relation to.
- We found consent forms within one person's care file which had not been completed and signed by the person, despite them having capacity to do so.
- One person had a 'Do not attempt resuscitation' (DNAR) in place which had been completed by a consultant at the local hospital following a short stay. The DNAR stated that the person did not have the mental capacity to consent to DNAR and the consultant had put it in place without any discussion with the person or their relatives. The provider had not challenged this DNAR on the person's return from hospital or spoken with them about it. Staff checked with the person and their relatives during the inspection, they did want to be resuscitated and were shocked that this had been put in place. We asked the provider to make contact with the GP to ensure that this DNAR is cancelled.

The failure to follow the Mental Capacity Act 2005 was a breach of Regulation 11 of The Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed that people made decisions about their care and treatment. We heard people declining and accepting offers of food, drink and people chose whether to participate in activities.
● Where people had a Lasting Power of Attorney (LPA) in place, this was recorded their care records. An LPA is a legal document that lets the person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

Adapting service, design, decoration to meet people's needs
● The garden was difficult to access for many people and there was nowhere pleasant for people to sit and relax outside. A friend of a person said, "I'm disappointed there is no outside space, the environment is quite run down. [Person] used to love the garden. There's nowhere to sit outside for people at Garlinge Lodge. It's good for older people to get some vitamin D."
● There was wear and tear around the service. The provider did not employ a maintenance person. A staff member said, "[Provider] will fix things himself if he can rather than pay to get done. The lift does work but sticks sometimes and we have to pump it. We all tell [provider] if he did this or that things would be better but it's money. He agrees with what we say but nothing changes." A relative said, "It is very sad that he [provider] encourages people to bring their own furniture, as it looks shabby."
● There were some picture signs around the service to help people, particularly those living with dementia, to find their way to communal areas such as bathrooms, lounges and the dining area. There were pictures outside people's bedrooms to help them find their room. However, one person had moved bedrooms in between day one and day two of our inspection due to safety concerns. On day two we checked which bedroom they were in. We found their photograph and name on their old bedroom and most of their belongings were still in the room. The registered manager told us the person was sleeping in the new room, but their things were still in the old room. This meant the person could be confused and disorientated sleeping in a room which had not been personalised for their use and they were at risk using the old room to access their belongings due to safety concerns.

The failure to properly maintain the premises and equipment and ensure that the premises were suitable for use was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff had not always received training to enable them to meet people's specific needs. For example, how to use specialised fire equipment. Despite the service supporting people that have had strokes, the provider had not ensured staff had training in stroke awareness. The provider had put a document on the notice board for staff to read about strokes. One staff member said, "[Provider] has a leaflet and package about strokes and TIAS (transient ischemic attack) I've read and signed it to say that I have."
● Staff all told us that no training had been provided this year. The provider confirmed this. We tried to verify the validity of the staff training and speak with the trainer, but the provider had lost contact with them as their number was no longer valid.
● No new staff had been recruited since the last inspection.
● A senior staff member said they did not do any supervisions with staff and formal supervisors did not take place only informal conversations each day. Other staff told us they have not had supervisions. One staff member said, "I don't get supervisions, but I'm asked to sign paperwork (supervision records). If I don't sign he withholds pay." This meant staff had not received adequate support.
● The provider said, "We haven't had a staff meeting since the last inspection. We have informal conversations. We don't have a communication book."

Registered persons had failed provide support, supervision and training to enable staff to carry on their roles to meet people's assessed needs this was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● We observed the cook asked each person for their meal choices for lunch which included a choice of two main meals and two puddings. The cook said, "We do have picture aids but the people we have now don't need them." People's choices had not always been respected. One person had chosen an omelette for their lunch. We observed that at lunchtime they were served bacon pudding. We checked with the cook who confirmed they had made a mistake and should have made the person an omelette.
● Food records for everyone showed that mashed potato was eaten every day. Staff told us that everyone liked mashed potato. Food records did not evidence that people were offered other choices as well as mashed potato.
● People were offered a variety of meal choices and alternatives were prepared if people did not like what was offered on the daily menu.
● Food was bought each week and the fridge, freezer and food stores were well stocked.
● People had nutrition assessments and dietary preferences in their care records. Food charts were completed, people's weight was monitored and had remained stable.
● Hot drinks were offered frequently throughout the day and people could help themselves to cold drinks such as water and different flavoured squash.
● We observed lunchtime, some people were sitting together, some people chose to have their meals in their bedroom. There was a relaxed atmosphere and people told us they had enjoyed their meal. One person told us, "I like the food, I have enough of it. I have plenty to drink."
● There was information in the kitchen regarding people's dietary needs and preferences, for example, two people were vegetarian. People's care records included food preferences and dislikes which the staff were aware of. One relative told us, "He's vegetarian, has been most of his life. He is given vegetarian food, he wouldn't eat meat. He eats well."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Nobody new had been admitted into the service since our last inspection.
● Although assessments were in peoples care records for various areas such as medicine, dependency, and nutrition the provider was unable to tell us how assessments had translated to the care provided.
● For example, the dependency rating for one person dated April 2019 stated the person was assessed as being a 'low risk' and 'needs the assistance of one carer'. The provider was unable to tell us how this corresponded to the number of staff deployed at each shift.
● Another person was assessed as medium falls risk, but their dependency rating was 'low risk'. The provider was unable to tell us how they used information in assessments in a joined-up way to assess how to meet people's care needs. This was an area for improvement.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People had been supported to access healthcare resources such as mental health teams, consultants, and specialist nurses.
● The GP made regular visits to the service and on an individual basis, if needed.
● The chiropodist visited every six weeks, and the opticians visited twice a year.
● Relatives told us people's health needs were well met. Comments included, "[Provider] takes him to hospital appointments. They call the doctor if needed"; "She has only been to hospital once since being there. She is hydrated, eats well, her weight is steady and she's taking her medicines"; "They are quick to get

doctors if needed" and "They are on the ball they ring me to say that they have called the GP, sometimes she has bruises because of her medicines and they tell me."

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence

At the last comprehensive inspection on 20 November 2018 we reported that people were not always offered choices about when they received baths and showers as there had not been enough staff deployed to always enable this. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that there was no evidence to showed this had improved.

● Staffing rotas, information supplied by relatives and staff and the registered manager evidenced that at times there were insufficient staff on duty to meet people's needs. It was not clear how this had impacted on people because people's personal care records showed that some people had received baths. Some records showed that people had been declining to have a bath. One person told us, "I like to have a bath when [staff member] is on as [staff member] makes me feel safe when getting in the bath and helps me to wash my hair." Some people's relatives told us their loved ones had been refusing baths.
● The provider's actions evidenced that they had not treated people with dignity and respect. The provider had failed to provide enough staffing and failed to maintain the service to a reasonable standard. The provider told us during the inspection, "I put my hand up, I have not been up to the level." The provider had been winding down the business and had not been honest and up front with people to tell them this was their intention. After the first day of our inspection the provider served all eight people living at the service with notice and asked them to move out because they had chosen to close the service. One person's friend told us, "[The provider] phoned yesterday to say he had given six to eight weeks' notice. The move will distress her, she's very routine. I hope where she goes has some outside space." A relative told us, "I'm saddened to hear he is closing it. My son and grandchildren are close by and visit and so do her friends." One person told us they were worried as they liked living in the area and didn't want to be made to move out of Tunbridge wells.

The failure to treat people with dignity and respect was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed people being treated with kindness and respect by staff.
● People's independence was promoted by staff. Care plans detailed how to offer choices and how to promote people's independence with their personal care. Staff could tell us how they would encourage

people to do certain things for themselves.
● Relatives told us staff knew people well. One relative said, "Staff know her well, her likes are documented in her care plan. She likes to have banter with staff. They involve her in the service she likes to feel useful, so she is enabled to put the carpet sweeper round and lay the table. She knows all the staff."
● Staff told us they ensured people's curtains and doors were closed when they supported people with their personal care. Staff said they protected people's dignity by covering people up with towels when supporting people to wash and dress. One staff member told us, "When doing personal care, I knock on the door even if it open, greet them, ask if it is ok to help them on to the commode or to do a pad change. Ask their consent, close the door and close the curtains."

Supporting people to express their views and be involved in making decisions about their care
● People had been involved in making decisions about their care and support. However, people's views had not always been respected. One person told us their bed had been broken since they moved in. The bed was an electric adjustable bed. The head end of the bed did not work which meant that the person was unable to self-adjust the bed to suit their needs. They had spoken to the registered manager about this who had provided an adjustable back rest which sat on the mattress. However, this did not fully meet their needs. They told us they were, "Anxious and worried about making a fuss as I don't want to be made to leave the home. I have offered to pay for the bed to be fixed so that it could meet my needs." We observed that the person was not able to sit comfortably in their bed and watch television because of the layout of the room and the angle of the back rest. We observed the person standing leaning on their Zimmer frame watching television to get a better view.

We recommend that the provider seeks guidance from a reliable source on making reasonable adjustments to meet people's assessed needs.

● People self-advocated (where they could) and relatives advocated on their loved one's behalf if they lacked capacity or wanted assistance to help them make decisions about their lives. One person had an advocate to help them make decisions and choices about their life. The registered manager told us that the advocate visited the week before to talk with the person about moving.
● The registered manager told us that church services took place at the service each week. People's care records identified their religious needs. For example, one person's care file showed that they were catholic and another person's showed that they were church of England. A relative told us, "People from the church come in."

Ensuring people are well treated and supported; respecting equality and diversity
● People were able to spend time with their relatives in private in their own rooms. A staff member told us, "Relatives and visitors can spend time in the conservatory if they would like to have more private chats."
● People's personal records were stored securely.
● Staff knew people well and knew their likes and dislikes. One staff member asked people when they were in the lounge what they would like to do, music was put on which people enjoyed. One person sat dancing in their chair, they told us they enjoyed music as they used to be a dancer.
● One person told us, "Staff are kind and caring."
● A relative said, "I take her out and she's always happy to go back there. I'm glad she has settled there and feels it is her home." Another relative told us, "The carers are brilliant and look after mum."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Each person had their own individual care plan which detailed the support they required.
- Some information was missing or inaccurate. For example, there were no behaviour guidelines to help staff support one person who the provider told us could display behaviour which may challenge others. A document in the care plan stated, '(Person) Can be intimidating and challenging at times' but there was no specific information about how this may be presented of how staff should respond.
- Another document in the person's care record said they could be intimidating, verbally aggressive and uncooperative at times. There was no further description of what the person would say or do or how staff should respond. Potential triggers for the persons behaviour, when it was most likely to occur and how to support them was missing.
- Other information in people's care records was non-descriptive and did not help staff understand how to support people in a person-centred way. For example, a person's care records stated, 'If I am angry I shall express my concerns and demonstrate my disagreement' and 'Staff to give (person) attention when they are expressing their needs'. There was no further description of how staff could achieve this.
- A staff member said, "A lady comes once a week to do reminiscence, someone else comes every other week for motivation session. Church lady comes on Mondays. Physio comes on Thursday to do activities." Staff told us activities were only provided for one hour a day on a Monday to Thursday. This meant people were at risk of becoming bored.
- During the inspection a reminiscence session was offered to people where they sang and did exercise with rubber bands. Four people took part. People smiled, laughed, sang and clapped when taking part. One person chose to leave the room and do some knitting instead. One person slept in the chair and two people remained in their rooms.
- Apart from this session there was little activity offered to people to engage with and most people spent the day in the lounge with either the television or radio on in the background.
- A staff member told us, "People don't go out unless their family take them, we have no transport and we are not near to the shops." Another staff member said, "I think we could have more activities, motivation is every other week. [Physiotherapist] comes every Thursday and [singer] on Tuesday. I do games with people like snakes and ladders. [Person] outright refuses activities."

The failure to provide care and support to meet people's needs and preferences was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A relative told us "They have quizzes and activities, they keep him as active as they can. He looks out of the window at the birds, he is a keen ornithologist. He doesn't get out now, he's too frail." Another relative said,

"They have activities, they also celebrate Easter, Christmas, birthdays and remembrance events. There is person centred care going on."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● One person's 'This is me' document stated they could not read and had poor eyesight. The provider did not provide information in other formats such as pictorial information or large print and asked us what format he should use. This demonstrated a lack of understanding around supporting people and assessing their individual needs.

We recommend the provider seeks guidance from a reliable source about how to ensure people's communication needs are met.

Improving care quality in response to complaints or concerns
● There was a complaints procedure displayed in the service that described how people could make a complaint or raise a concern. This was displayed in an inaccessible way; high up on the wall and people would struggle to read it.
● The complaints procedure had not been written in an easy to read format for people living with dementia. The policy was not available in large print or any other formats for people.
● Some people were able to voice concerns or complaints, but the provider could not tell us how they supported other people with different communication needs.
● No complaints had been recorded since the previous inspection. The provider told us one person frequently complained but they did not record this.
● A relative told us, "He's happy and hasn't complained". They also told us they felt happy to discuss concerns with the provider if they had any. This was not everyone's experience. Some relatives told us they and their loved ones were worried about raising concerns with the provider for fear of repercussions.

End of life care and support
● Within people's care plans there was a section in relation to people's wishes regarding end of life care.
● One person's plan stated at the bottom of the document '(Person) refused to talk about this care plan and finds it uncomfortable to talk about it'. The document was undated and there was no other information about how this could be followed up with the person at a later time or in a way they felt more comfortable with. This is an area for improvement.
● Other people and their relatives had been involved in planning and discussions about their wishes and preferences in relation to their end of life care.
● Information included the type of funeral the person wanted, if they were religious, and who they wanted to be notified in the event of illness and death.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection on 20 February 2019 the registered manager had failed to develop processes and systems to analyse incidents and accidents for trends or lessons learned. Sustainability of the service was not ensured as the leadership was heavily reliant on the registered manager who was also the provider. The registered manager was consistently working long days, six days a week which was not sustainable. There was no emergency plan in place should they become absent for any reason and no deputy manager deployed. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that there was no evidence to showed this had improved.

- The systems to check the quality of the service were not always robust as they had not identified the concerns we raised in relation to risk management, environment, staff training, mental capacity assessments and person-centred care.
- The provider still did not have a system in place to analyse incidents and accidents for trends or lessons learned.
- The registered manager was still consistently working long days. The rota showed that they had worked 13 days without a day off, which was not sustainable. They agreed this was not sustainable, they were visibly exhausted and told us they were finding it difficult to have a work life balance. We were concerned about the registered manager making mistakes due to their level of exhaustion and stress and advised them to put in place a backup plan to enable them to have a day off.
- The provider did not have a good understanding of their role and their responsibility to abide by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, The Health and Safety at Work Act 1974 and The Regulatory Reform (Fire Safety) Order 2005.
- People had not been asked for feedback since the last inspection.
- Staff had not received had any staff meetings since the last inspection. One staff member said, "We have not had any staff meetings, we need more of them." Another staff member said, "We have had no staff meetings. We keep asking for meetings to discuss and outline the jobs between day and night staff, but it hasn't happened."

● There had been no residents and relatives' meetings held.
● It was difficult to gain information from the registered manager as they did not always provide a truthful answer. This was found out through further questioning and reviewing evidence during the inspection. For example, the registered manager told us staff had not turned up for their shifts which caused the staffing numbers to be low, however records within the office showed that staff had booked and planned annual leave for the days they had not worked. The registered manager had also told us that the lift had been maintained and fire alarm servicing and maintenance had taken place, when it had not.
● The providers filing system was poor which meant that many records both relating to the management and running of the service and some records relating to people could not be found.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff felt supported by the registered manager and knew their roles. Staff comments included, "I feel [registered manager] is quite supportive. He has given advice" and "I get on with him very, very well but he infuriates me, I try to get my point across, he listens to some degree." One staff member said, "He has seemed not to have done anything to improve since the last inspection. He doesn't run it how it should be run, it could be a lovely little home, but he won't spend the money."
● Although some staff felt they could talk with the registered manager. There was not an open inclusive culture in the service. Staff were fearful that providing feedback would result in the registered manager cutting their annual leave allowances and withholding pay. Staff gave us examples of where this had happened previously. All staff we spoke with told us they regularly received their pay late. We advised staff to contact ACAS (Advisory, Conciliation and Arbitration Service) who provide free and impartial information and advice.
● The registered manager made it clear that they were not committed to improving the service as a result of this inspection. They served 28 days' notice to people, relatives and the local authority to detail they were closing. On the second day of the inspection the registered manager told us that they were unable to continue the service for the full 28 days and decided that it was best to shorten the notice period to two weeks.
● The provider's statement of purpose which was dated November 2017 stated, 'It is our aim to provide the highest standard of care and to ensure that all residents at Garlinge Lodge are treated with respect and maintain their dignity'. It was clear from the experiences of people living at the service and our observations that the provider was not meeting their aims and objectives for the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care
● The registered manager had deliberately not carried out essential maintenance which had decreased the quality of the service for people. The registered manager confirmed that they had not scheduled maintenance and servicing because they planned to close.
● The registered manager had not kept up to date with best practice and developments. They had not attended events to learn about and share best practice such as a series of local workshops held by the local authority for care providers.

The failure to effectively monitor and improve the service was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had notified us of specific incidents relating to the service. These notifications tell us about any important events that had happened in the service.
● It is a legal requirement that the 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 judgments. The last inspection rating was prominently displayed at the main entrance.
● There were a range of policies and procedures available to staff governing how the service needed to be run. These had been regularly reviewed and updated.

Working in partnership with others
● The staff and registered manager worked in partnerships with other community agencies, for example their local churches, healthcare agencies and activity providers.
● Relatives continued to tell us they were kept informed where they had the right to be informed.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide care and support to meet people's needs and preferences. Regulation 9 (1)(3)

The enforcement action we took:

We decided through our enforcement processes that we would take action to close the service. Before we commenced this action, the provider closed the service. People were moved to new services to meet their needs and the provider submitted an application to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to treat people with dignity and respect. Regulation 10 (1)(2)

The enforcement action we took:

We decided through our enforcement processes that we would take action to close the service. Before we commenced this action, the provider closed the service. People were moved to new services to meet their needs and the provider submitted an application to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to provide care and treatment with the consent of the relevant person and act in accordance with the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)

The enforcement action we took:

We decided through our enforcement processes that we would take action to close the service. Before we commenced this action, the provider closed the service. People were moved to new services to meet their needs and the provider submitted an application to cancel their registration.

Regulated activity	Regulation

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 health and safety and do all that was reasonable to mitigate risks. Premises were not used in a safe way. Regulation 12 (1)(2)

The enforcement action we took:

We decided through our enforcement processes that we would take action to close the service. Before we commenced this action, the provider closed the service. People were moved to new services to meet their needs and the provider submitted an application to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to maintain the premises and equipment. Regulation 15 (1)

The enforcement action we took:

We decided through our enforcement processes that we would take action to close the service. Before we commenced this action, the provider closed the service. People were moved to new services to meet their needs and the provider submitted an application to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively monitor and improve the service. The provider had also failed to seek and act on feedback received from people living at the service. Regulation 17 (1)(2)

The enforcement action we took:

We decided through our enforcement processes that we would take action to close the service. Before we commenced this action, the provider closed the service. People were moved to new services to meet their needs and the provider submitted an application to cancel their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient staff to meet people's needs and keep people safe. The provider had failed to provide staff with training, support and supervision to enable them to carry out their roles.

Regulation 18 (1)(2)

The enforcement action we took:

We decided through our enforcement processes that we would take action to close the service. Before we commenced this action, the provider closed the service. People were moved to new services to meet their needs and the provider submitted an application to cancel their registration.