Keychange Charity

Keychange Charity Walmer House Care Home

Inspection report

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Date of inspection visit:
10 July 2018
11 July 2018

Date of publication:
26 September 2018

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 the 10 and 11 July 2018 and the first day was unannounced. The inspection started at 7am to allow us to meet with the night staff team, be present at the staff handover and see how duties were allocated for the day.

Walmer House is a 'care home' without nursing, operated by Keychange Charity, who operate 10 care homes nationwide. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home has a Christian ethos, but people of all faiths or none were welcome to live or work there.

People living at Walmer House were older people, many living with long term health conditions or dementia. The service accommodated up to 17 people in one adapted building, with a lift to access many of the rooms on the first floor. A short stair lift was in use to access other rooms. 16 people were living at the service at the time of the inspection. Walmer House had an underpinning Christian ethos, but managers we spoke with were clear the service was open to people of all faiths or none. There was a regular communion at the service but people were free to attend this or not as they wished.

At the time of the inspection the service did not have a registered manager in post. The registered manager had left the service at the end of April 2018. A new manager had been in post for five days at the start of the inspection, and was making plans to apply for registration. Throughout the report they are described as the manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection of the service on 17 and 18 December 2015 the service was rated as 'good' in all areas. On this inspection we found the service had not maintained this and we have rated them as requires improvement overall. This was because we identified failures of management systems had led to breaches of legislation across many areas of the service.

People were not always being kept safe, because the service had not always identified or acted on concerns about risks to people's safety. We identified concerns over risks to people from their care, healthcare needs, and risks from the environment. These included support for people to eat and drink sufficient amounts to maintain their health, and the oversight and understanding of risks from long term health conditions. Although many of these had already been identified by the service, plans to address them were either still in development or had not yet demonstrated sustained improvement.

Care plans did not always contain sufficient detail to enable staff to respond to people's needs in a person centred way. For example staff understanding how to support them in ways that made use of known

information about the person's history. People living with specific support needs such as dementia had not always received information in formats tailored to meet their needs. Some care plans for people at most risk had been prioritised for re-writing which was being done while we were at the service. We saw this was being done with the person concerned who was encouraged to express their wishes about the plan, likes and dislikes.

People were not always supported by sufficient numbers of staff on duty to meet people's needs and there was no formal system in use to assess how many staff were needed. Systems for the safe recruitment of staff were not robust, and recruitment files showed there had been gaps in the recruitment process that had potentially put people at risk. Immediately following the inspection the manager took action to increase the staffing levels to enable people's needs to be met. Recruitment for new permanent staff was underway.

People were supported by staff who did not all have the skills, training or support to help them understand and meet people's needs. Staff training had been put in place in core subjects such as fire, safeguarding and first aid to be delivered immediately after the inspection.

Systems were not in place to learn from accidents or incidents and some records relating to previous accidents or incidents could not be located. People were not always protected from abuse, because staff were not always clear about who to report concerns to outside of the service. Staff had not received training in identifying and reporting concerns about abuse, but told us they would report any issues to the senior staff on duty.

People did not always receive their medicines as prescribed. The medicines cupboard was untidy and this meant delays for staff identifying the medicines people needed in a timely way. Some medicines were 'out of stock' or had not been given to people on the day of the inspection because staff were engaged in other tasks. We have asked the service to seek clarification on how some people's medicines should be given to maximise their effectiveness.

People's rights with regard to the Mental Capacity Act 2005 were not well understood. Where Deprivation of liberty authorisations (DoLS) had been granted, conditions of the DoLS were not always well understood or being followed. This meant people's rights were not always being supported.

Walmer House is a long established care home, set in a converted Victorian villa in a residential area of Torquay. Areas of the building were looking tired and worn. Some furnishings were in poor condition or unstable which presented risks. Some bedlinen was in very poor condition and the service did not have measures in place to identify when items needed routine replacement. Where we identified one person's bed was in poor condition the manager took immediate action to order a new higher quality profiling bed for them, and plans were being developed to improve the environment. We have made a recommendation regarding this to reflect the needs of people living with dementia. People's rooms contained evidence of their own personal belongings, pictures and ornaments.

Activities were provided that people enjoyed, but opportunities were also being missed to engage with people living with dementia in positive ways that reflected their interests. We saw some positive examples of support and involvement, such as staff supporting one person to listen to music they enjoyed. We also saw instances where staff were supporting people to eat while using a phone or leaving people unsupported mid task to attend to others in more immediate need with no discussion.

Visitors were able to visit the service at any time and one told us they felt welcomed at the service. They told us they were satisfied with the care their relation received.

We identified eight breaches of Regulations on this inspection. You can see what action we told the provider to take at the back of the full version of the 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 always safe.

People were not always being kept safe, because the service had not always acted on or identified concerns about risks to people's safety.

Risks from the environment, such as from the laundry or to people's health were not always being assessed and risks mitigated.

There were not enough safely recruited staff on duty to meet people's needs.

People did not always receive their medicines as prescribed.

People were not fully protected from abuse, because staff were not always clear about who to report concerns to outside of the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive the training and support they needed to support people and meet their needs.

The service had not adapted the building to meet the needs of people living with dementia. The building was tired and in need of renovation.

The Mental Capacity Act 2005 was not always well understood, and where legal restrictions were in place staff did not always follow conditions to protect people's rights.

People did not always receive choices for their meals and were not always supported to eat well.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always respect people's privacy or dignity.

People were not always supported by staff who demonstrated caring and compassion towards them.

People did not always have opportunities to express choices or their views about the service and what could be changed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning and delivery did not always reflect the person's individuality. Plans were insufficiently personalised or detailed to guide staff on how to meet people's needs.

The service did not routinely involve people in making decisions about their end of life care.

People's communication needs were not always fully assessed or met.

Activities were not provided following consideration of people's interests.

Systems were in place to support the investigation of complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems had not been operated effectively to assess, monitor and improve the quality and safety of the services provided or mitigate the risks.

We identified a number of breaches of legislation on this inspection that had been allowed to develop as the service's quality assurance and management systems had not been implemented appropriately.

Although there was a new manager in post they had not yet applied for registration.

The new manager had made some changes to reduce risks to people. However, insufficient time had passed for it to be clear how effective the changes had been.

The culture and values of the organisation were not always well understood or shared amongst the staff.

People and staff had been involved in having a say about the service, leading to some positive changes.

Keychange Charity Walmer House Care 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 checked whether the provider was 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 10 and 11 July 2018 and the first visit was unannounced. The inspection started at 7am to allow us to meet with the night staff team, be present at the staff handover and see how duties were allocated for the day.

The inspection team comprised one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service and the notifications we had received. A notification is information about important events, which the service is required by law to send us. The previous registered manager had last completed a PIR or provider information return in 2017. This form asked the registered manager to give us some key information about the service, what the service did well and improvements they planned to make. We looked at this information, in the knowledge that some of this was out of date.

During the inspection we spoke with or spent time with ten people who lived at the service. We met with the manager, the nominated individual from Keychange Charity and a quality assurance and leadership manager. We also spoke with a visiting relative, five care and support staff, a maintenance person and a health and safety advisor, a cook, two cleaners and a visiting healthcare professional. Most people living at the service were living with dementia and could not share their experiences of the service with us in any detail. We spent several periods of time carrying out a short observational framework for inspection (SOFI).

SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

We looked at the care records for four people with a range of needs and sampled other records. These records included care and support plans, risk assessments, health records, medicine profiles and daily notes. We looked at records relating to the service and the running of the service. These records included policies and procedures as well as records relating to the management of medicines, accidents, staff training, moving and positioning, nutrition and fluid support, food and health and safety checks on the building. We looked at two staff files, which included information about their recruitment and other training records. We also viewed a number of audits the organisation's quality assurance team were implementing, but were not currently in use.

Requires Improvement

Is the service safe?

Our findings

On our last inspection of December 2015 we rated this key question as good. On this inspection we identified some significant concerns and have rated the service as requires improvement as a result. People were not safe and risks had not been clearly identified and mitigated. We identified risks to people from the environment, from their care and from the poor oversight and review of health conditions. By the second day of the inspection the new management team had taken action to begin to reduce risks.

Risks to people from their care or long term health conditions were not clearly identified. People's care and support plans were not sufficiently detailed and did not guide staff on how to reduce risks to people's health and well-being, for example from dehydration or eating insufficient food to maintain their health.

One person was living with diabetes, requiring daily insulin injections from a community nurse. This meant they needed to take regular meals to maintain a healthy blood glucose level. The person had been assessed as being at risk of choking and had poorly fitting dentures. The person's care plan stated "staff should prompt me" to eat their meals, and the person's plan indicated their food and fluid intake should be monitored. On the first day of the inspection we saw the person was given their lunchtime meal, but had not been supported to be in the correct upright position to eat this, or encouraged to eat their meal. The cold meal was taken away an hour later untouched. This had been seen by the quality assurance and leadership manager who arranged for the person to be supported to be in a correct position to eat safely and be given a bowl of ice-cream which they had eaten with relish. The person had not received the support they needed to eat their meal.

Records guiding staff on the person's diabetes were not sufficiently detailed. Guidance about what was a safe blood sugar for this person was not recorded. This meant staff would not have information available to know what might be a dangerous level for the person, to guide them on when to seek further medical support. On the second day of the inspection a staff member updated the person's plan to include much greater detail on the person's needs, choices and preferences, and advice and training had been sought from the community nurse on identifying signs of low blood sugar levels.

People's food and fluid charts were poorly completed and there was no oversight to ensure people received sufficient fluids over several days. Cleaning and catering staff told us that sometimes they were asked to give people their meals and drinks. However, they did not have access to the computerised care records. The service relied on them telling care staff to update each person's records, but they had no way of telling if this had happened.

One person had a urinary catheter in place and a long term condition affecting their kidney function. There was a risk assessment, but no detailed care plan around how the catheter should be supported by care staff, including keeping the area clean. A community nurse visiting on the second day of the inspection reported to staff the person's urine was looking dark in colour, indicating they may not have been taking in sufficient fluids to maintain their health. This left the person at risk of poor health outcomes. There was no individual target figure for fluid set to maintain each person's health, based on their weight. This meant it was not

possible for staff to determine the level of risk to the person from their individual intake. For example the person's plan guided staff to give the person 2000mls of fluid over a 24 hour period. Staff at the service were not clear what this figure was based on, or how this 'target' had been arrived at. The person's records indicated they had taken 1270 mls in the preceding 24 hours. There was no way in the care plans of telling if this was the amount needed to maintain the individual person's health.

We found there were discrepancies and gaps in people's fluid charts which meant they could not be relied on to give an accurate picture of how risks were being managed. One person's care records on the tablet computer did not contain the same information as on a paper copy fluid balance chart in the nursing records. Following discussions between the community nurse and manager on the day of the inspection it was agreed that having two systems in place was leading to higher risk and the service agreed to discontinue the paper record.

One person had been prescribed a thickening agent to make it easier for them to swallow fluids. There was no record in the care plan of the required consistency of fluids to be taken. A staff member told us they believed this was to be a 'custard consistency' but there was no record in the care notes or on the prescription to detail what the Speech and Language Team had identified was a safe texture to support the person swallowing.

The environment at Walmer House did not always ensure people's safety. Maintenance records or audits were not always in place, for example infection control audits could not be located. The facilities business manager had visited the service recently and had advised the service on priorities for action. One part of the service, leading to a sluice room had subsequently been closed off due to a water leak that had damaged joists. The garden was not currently considered safe for people to access, so even though it was a very hot day during the inspection people were not able to use the outside space. Some furnishings such as wardrobes were unstable and had not been secured to prevent them toppling over, and we were told there were no room by room assessments based on the needs of the person using that space.

The laundry could only be internally accessed through the kitchen. This presented risks from infection or contamination. Staff had been in the practice of throwing laundry bags full of soiled or contaminated linen out of the dining room window for collection and transfer to the laundry. There was no significant separation between clean and dirty laundry in this area. The walls and flooring could not be kept clean and there were items of soiled and potentially contaminated laundry next to open sacks of potatoes. There was no dedicated hand-washing sink in this area. Signs up reminded staff to keep this area clear because of 'furry friends'. The service had a clinical waste disposal policy, but no infection control audit could be located. This told us risks from poor control of infection were not being identified or managed. We were told plans were being drawn up to give more direct access to the laundry.

Risks from fire at the service had not been well managed. During the handover we heard a member of the night staff saying they were too short to reach the 'catch' on the front door, which turned out to be a hook and eye fastening set over 6 feet above the ground. This door was a fire exit, so there were risks the door could not be opened quickly in case of an emergency. The fastening was removed while we were at the service, however had been in place for some time. Each person did have an individual personal evacuation plan available. The health and safety person confirmed there was a fire precautions workplace risk assessment in place but as this could not be located at the service they would immediately forward this from their London office. This was later supplied to us, but identified a number of issues. We have requested an update from the service in relation to the areas identified in the fire report.

The manager told us they had not been able to identify a clear system in place for auditing and analysing

incidents or accidents. We found only a few accident reports for the preceding weeks recorded in the accident book, but previous records could not be located. The failure to analyse incidents or accidents meant the service may not be learning from them or taking actions to prevent repeated incidents of harm.

People did not always receive their medicines safely. The service used a blister pack system to administer people's medicines. However, guidance on the administration of medicines was not always clear. For example one person had a medicine regime to support them with a long term lung condition. This required a number of medicines to be given via inhalers or nebulisers. To ensure the beneficial effects from the medicines, these would best be given in a particular order. However this was not outlined in their plan or on the medicine sheets. The person's nebuliser chamber contained some medicine which had not been fully administered and there were no records to show when the face mask or tubing had been changed or cleaned. This meant it could be harbouring bacteria that could present risks to the person's health.

Some other prescriptions were not clearly written, so it would not always be clear to staff how these should be given, or in which order to make them most effective. The medicines trolley was untidy and too small for the amount of medicines contained in it. As a result people's medicines were not clearly or immediately available. An agency member of staff who had been administering medicines to people told us the cupboard was messy and it had taken them a long time to give people their medicines. We saw some people were receiving their 8 am medicines at 11am as a result. Some prescription medicines were left out in people's en-suite bathrooms. The manager told us they would organise for each person to have a secure storage facility in their room.

We found numerous dressings for people who were no longer at the home stored in a drawer. These had not been destroyed or returned to the pharmacy for destruction. We also found some out of date equipment test strips for monitoring blood glucose levels. These could not be relied upon to give an accurate reading, so could potentially put people at risk.

One person asked a member of staff "did you put my cream on this morning?" The staff member said "No, I missed that this morning with all that's going on", but did not make any arrangements to ensure this was applied. The person had also not received a tablet they were due, as they were out of stock. On the records we saw one person's eye drops had not been 'in stock' for preceding four days.

The failure to assess and mitigate risks to people and ensure medicines are administered safely is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment).

The failure of the service to provide safe systems for controlling infection and the management of laundry was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and Equipment).

The manager told us there had been an audit of medicines risks carried out by a nurse from another service within the organisation in February 2018, as a part of a quality review. This had resulted in improvements for example to storage arrangements for controlled medicines and the re-training of some staff to ensure their safety while administering medicines.

There were not always sufficient staff on duty to meet people's needs. The manager told us there was no tool or system in place to assess the level of staffing needed, based on the needs of the people living at Walmer House. People, including those living with significant dementia did not always receive the support or monitoring needed to keep them safe or meet their needs. For example, one person was living with

dementia and purposefully walked around the service throughout the day. We saw this person repeatedly entering the kitchen whilst meals were being prepared. We were told this was a regular occurrence. This presented significant risks from hot surfaces or scalds. There was no risk assessment or guidance for supporting the person with this behaviour and the cook had to repeatedly remove them from the kitchen to reduce risks. Other people were seen unsupported in the lounge. One person told us they wanted to go to the toilet. They had no call bell near them and there were no staff in the area. The person said they would have to wait until a staff member came in. We observed staff being conflicted between having to support two people mobilising, both needing attention at the same time. Staff told us people had complex needs and they didn't have enough time to address them.

The failure to provide sufficient numbers of staff to meet people's needs was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

On the second day we saw the manager had purchased another five call bell alarms for people using the lounge to have by their side to enable them to request staff support. An additional staff member had been provided, to better meet people's needs, and we saw a staff member sitting in the lounge with people chatting and supporting their mobility during the day.

People were not being kept safe, because robust systems for staff recruitment were not in place. The manager told us they could not identify from the records available that a full recruitment process had been followed and they were arranging for an audit of the staff files to be carried out. We looked at the files for two members of staff. The files did not evidence that a full recruitment process had taken place. Neither file contained any reference to a disclosure and barring service (police record) check having been undertaken. We were made aware this had also been the case for another staff member who had previously worked at the service. In the second file a reference had not been sought from a previous employer, for whom the staff member had worked for seven years. The staff member concerned told us their employment had ended suddenly at the previous service, but we saw no evidence the service had looked into this further.

The failure to ensure safe systems for the recruitment of staff is a breach of Regulation 19 Health and Social Care Act 2005 (Regulated Activities) Regulations 2014 (Fit and Proper Persons Employed).

The service used agency staff to fill gaps on the staff rota. One person from an agency told us they had received enough information from the service about people's needs and risks prior to their shift starting. Another agency staff member had carried out a shadow shift before working at the service to ensure they understood for example how the medicines systems operated. New staff were being recruited, as there had been staff who had left prior to the inspection. The manager told us there were no staff requiring 'reasonable adjustments' to be made to their working conditions as a result of disability or other protected characteristics under the Equality Act 2010. This is legislation that protects people from discrimination in the workplace and in wider society.

We looked at how people were being safeguarded from abuse. The service had policies and procedures available to identify what constituted abuse and how to raise concerns about people's welfare. Staff told us they were clear about the need to raise concerns about any potential abuse. However we identified a lack of knowledge about addressing concerns over safeguarding outside of the service. Some staff had not received safeguarding training other than in their induction. Staff said they would raise any concerns to the manager, but were not able to tell us how and to whom they would address any issues outside of the service should they need to do so, other than they would 'take it higher'. Another staff member was able to tell us "I would always tell a manager or senior carer if nothing was done, or would call the safeguarding number." The manager confirmed they had found staff needed 'upskilling' in recognising and reporting abuse. As a result,

training had been scheduled for the week following the inspection for all staff in safeguarding procedures and reporting concerns.

Walmer House is an adapted period property, registered for many years. Rooms have character and are individual, but this also means the layout and access to rooms is not always ideal. For example not all rooms had level access from the passenger lift, which meant the additional use of a chair lift for some people to go down a small number of stairs. Tests of the fire alarm systems took place regularly; other regular health and safety checks such as for wheelchairs, call points and the availability of personal protective equipment were in place.

Records were maintained securely on the computer tablet system. Tablets were password protected, and could identify a full audit trail of staff members who had accessed records and who had made changes to them at any given time.

Information on how to reach senior staff in case of an emergency or other emergency contact numbers was on display in the office.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in 2015 we had rated this key question as good. On this inspection we have rated this key question as requires improvement.

We found staff did not always have the skills and experience they needed to support people. The training matrix we saw showed staff had not all received core training and staff confirmed this to us. For example one staff member told us they had worked at the service since February 2018, but had not yet done any training other than shadowing staff for three shifts. Another told us while they had received training in moving and supporting people the other two staff on duty had not. Staff told us they had learned skills from working alongside other staff. However, we saw staff were not always well equipped to know how best to support people. For example, we found a person who was looking dishevelled, unshaven and malodorous. We spoke with staff about this and they told us the person had refused to wash that morning and it was 'their choice'. Whilst acknowledging people's rights to choose there was no information to guide staff as to how to encourage the person to have more involvement in their personal hygiene, to help improve their health and self-esteem.

The service did not have a system for identifying where staff needed additional skills or the overall training needs for the service. Systems for supporting staff were not robust. The manager told us they had not been able to find records of or schedules for staff supervision or appraisal. Staff told us they had not received supervision or appraisals. Staff told us they felt they worked well as a team, but we also identified some areas of conflict through discussions with staff. These were shared with the manager and quality assurance and leadership manager at the inspection.

The failure to ensure staff had the necessary skills and experience needed for their role and received support to do so was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) 2014 (Staffing).

Urgent training in core issues had been booked in for staff the week following the inspection as the manager had recognised past training had been insufficient to equip staff with some of the basic skills to work with people. This included safeguarding, moving and positioning and fire training. We spoke with the head of care following the inspection, who told us 16 staff needed fire training but in the meantime they would ensure guidance was given to staff at each handover about fire practices and precautions at the service. Written policies and guidance were available and on display. Following the inspection we also spoke with the local authority quality improvement team to discuss the support needed by the service.

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.

Staff had not all received training in the MCA, but we saw people being given choices and supported to make

decisions. We saw for example one person had made a decision they did not want to be hoisted. The service had acted to assess the person was able to understand the impact of the refusal and had the capacity to make this decision in the knowledge of this. They had involved relevant professionals and the person's family. The assessment showed the person had capacity to understand if they could not be hoisted they would spend time in their room, as they could not mobilise otherwise. The person remained in their bed.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications had been made to appropriately deprive people of their liberty; however there was little understanding amongst the staff group of what this meant for people in practice. For example, one DoLS authorisation granted contained several conditions for the service to follow. These stated the service needed to "Consider provision of 1:1 time from in house staff or external voluntary agencies for (person's name) to explore his cultural and spiritual needs and to pursue meaningful activities and social interaction." There was no evidence these had been followed, and they did not form part of his care plan. The manager told us they believed staff were not aware this condition was in place.

The failure to support people in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) 2014 (Need for Consent).

The overall environment was looking tired and in need of renovation, including carpets and furnishings. Some bedrooms had low divan beds or damaged furnishings. Bedding was poor, including some linen which was so threadbare the mattress could be seen through them. Some towels were frayed and there were no housekeeping audits in place for example to assess and report on the quality of furnishings, pillows and mattresses and when these should be replaced. We raised concerns with the manager over the quality of one bed, which had a stained divan base, torn cover and smelled strongly of urine. By the second day of the inspection a new profiling bed had been ordered for this person. Some areas of the building needed additional cleaning and some rooms had a strong odour associated with incontinence. Cleaning staff told us they were regularly drawn away from their cleaning duties to support care staff with helping provide basic care tasks. Cleaning staff told us they had sufficient cleaning materials to carry out their role and had regular plans, including deep cleaning of rooms to follow.

Many people living at Walmer House were living with dementia. We did not find there had been any environmental adaptation of the premises to support people living with dementia orientate themselves or make sense of their environment in line with best practice. Carpets were highly patterned which can cause visual difficulties for people living with dementia, and there was no obvious pictorial or directional signage to support people, such as "This way to the toilet." The manager told us they had already identified the environment had not been well adapted to meet people's needs, and would be taking action to address this.

We recommend the provider seeks and follows guidance on the adaptation of the premises to meet the needs of people living with dementia, and develop a programme for the renovation of the premises.

People did not always experience positive support at mealtimes. Feedback on this was given to the manager on the first day of the inspection. People told us the meals were good and they ate well. We were told people had choices available, but we did not see people being offered choices and everyone except one person ate

the same meal while we were at the home. During the afternoon the quality manager gave people ice lollies to eat, as it was a hot day. This was really enjoyed by people. In the afternoon a tea trolley was taken around with cake, biscuits and chocolate which people also enjoyed.

Information on special diets was detailed on a board in the kitchen. The chef told us a person living with diabetes made good choices for their meals and they understood what they liked, for example the person liked an evening supper of cheese and biscuits prepared as a platter. On the second day of the inspection this had been reflected in their updated care plan, along with information on their likes and dislikes. One person needed a gluten free diet. The service had provided gluten free bread, biscuits, cakes and was aware of other foods where gluten may be contained However the gluten free products were not sealed from circulating air, which meant in a busy kitchen environment they could be contaminated with items containing gluten. This was addressed immediately.

Staff at the service worked with other agencies to ensure people's healthcare was maintained. People had hospital packs or summary care plans in place in case of the need for a sudden admission, but these did not all contain the most up to date information about the person's needs. The manager told us they would be addressing this and that information could quickly be printed from the computer IT system if needed. The service had regular contact with visiting community nurses who carried out nursing tasks and we saw evidence of GP visits, podiatry, optical and other healthcare services taking place. Where we had concerns over people the manager made immediate referrals to agencies such as GPs, district nurses and the speech and language teams for assessments and support.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we had rated this key question as good. We found this had not been sustained and we have rated the service as requires improvement. When we asked people about their care and support, they said "It's OK" or when asked if they were happy one responded "I must be."

Walmer House's values referred to the service and provider organisation as having a Christian ethos. There was a weekly service of communion which people were free to attend or not as they wished. Managers we spoke with had a clear understanding the service was actually open to all faiths or none, and would not discriminate against people protected under the characteristics of the Equality Act. However this was not explicit on the services website or documentation we saw, which might discourage people from considering the service as a supportive place to live or work. We shared this with the service who said they would consider reflecting this better in their publications.

We saw staff were very busy supporting people, however we also saw a number of instances which demonstrated a lack of care and compassion for people. For example people were left for long periods before and after each meal, sitting in the dining room waiting to be supported to return to the lounge. We saw some people fell asleep while waiting for staff support.

There had been a significant change of staff prior to the inspection and some staff were new and did not know everyone receiving care very well. They could not all tell us information about the person and their life history, people who were important to them or details of the support they needed and liked. As a result there was not much meaningful interaction between people and staff. Opportunities to engage people with their environment or cheer their mood were not always taken. For example, we saw a member of staff supporting a person to eat. They were using a phone while doing so, which showed us they were not giving the person their full attention, or helping them enjoy their meal. There was no conversation during the meal between the care staff member or the person being supported, or effort to engage the person, to make this a more sociable or enjoyable occasion for them.

We saw instances where people's dignity was not respected, for example one person spent much of their time in their room. Their catheter bag was on full view from people walking past their door to the dining room. People were not being supported to keep clean or maintain their dignity through clean clothing or maintaining a pride in their appearance. We asked a staff member about this, in particular in relation to one person. They told us "I ask him if he wants a wash and he doesn't. He puts on yesterday's clothes." This did not demonstrate a caring approach or any understanding of the person's need for support.

Staff were not always attentive to people's needs. We saw an instance where staff needed to leave one person unsupported on their way to the toilet, to support another person back to their seat as they were at risk of falling. The person in the hallway looked distressed, and there was no compassion or conversation shown to support the person who had been 'abandoned' mid task.

People were not always written about or spoken about respectfully. For example a sign in the laundry area

referred to not putting 'nappy sacks' in with the laundry.

The failure to treat people with dignity and respect was a breach of Regulation 10 Health and Social Care Act 2005 (Regulated Activities) Regulations 2014 (Dignity and Respect).

The television in the lounge was repeatedly showing an advert for Netflix throughout the two days of the inspection, and in any case no one was watching this. Chairs were arranged around the room with very few places situated where people could watch television or enjoy views of the garden.

We spoke with a visitor who told us they were welcomed to visit the home and that staff knew them well. They spent time with their relation which had a calming influence on them. They said they were happy with the care provided by the service and said "Yes I'm pretty sure she's happy here." People's rooms contained evidence of their own personal belongings, pictures and ornaments.

When people were supported with something they were interested in we saw improvements in people's mood. We saw an instance when a member of staff interacted with a person and put their favourite music on to play. They were delighted with this and also discussed with us a television programme they had watched. This told us people had the capacity to experience positive improvements more than were routinely being provided for them.

We were told people had been invited to be involved in "Residents' meetings" to share their views about changes they would like at the service. However we could not identify any minutes of these or when they had last happened. This did not give us confidence people's views on the service had been sought or were being acted on.

The provider is recommended to seek information on how to better gather people's views about choices or changes regarding the service.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in December 2015 we had rated this key question as good. This had not been sustained and we have rated the service as requires improvement for this key question.

Each person living at Walmer House had a plan of care, information on which was completed on an phone based software system. Staff had access to people's care and support plans on a mobile phone system throughout the home. This meant they could have immediate access to information about the persons' needs, for example with moving and positioning. However we found plans did not always contain sufficient detail to guide staff on how to meet people's needs or wishes. This left people at risk of receiving poor quality or inappropriate care that was not in accordance with their wishes.

Information on how to support people with specific health conditions or care needs was not always in place or guidance given to staff on how best to support the person. A care plan review had been undertaken by the quality review team for the organisation in February 2018. This had identified concerns over a 'sparse' level of information being available in some plans and a lack of personalisation in the plans. We found this was still a concern. For example in one person's file we saw guidance from a mental health professional had been given to the service to suggest how to support one person living with dementia with a behaviour problem that left them finding difficulty in making choices. The guidance provided was not included in their care plan, which left staff unaware on how to best support the person's needs in line with good practice. A relative told us they understood they could see their relations care plan if they wanted to but had not wanted to do so.

Where people's plans contained guidance for staff on how to support the person we saw they were not always being followed. One person's plan stated "I prefer to wash and dress myself, but sometimes I need prompting and reminding to this properly. Someone needs to check I am wearing clean clothes" and "I will dress myself but I will need prompting to put clean clothes on each day and to wash thoroughly. Sometimes I will have accidents and won't tell the staff". The goals for their care were for the person to be "clean and tidy at all times." We saw this person was not wearing clean clothes and was malodorous, unshaven and looked dishevelled. We discussed this with the manager and staff during the inspection.

Where people were living with dementia, information used about people's personal history was not being used to support understanding of their needs or behaviours. For example in the handover we heard one person had been restless around the home during the night. Their care plan did not suggest a reason for this, and night staff had not identified possible reasons for this. However we saw information supplied by the person's family recorded in a summary/life history plan which indicated the person had always been very anxious about 'locking up their home' at night. They would often check several times that all was secure before settling down for the night. The manager suggested ways in which the person might be helped to settle, which included using this knowledge of the person's previous history to help understand their behaviours now. They communicated this to staff while we were at the service.

One person living at the service was receiving end of life care. The person's care records contained no

information about the person's end of life wishes and they had no relatives to give advice about what they might have wanted or was of significance to them. The person was being supported with pressure ulcer prevention and their needs were being anticipated in advance with regard to any medicines they may need. However any wishes they may have had regarding the end of their life were not known, so could not be fulfilled. Other people's care and support plans also did not contain this information.

The failure to ensure person centred care is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person Centred Care).

The quality assurance and leadership manager had provided a guide to the level of detail needed for future advice when compiling plans. Some care plans for people at most risk had been prioritised for re-writing which was being done while we were at the service. We saw this was being done with the person concerned who was encouraged to express their wishes about the plan, likes and dislikes.
The newly amended care plans we saw were a considerable improvement, contained more detail and reflected people's wishes regarding their care better.

All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment or sensory loss. We looked at how the home shared information with people to support their rights and help them with decisions and choices. The manager told us they had not identified any ways in which people were being supported to understand information about the service or their care in ways they could understand.

People's care plans included some information on how their communication needs could be supported, including with regard to those people living with dementia, hearing or sight loss. Plans explained that people might find it difficult to express themselves, find the correct words, misinterpret what they see or need time to process information, but did not always contain detail on how to support the person overcome this. For example, one person's plan stated "at times my words can become muddled" but did not say in what way. We saw staff supporting this person, and saw they gave them sufficient time to think about what they wanted and needed to say, which helped the person be able to express themselves.

The service had some planned group activities for people to participate in, and a programme for the coming month was on display in the hallway. We saw information about people's hobbies and interests was not always being used to help provide activities and stimulate people. One person told us how they had watched in their room a programme about the 100 anniversary of the RAF, but this was not on in the lounge, and might have been used as a positive way to engage with people. Likewise another person's file said they had always enjoyed watching football and cricket. There was no activity planned to support this person to engage with this even though England was playing in the world cup semi-final that evening.

The planned activity did not take place on the first day of the inspection and activities were very much left to staff to organise. On the second day a person came in to play the piano in the lounge. We saw some people sat and watched or listened and tapped their toes. There were no one to one activities available and staff told us they had little time to do this.

We recommend the service takes advice on the provision of person centred activities that meet people's interests, wishes and choices.

The service had a complaints procedure that ensured complaints were listened to and acted upon. People who were able told us they would feel able to raise any concerns or issues with the services staff or

management. One person mentioned a particular member of staff who they felt close to and said they would tell them if they were worried about anything.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of the service in December 2015 we had rated this key question as good. However, on this inspection we found this had not been sustained. We have rated this key question as requires improvement as a result. Although a new management team had been put in place five days before the inspection and we saw they were making improvements, the service still presented risks to people and people were experiencing a poor quality of service.

Walmer House was owned by Keychange Charity Limited, which operated 10 other care homes across the country, along with other services supporting people which did not need to be registered with CQC. Other care homes were rated as good, with one having an outstanding rating. However, we found the management of Walmer House had not always been effective. We found there was not yet a clear shared sense of ethos or culture at the service that was well understood or operating in practice. In their statement of purpose the service told us their aims were "To create caring communities with a Christian ethos that are well led; where staff are enabled to give the best of care, that is responsive and person centred, in an environment which makes people feel safe and supported." We did not find that was always being met.

The service did not have a registered manager in post. A new manager had been appointed who had been in post for five days. They told us they were making arrangements to apply to be registered with the commission. The previous registered manager had left in April 2018, but had been absent for several months before their departure. A deputy manager had been 'acting up' in their absence with support and monitoring from the provider's quality team.

We identified a number of breaches of legislation on this inspection that had not been identified in the service's own quality assurance systems, or where these had been identified, the plans had not been effective in addressing issues. Breaches covered a wide range of issues including concerns over people's safety, staffing levels, staff recruitment and training, the understanding of the Mental Capacity Act 2005 and a lack of personalisation in care approaches.

People could not always be assured of safe or high quality care because audits in place to assess the quality and safety of services had not always identified issues or been effective in addressing them. For example, we identified concerns over the laundry area and risks to people from poorly completed care plans and records. The service had conducted their own quality audits, most specifically in February 2018, when the registered manager had been on a prolonged period of absence. This had identified some of the issues we identified and plans had been put in place to make improvements. However these had not been fully effective in addressing the issues.

Following the appointment of the new manager more robust assessments had been completed and new action plans put in place to improve the quality and safety of the service, including reviewing and improving the care plans and changes to the building to improve access to the laundry. However these had not yet been fully actioned or were in development so people still remained at risk. For example the service had not undertaken an assessment of the staffing levels, based on the needs of people living at the service. This had

led to a shortfall in staffing which meant people's needs were not always being responded to in a timely way.

The failure of the services own quality assurance systems to identify the issues, the multiple breaches identified and the failure to take effective action on identified concerns did not give us confidence systems had been operating effectively or were robust.

This was a breach of Regulation 17 Health and Social care Act 2008 (Regulated Activities) Regulations 2014. (Good Governance).

Evidence was not available to show how people had been encouraged to give their views about how well the service was working and what could be improved. There was little sense that quality was everyone's responsibility at the service or that staff had a shared sense of values. There was a heavy reliance on agency staff. We saw for example issues over worn linen and furnishings that had not been identified for replacement.

The service remained disorganised, despite recent changes to handover procedures which had been made to develop accountability in day to day support needs. We found staff were not unhappy in their work, but felt that more could be done to improve things. One staff member told us they had some ideas for improvements at the service and were sharing these with the new manager. They felt confident they were being listened to.

People and staff told us the new manager was approachable and they were looking forward to a change of management and culture at the service. They told us the new manager was listening to concerns they raised and they had confidence in them. The new manager and quality assurance and leadership manager had experience in leading improvements in a failing service, and had made some immediate changes which had reduced risks to people.

The nominated individual told us the service had the resources to make the improvements needed, including financial resources to make changes happen quickly. They shared plans and documents with us that showed they had an understanding of what needed to improve.

The service acted immediately to address issues during the inspection. They were transparent and open about the issues they had experienced and the service had a history of meeting standards and regulations. They were engaging with services to support improvement, for example the local Quality Improvement Team from the local authority. However the changes needed had not yet been embedded into practice or put into place so we could not yet be assured they would be effective in making the changes needed.

Since the quality review of February 2018 the service had ensured notifications had appropriately been sent to the Care Quality Commission as required by law. These are records of incidents at the service, which the service is required to tell us about. However it had been identified these had not always been made in a timely way previously. This had been done retrospectively, for example to report a person where there had been a concern over a break in their skin.

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 Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person centred care). How the regulation was not being met: People were not receiving person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Dignity and respect). How the regulation was not being met: People were not always being treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent). How the regulation was not being met: People were not being supported in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment). How the Regulation was not being met: Risks to people were not always being assessed or mitigated. Safe systems for the management of medicines were not in place

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and equipment). How the regulation was not being met: Standards of hygiene were not being maintained, in particular with respect to the management of laundry.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). How the regulation was not being met: Quality assurance, management and governance systems had not been robust or effective enough in ensuring people received high quality safe care.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and proper persons employed). How the regulation was not being met: Safe and robust systems for the recruitment of staff had not always been followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing). How the regulation was not being met: Sufficient staff were not deployed to meet people's needs. The service had not ensured staff had the necessary skills and experience to fulfil their role.