Abbey Health Care Limited

Abbey Court Nursing Home - West Kingsdown

Inspection report

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19 December 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
We inspected the service on 17 December 2019 and 19 December 2019.

Abbey Court Nursing Home – West Kingsdown is registered to provide accommodation, nursing and personal care for 22 older people and people who have physical adaptive needs. There were 10 people living in the service at the time of our inspection visit. Most people lived with dementia and had special communication needs.

The service was run by Abbey Health Care Limited. The company was operated by two directors one of whom was also the registered manager.

People's experience of using the service and what we found
People said they did not consistently receive care meeting their needs and expectations. A person said, "The best you can say is the staff do try hard but it's just not organised right. It's hit and miss if you get the help you need. I'm not happy here and I want to move."

We found there were continuing, multiple and serious shortfalls significantly increasing the risk people would not receive safe care and treatment. Safeguarding incidents were not reported or investigated appropriately. The registered provider and staff did not recognise or respond to safeguarding incidents or follow established local procedures for reporting and investigating them.

People were not adequately protected from the risk of harm in the event of a fire due as staff did not know what they should do in the event of an emergency. Known risks to people in relation to skin integrity, how people were moved safely and choking risks were not managed well which placed people at an increased risk of harm. Poor medicines practice and recording was identified as well as a lack of robust oversight of what actions should be taken to reduce the risk of incidents and accidents re-occurring.

There was a lack of staff which impacted on the care people received and recruitment practices were poor with little or no action taken by the registered provider when concerns about staff conduct were raised. Staff did not have the appropriate knowledge, competency or skills they needed to consistently provide people with the right care. This should have been identified by the registered manager and provider.

There were continuing, multiple and serious failings in the systems and processes used to monitor the safety and quality of the service. Quality assurance systems were ineffective and had not identified the serious concerns we found. The registered provider did not fully understand the duty of candour and had not always been open and honest when things had gone wrong. Important incidents that required CQC to be notified were not completed meaning we could not be assured we could effectively monitor the service.

People had not been fully consulted about the development of the service and good team work was not

promoted. These shortfalls had resulted in people not consistently receiving the high-quality care they needed and had the right to expect. There were defects in the accommodation. The provision and recording of care did not enable people to be fully supported to receive coordinated care when they moved between or used different services. The registered manager had not worked effectively with other agencies to develop the service. Suitable provision had not been made to comply with the duty of candour.

Care was not always provided in ways promoting people's dignity and respecting their right to privacy. Staff did not always consider or uphold peoples dignity. The culture in the service was one of being 'done to' rather than people having genuine choice and freedom to live as individuals.

People were not always supported to safely eat and drink enough to have a balanced diet and food choices were not always available to people. People were not supported to have maximum choice and control of their lives and they were not always supported in the least restrictive way possible and in their best interests.

People did not always receive responsive, person-centred care. Information was not given to people in a user-friendly way and they were not given regular opportunities to review their care. People were not suitably supported to pursue hobbies and interests to reduce the risk of social isolation. Activities were extremely limited and we saw people spending large parts of their day having no meaningful engagement.

Complaints were not robustly managed, responded to or learned from. Feedback from people who could tell us was that when they raised issues or concerns with the registered manger these were not taken seriously or acted upon.

Equality and diversity were promoted and people were supported at the end of their life to have a dignified death. The quality-rating we gave the service at our last inspection had been displayed in the service and on the registered provider's website.

After the inspection visit the registered manager sent us positive feedback received from five relatives. One of the relatives said, "The staff are always polite, helpful and friendly."

For more details, please read the full report which is on the Care Quality Commission website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 5 February 2019). The registered provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, enough improvement had not been made and the registered provider was still in breach of regulations.

Why we inspected
This inspection was brought forward. This was because we received concerning information people were not receiving safe care and treatment. In addition, there were concerns people were not being robustly safeguarded from the risk of experiencing abuse.

Enforcement
We have identified two continuing breaches of regulations. One concerns failure to provide safe care and treatment. The other continuing breach of regulations concerns shortfalls in quality checks and governance. There were nine new breaches of regulations concerning safeguarding, staff deployment and training,

recruitment and selection, eating and drinking, dignity and respect, person centred care, management of complaints and the submission of statutory notifications.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have cancelled the registration of the provider and registered manager. This means the provider can no longer deliver accommodation and care for people who require nursing or personal care. CQC had commenced the enforcement action to cancel the registrations of both the provider and registered manager prior to the COVID-19 pandemic.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Abbey Court Nursing Home - West Kingsdown

Detailed findings

Background to this inspection

The 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 registered 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.

Inspection team
The inspection was completed by two inspectors and an inspection manager. There was also a specialist professional advisor who was a registered nurse.

Service and service type
Abbey Court Nursing Home – West Kingsdown is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission 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 they and the registered provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced and the second day was announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from local authority commissioners and professionals who work with the service. We used information the registered provider sent us in the Provider Information Return. This is information registered providers are

required to send us with key information about their service, what they do well and improvements they plan to make. This information helps support our inspections.

We also examined the service's Statement of Purpose. This is a document the registered providers are required to have describing how they provide people with safe care.

We used all this information to plan our inspection.

During the inspection
We spoke with six people living in the service using sign-assisted language when necessary.

We also spoke with three care staff, two nurses, the chef, laundry manager and housekeeper. We met with the registered manager and the other director of the company running the service.

We reviewed documents and records describing how nursing and personal care had been planned, delivered and evaluated for seven people.

We examined documents and records relating to how the service was run. These included health and safety, the management of medicines and staff training and recruitment. We also looked at documents relating to learning lessons when things had gone wrong, obtaining consent and managing complaints.

We reviewed the systems and processes used by the registered provider to operate, monitor and evaluate the service.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

After the inspection
We examined additional documents and records we asked the registered provider to send us. These included more information about safeguarding, the provision of care, hydration and fire safety.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to support staff to keep people safe from harm and abuse
• Systems to safeguard people from abuse were poor and did not work effectively. People were not safeguarded from situations in which they may be at risk of experiencing abuse. Shortly before our inspection allegations of abuse were made which had not been robustly investigated by the registered provider. No action had been taken by the registered provider to safeguard people and limit further instances occurring.
• During the first day of the inspection further allegations of abuse were made that had already been raised which had also not been robustly investigated by the registered provider. These concerns related to the inappropriate behaviour of a member of staff towards people.
• We raised this with the registered provider who lacked understanding in how safeguarding matters should be investigated and who did not investigate the allegations robustly.
• Where potential safeguarding concerns were raised the registered provider failed to recognise these and did not follow local safeguarding procedures. One person told us they had raised a specific concern about how a member of staff had spoken to them whilst they were being supported with personal care. The registered provider dismissed their concerns and failed to report them to the local authority safeguarding team or act to safeguard them further. We had to repeatedly ask for them to do so.
• Staff had received training about how to recognise allegations of abuse but did not demonstrate a clear understanding on how to respond or report safeguarding concerns to the relevant authorities. This lack of robust provision to address allegations of abuse placed people at increased risk of harm.

Failure to have systems and processes to safeguard people from the risk of abuse was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
At the last inspection the registered provider had failed to reduce risks to people's health and safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A doctor's advice had not been sought, medicines stock was not correct and a fire exit was obstructed.

The registered provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection these individual points had been addressed although significant shortfalls remained in the service's fire safety regime. However, additional serious shortfalls in providing safe care and treatment meant the registered provider continued to be in breach of regulation12.

• People were not protected in the event of a fire. Not all staff knew the correct procedure to follow if the fire alarm sounded. Staff did not understand the importance of notifying the Fire Service with some not knowing the correct name and address of the service. This would affect how quickly emergency services responded.
• There were serious shortfalls in the arrangements to assist people with reduced mobility to move to a place of safety in the event of fire. Each person had a Personal Emergency Evacuation Plan (PEEP) which described the action staff should take in the event of fire. The registered manager said it was "Essential" for staff to follow the guidance in the PEEPs. However, staff did not know about the PEEPs and information in three PEEPs we reviewed was incomplete and/or incorrect. This was unsafe.
• Not all staff attended fire drills to ensure they knew the correct procedures in the event of a fire. Staff lacked understanding about which fire extinguishers should be used should one occur. Fire doors were propped open and emergency lighting required in some areas was not in place. We referred our concerns to the Kent Fire and Rescue Service. We were told by the registered manager after the inspection the emergency lighting was now in place.
• People with reduced mobility were not always assisted to move safely which placed them at risk of harm. Some people needed assistance to transfer using a hoist with slings attached. The registered manager said it was very important two members of staff were present when a hoist was used. This was so a member of staff could steady the person in the sling while their colleague manoeuvred the hoist. However, two care staff said they sometimes used the hoist on their own as there was no colleague on hand to help them. This placed people at risk of avoidable harm.
• An occupational therapist had recommended a person use a special kind of 'in-situ' sling to make it safer and more comfortable for them to transfer. However, the registered manager was not aware of this advice and had not acted to obtain a new in-situ sling. As a result, the person continued to be partially lifted and repositioned when this should have not been necessary.
• People were at risk of developing pressure sores. One person needed full support with a sling when being hoisted to reduce pressure-points on their skin. This meant using a full-body sling rather than a partial one. However, staff did not know this and said they routinely used a partial sling in place of the full-body alternative. This increased the risk the person's skin would be damaged.
• The registered manager told us it was "essential" to encourage a person cared for in bed to change position regularly so they did not develop sore skin. There was no written guidance which led to an informal and inconsistent approach by staff. A nurse said they reminded the person to change position while three members of care staff said they took no action. Another person spent a lot of time in bed and was also at risk of developing sore skin. The registered manager said it was necessary for nurses and care staff to "encourage" the person to regularly re-position to reduce pressure on their skin. However, staff were not able to describe how they supported them to do this. These shortfalls increased the likelihood people would develop sore skin and possibly pressure sores.
• Other risks to people were not managed to reduce the risk of harm. One person used a catheter. There was no guidance to help staff recognise and quickly respond to known risks such as the person developing a urinary tract infection. The system in place to monitor how much fluid the person had or monitor fluid they had passed was not either not followed or acted upon. This increased the risk of the person either receiving too little fluid and becoming dehydrated or not passing enough fluid which would require medical attention. Where amounts were recorded they were either not totalled correctly or illegible. These shortfalls increased the risk of infection or illness should medical attention not be sought promptly.
• One person's fluid intake and output had been recorded but no action taken when totals did not match. Based on the records medical advice should have been sought but had not been. This had not been identified by the registered manager and they did not recognise this as an issue when we spoke with them about it.
• People at risk of choking were not kept safe. One person needed drinks thickened to make them easier to swallow. Although information was available to guide staff they did not know how to prepare the drinks to the correct consistency. A member of care staff said, "I don't know I just shovel it (the thickener) in I suppose

until it looks right." Another member of care staff said, "It needs that I put in like this and give drink. One, two spoons of stuff in tin add to drink." This lack of understanding increased the risk to people. This was the case even though after the inspection the registered manager said staff had received regular training in how to correctly modify drinks.
• Another person sometimes declined modified drinks. No action was taken to seek advice from a healthcare professional. Instead, an informal arrangement had developed with staff offering them unthickened drinks. This was unsafe and placed the person at increased risk of avoidable harm. Other people needed to be assisted to sit in an upright position when eating or drinking. This was not being done and also placed them at risk of avoidable harm. Staff did not know what to do in the event someone started to choke.

Failure to provide safe care and treatment by managing known risks to people was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Hot water was temperature controlled and radiators were guarded to reduce the risk of scalds and burns. Equipment including the passenger lift had been serviced. Windows had restrictors, so they did not open too wide and could be used safely.
• Air-filled mattresses were used in the correct way to provide a soft surface to help keep people's skin healthy.

Using medicines safely
• People's medicines were not managed safely. The registered manager said it was important for staff to know about national guidance alerts concerning the correct use of medicines, medical devices and equipment used in providing personal care. The registered manager said there were records showing nurses and care staff had read and understood the alerts. However, records were not available to us to confirm this despite repeated requests to do so. Staff whose first language was not English were unable to tell us about whether they received and read these.
• There was a monitored dose system involving a pharmacy preparing blister packs holding each person's medicines and printing medicines administration records. These records listed the medicines due to be given to each person with a nurse signing each time one was administered. Where medicines records had handwritten entries the registered manager told us two staff signatures were required to ensure the correct medicines were given. This was not being consistently done by staff who did not always know of the need to do this.
• Medicines records were inaccurate and confusing. For one person on two days too much medicine had been administered whereas stock records indicated it had been given correctly. The recording error had not been identified by the registered manager. Staff could not explain how the mistake had occurred. Poor record keeping increased the risk of staff misunderstanding how much medicine to administer and giving the wrong amount.
• Shortfalls in the planning, recording, administering and evaluating the use of medicines had increased the risk people would not be fully protected from the unsafe use of medicines.

Failure to provide safe care and treatment by managing medicines safely was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Medicines were stored in clean and temperature-controlled conditions with enough medicines in stock.

Learning lessons when things go wrong
• People were at risk of avoidable harm as accidents were not analysed and lessons not learned or

improvements made. There was written information about each accident contained on an 'accident form' completed at the time as well as a monthly 'falls and bruises' audit. Two accidents occurred in November 2019. The registered manager said the person concerned was at high risk of experiencing further accidents and sustaining an injury. In both cases they had rolled out of bed and fallen on the floor.
• No action had been taken to reduce the likelihood of the same thing happening again. Although the person was offered bed rails to be fitted other options had not been considered. These included more frequent checks or the use of a 'crash mat' to reduce the risk of injury occurring again.
• After the inspection the registered manager informed us a specialist falls clinic had not recommended any additional steps be taken. However, at the time of the inspection the systems and processes used to record, analyse and respond to accidents increased the risk avoidable accidents would reoccur.

Failure to provide safe care and treatment by not robustly reducing the risk of avoidable accidents was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• There were not enough staff to keep people safe. A 'dependency tool' was used to help calculate how many nurses and care staff were needed. However, the dependency tool was poorly completed and did not fully consider how individual needs had been used to calculate the number of staff needed. There was always a nurse on duty supported by a small number of care staff. Although the service was being staffed in line with the recommendations of the dependency tool we found in practice there were not enough of them which impacted on people.
• People told us they often had to wait too long to receive support from staff. One person said, "If I ring my call bell from my bedroom I often have to wait quite a long time. The problem is there are only two care staff and lots of the people here need two care staff to help them. Obviously, if you ring when they're busy with someone else you have to wait. This is particularly the case at tea time when one of the two carers will be serving tea. I've waited for more than half an hour then." Another person said, "At busy times of day it's often a long time before you see a carer as they've only got one pair of hands. There are just not enough on duty."
• We saw two occasions in the lounge when different people said they wanted to be assisted to the bathroom with care staff available to assist them. After 10 minutes we had to find a member of staff who was elsewhere in the building helping other people.
• These shortfalls in deploying staff had resulted in the provision of care sometimes being delayed and not meeting people's needs.

Failure to deploy sufficient care staff to promptly provide people with the care they needed and expected was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Safe recruitment and selection procedures were in place but were not effective or followed. The disclosure (police check) received from the Disclosure and Barring Service for one member of staff showed they had previous convictions. The registered provider had not considered their suitability to be employed and had not assessed the risk this could pose to people. They addressed this by the end of the inspection.
• Pre-employment checks for two members of care staff did not have a full and continuous employment history. This shortfall had reduced the registered provider's ability to identify the assurances needed about the applicants' previous good conduct.
• These shortfalls in the recruitment and selection of care staff had increased the risk people would not always receive care from trustworthy members of staff.

Failure to ensure people employed in the service were of good character was a breach of regulation 19 (Fit

and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• There were good standards of hygiene. Nurses and care staff were correctly following guidance about how to prevent and control infection. A person said, "Yes, it's pretty clean here. There's a cleaner and she does a good job and she always seems to be happy in her work. She's always beavering about."
• Nurses and care staff wore clean uniforms and used disposable gloves and aprons when providing people with close personal care.
• The environment people lived in was clean and well maintained, this included the laundry which was clean and organised. Other fixtures, fittings, carpets and furnishings were also clean.

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 now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough with choice in a balanced diet
• There were significant shortfalls in the arrangements to support people to have a balanced diet. An assessment tool completed for a person who was at risk of not eating enough said they needed to be weighed weekly to make sure their weight remained at a safe level. This was not being done and instead were weighed monthly. This placed them at risk.
• Where people required their food intake to be monitored this was not done accurately which placed them at risk. In a one-week period accurate records of peoples food intake had not been completed or monitored. These shortfalls increased the risk the people concerned would not eat enough to stay well.
• Two people were at risk of not drinking enough and could become dehydrated. The registered manager said they needed at least two litres of fluid each day to maintain their health. However, there was no system to monitor how much fluid each person had. Staff did not know what the target amount set in their care plans was. This placed them at risk of dehydration.
• After the inspection the registered manager said people had been referred to dietitians when concerns had arisen about them not eating and/or drinking enough. However, at the time of the inspection the omissions we found had increased the risk people would not be consistently supported to eat and drink enough to avoid the risk of dehydration and under-nutrition.
• Although there were pictures of the main dishes to help people understand the menu, the board on which they were displayed was hung in a little-used part of the lounge. We did not see anyone looking at it. Staff chatted with people at meal times to help them decide what they wanted but this was of limited value. On the second day of the inspection one person ate only a small part of their lunch. Staff offered them a sandwich as an alternative which the person agreed to and asked what the choice of fillings were. Staff ignored this question and offered to get a sandwich they might like. After their question had not been answered the person declined, their plate was removed and their pudding was served. No other food choices were given to them.

Failure to support people to safely meet their nutrition and hydration needs was a breach of regulation 14 (Meeting Nutrition and Hydration Needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were offered a choice of dishes at each meal time. Drinks and snacks were available at other times.
• People were free to dine in the privacy of their bedroom and were assisted if they needed help with using cutlery.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience
• People were supported by staff who lacked the skills, knowledge and competency to care for them well and in line with national guidance. Key examples were staff not being able to demonstrate sufficient competencies in relation to communication, skin care, assisting people with reduced mobility, enabling people to eat and drink safely and fire safety as described elsewhere in this inspection report.
• A nurse was not able to answer basic questions about how they would ensure safe catheter care. The majority of staff did not have English as their first language. We could not confirm their understanding of their role as they lacked the ability to speak English sufficiently and were unable to understand some of the questions we asked.
• Records showed new members of staff had received introductory training. However, records were not sufficiently detailed for us to determine which staff had then completed the refresher training the registered manager said was necessary.
• The registered manager regularly met with staff in a supervision session. This was to discuss the member of staff's work and to help address any shortfalls in performance. In practice, this arrangement was poorly organised and delivered. Records did not show why issues were discussed. The actions to be taken to address shortfalls were sometimes too general or limited to be meaningful. An example was a nurse's agreed action reading, "Raising standard of care at Abbey Court."
• Staff were not able to answer a series of basic questions about the care provided. These questions related to how to identify risks of pressure ulcer or moisture lesion. A nurse said, "What you mean. If I see skin sore I know what to do but it not happen here so not important here. I just watch and see." Asked about the signs of a person becoming dehydrated one staff member said they did, "Not understand and cannot answer you." This lack of knowledge increased the risk people would not receive safe, effective care.
• Suitable arrangements had not been made to support people who lived with dementia who needed reassurance if they became distressed. Nurses and care staff had not been given guidance and did not have the competencies they needed to support people living with dementia. These shortfalls resulted in people receiving inconsistent and contradictory care rather than the reassurance they needed.
• One person in the lounge became anxious and called out. Their care plan did not contain information about how staff should respond when they became distressed. As a result, staff had developed their own informal responses. Some of these were not appropriate and others were not delivered consistently. Initially, a member of staff sternly told the person their conduct was unsettling other people sitting nearby. This resulted in the person becoming more distressed. Another member of care staff chose not to engage the person because they felt it was best to "not encourage" them. A nurse then patted the person on the hand which gave them reassurance. However, the nurse soon left the lounge and the first member of care staff spoke sternly again resulting in the person becoming distressed again. Eventually, we raised our concerns with the registered manager who identified the person wanted to be assisted to go to the bathroom.
Failure to deploy suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• No new admissions had been made to the service since the last inspection. The registered manager said they would meet each person before they moved into the service to answer their questions and to ensure the service could meet their needs.
• The registered manager said they considered how to meet a person's protected characteristics under the Equality Act 2010. This included respecting a person's cultural or ethnic heritage by enabling them to choose the gender of care staff who provided their close personal care. A person said, "I don't want my care provided by a man and after a bit of a tussle at the start this is now okay."
Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 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 make 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 the Act's application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the Act and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People were not consistently supported to make everyday decisions for themselves. One person wanted to remain seated at the dining table after their meal. During a period of 15 minutes three staff approached them and, with increasing firmness, suggested they move to the lounge. In the end a member of care staff lifted the person's arm motioning for them to get up from their chair and they reluctantly complied.
• The registered manager said they considered each person's capacity to make decisions about their care and consulted with relatives and healthcare professionals if a significant decision was needed. However, in practice decisions were not being made lawfully. For example, an assessment had not been completed to see if a person who occupied a shared bedroom had capacity to consent to the arrangement. In another example there was no evidence to show relatives and healthcare professionals had been consulted about a person who lacked capacity and who was regularly encouraged to have bed-rest in the afternoon.
• Authorisations had been obtained when a person lacked capacity and needed to be deprived of their liberty to receive the care and treatment they needed. However, there were shortfalls in the arrangements used to ensure any conditions placed on authorisations were implemented. The registered manager was not able to tell us if conditions were in place. Staff did not know conditions could be attached to authorisations. This had contributed to shortfalls in the arrangements made to implement them. An example of this was a condition saying a historic decision about a person being not being resuscitated in an emergency needed to be reviewed. The review had not been completed and there were no plans to address the shortfall. We raised the matter with the registered manager who assured us they would quickly address this.
• These mistakes in obtaining consent had increased the risk decisions would not be in people's best interests to ensure they experienced lawful care with the fewest restrictions possible.

Failure to ensure care and treatment was only provided with the consent of the relevant person was a breach of regulation 11 (Consent to Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• At the last inspection there were some defects in the accommodation detracting from the overall homely feeling of the service. We asked the registered provider to send us an improvement plan showing how and by when they were going to put things right but they failed to do so.
• At this inspection the defects noted previously had been addressed. We were given a copy of a refurbishment plan listing some repairs completed during 2019. However, the plan was incomplete and did not identify the need for repairs to be completed in a communal bathroom. The side panels of the bath were split presenting jagged edges increasing the risk of injury to people. We raised this with the registered manager who assured us they would quickly address this.
• Each person had their own bedroom, there was enough communal space and there were signs to help people find their way around. There were bannister rails in hallways, secure frames around toilets and an accessible call bell system.

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

• People were not fully supported to receive coordinated care when they used or moved between different services. This was because of shortfalls in the provision and recording of care described elsewhere in this inspection report. These shortfalls reduced the service's ability to pass on accurate information to other providers including when a person attended a doctor's appointment or was admitted to hospital.

• Arrangements had promptly been made for people to see their doctors if they became unwell. People had also been assisted to see other healthcare professionals including dentists, chiropodists and opticians.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that people were supported and treated with dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

• People did not consistently receive care promoting their dignity or respecting their privacy. Some people were critical of the service. A person said, "I'm fed up here as I don't feel there's any life and the staff just rush in and rush out. There's no real quality of care here. Just the basics. I get my food, the place is clean enough but nothing that makes me want to get up each day." A second person said, "Sometimes when a nurse comes to help me I feel like I'm a nuisance because she's on the telephone to someone, giving advice to carers, rushing off to answer the front door. It just shouldn't be how it is here."

• During lunch on the second day of inspection we saw a member of staff assisting a person to eat their dessert. Their first language was not English and they did not communicate with the person they were assisting. As a result the person became confused with the member of staff repeatedly trying to make them eat their dessert despite it being clear the person did not want to. We had to intervene and ask the member of staff to consider the person did not want to eat the food being offered. Staff sometimes displayed inappropriate behaviour towards people. One member of staff kissed a person on their forehead. This person lacked capacity and their care plan had no information in it to detail whether this was the appropriate way to interact with them.

• Three people said they were concerned about staff whose first language was not English. A person said, "I just give up some days. I won't ask for something to be done for me because they won't understand and then you have to answer a hundred and one other questions before we get to where we need to be." Another person said, "Actually, it's quite tiring to be surrounded by staff who simply don't speak English and having constantly to repeat yourself. The other day I asked for the television remote and the member of staff switched the light on for me instead."

• People's independence was not promoted. One person was helped by a member of care staff to go to the toilet. Before the door closed we heard the member of staff stop the person from undoing their clothes as it was quicker for them to do this for them. This did not promote the persons independence.

• People's right to privacy and dignity was not upheld. Staff spoke loudly in communal areas about the care to be provided to people which was undignified. Staff did not consider this was undignified which demonstrated the culture in the service was one of people being treated as objects rather than individuals. For example a member of care staff who called across the lounge saying, "I take (pointed to a person) to toilet as she need go first then we lift (pointed to another person) into wheelchair and we take to bedroom.

• A person was supported to use a communal toilet that did not have a lock on the door. There was a sign on the door to indicate if the toilet was occupied. After the person was helped into the toilet the member of

care staff did not change the sign to show it was in use or wait outside in case another person wanted to go in. Another person was about to go into the unlocked toilet so we asked them to wait to prevent embarrassment for both people.
• People were not fully supported to be actively involved in making decisions important to them. Bedroom doors had locks. The registered manager said all people with capacity had been asked if they wanted to have a key to lock their bedroom door. They also said records confirmed these people had been consulted. However, none of the people concerned recalled having been asked about this matter and two said they would like the key to their bedroom.
• Another person was quietly resting in the lounge after lunch. A member of care staff approached them without invitation and said, "You go now to bedroom, I take you now. You want to go now". Before the person could answer the member of care staff left to find a wheelchair for the person, returned and moved them from the lounge.
• The registered manager had not developed links with local lay advocacy resources and did not understand the importance of doing so. Lay advocates are independent of the service and can support people to weigh up information, make decisions and communicate their wishes. This increased the risk people would not have access to the support and assistance they might need to make their voices heard.
• These shortfalls in providing care respecting people's rights to dignity, independence and privacy had reduced people's opportunities to enjoy care as a positive and rewarding experience.

Failure to provide care respecting people's right to privacy and promoting the dignity was a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Equality and diversity were promoted. People had been supported to meet their spiritual needs by attending a religious ceremony held in the service each month.
• Care records were stored securely when not in use.

Inadequate

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 now deteriorated to Inadequate. This meant services were not planned or delivered in a way that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

• The service's Statement of Purpose said, "(People) should have the opportunity to be involved in all decisions affecting their lives." The registered manager said people with capacity were invited to review their care plan at least monthly. This was to ensure they received care reflecting their changing needs and preferences. The registered manager also told us relatives of people who lacked capacity were closely consulted about the care provided.

• However, in practice the arrangements to consult with people and their relatives were poorly organised and largely ineffective. We asked two people with capacity if they contributed to a review of their care in the three months preceding the inspection. They told us they did not recall having been consulted about their care. One person said, "My care is just provided. The nurse might stick her head around the door and ask how I am but that's it. I don't think you mean that when you ask me about me being involved in looking at my care." Another person said, "The care just happens. I don't have any real input into it."

• People who lacked capacity did not have relatives involved in a review of their care. Four out of 10 reviews completed in a three-month period had relatives involved whilst the remainder had limited detail about what was discussed, one merely recorded, "Care plan reviewed, unchanged."

• 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 adaptive needs such as sensory loss and in some circumstances to their carers.

• People did not have information presented to them in an accessible manner. Care plans and risk assessments were in small print making them difficult to read. A further difficulty was they were written in a management style unlikely to make it easy for people to understand. This was because people living in the service needed to have information presented in a user-friendly way using easy-read tools such as pictures and graphics.

• Important documents did not present information in an accessible way. A leaflet was displayed on a noticeboard in a communal area. The registered manager said it had been put up to advise people about exercising their rights under the Mental Capacity Act 2005 to receive the least restrictive care possible. However, the document was written in small print and presented information in a formal management style. In addition, it was not displayed at eye level making it even more difficult for people to read.

• A complaints procedure was also written in small print and presented information in a formal management style which people would again find difficult to read. One person picked up a television guide with print of a similar size to the complaints procedure. The person soon put the guide to one side and said, "I can't even begin to read that."

• These shortfalls resulting in people not being suitably supported to make decisions about their care and their meals had increased the risk they would not experience responsive care.

Failure to provide person-centred care by supporting people to make decisions about their care was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The Provider Information Return said, "We treat people as individuals to meet their specific needs. Our staff assess people's individual needs (and) we support (them) in creative and imaginative ways to take part in a wide range of activities." However, in practice activities were poorly managed and of limited interest. There was an activities coordinator who had completed an assessment of each person's interests. The assessments did not explore ways to engage people who lived with dementia. One person's assessment merely recorded, "She comes to the lounge, but she is not interested in being involved in social activities." Group activities that were provided were not always enjoyed by all who took part. People were recorded as showing no interest in these and staff told us one person was difficult to engage with. Despite this we were able to engage with the person.
• The registered manager said some people who did not like to take part in group activities were supported on an individual basis to enjoy hobbies and interests. Despite this we saw that one to one activities were not always appropriate. One person sat playing dominoes with a member of staff but, due to their condition, did not understand the game. They became disinterested and stopped engaging with the member of staff.
• On the first day of the inspection a carol service was held. However, apart from that and the person playing dominoes no other activities took place. In the lounge most people spent a lot of time sleeping in their armchairs. On some occasions people looked bored and disengaged. Three people spent most of time in their bedroom. mainly watching television. One said, "That's my day, watching television. There's nothing else for me to do. I don't want to go in the lounge and if there is a ball game it's not for me and I spend pretty much all my time alone in here. I'd like to do more. Even in the summer there's not much to do, we might go into the garden that's pretty much it. I've asked for more trips out but nothing's come of it. Nothing ever does here."

Failure to provide person-centred care by supporting people with meaningful activities to avoid social isolation was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People were helped to keep in touch with their relatives.
• With each person's agreement the registered manager and nurses contacted relatives to let them know how their family member was doing.

Improving care quality in response to complaints or concerns
• Complaints were not acted upon and meant people felt unable to speak up about matters they were not happy about. One person told us, "I've given up complaining as to be honest I don't think anyone really listens." Another person said, "When I do complain the owner just waves her hands around, tells me I'm always moaning and walks off. I'm not always moaning and why can't I say what I think?"
• The registered manager told us they followed the complaints procedure however the outcome of formal complaints was not always acted upon or resolved meaning it was ineffective. Two complaints had been received in the three-month period before the inspection. One relative was concerned their family member was left sitting uncomfortably in their wheelchair for long periods. Parts of the complaint record was illegible. Although the relative had been given reassurance it would not happen again there was no detail

about lessons learned to ensure it wouldn't happen again. The other related to a person complaining about sandwich choices. Whilst this had been responded to it did not show why they had not been offered a choice and did not indicate an apology was offered. There were no follow-up actions such as checking with the person afterwards to make sure the matter was resolved to their satisfaction.
• These omissions had increased the likelihood of people being discouraged from making complaints and reduced the service's ability to learn from complaints to improve care.

Failure to manage, resolve and learn from complaints was a breach of regulation 16 (Receiving and Acting on Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
End of life care and support
• At this inspection no one was receiving end of life care. The registered manager said it was important to support people at the end of their life to have a dignified death. Care plans showed people had been asked how they wished to be assisted as they approached their death. An example was establishing if someone wished to remain in the service while receiving palliative care or be admitted to a hospice.
• The service liaised with the local hospice who gave advice about caring for a person approaching the end of their life. There were arrangements for the service to hold 'anticipatory medicines' so they could quickly be given in line with a doctor's instructions to provide a person with pain relief.

Inadequate

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 now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; How the registered 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At the last inspection the registered provider had not established robust systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Quality checks had not been completed or been effective. This resulted in shortfalls not being quickly resolved. In addition people had not been fully consulted about the development of the service.

• The registered provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection there were continued, multiple and serious shortfalls in the systems and processes used to assess, monitor and improve the quality of the service. The registered provider did not have sufficient oversight of the service to ensure people received safe, effective, person-centred care to meet their needs and expectations.
• Although quality checks had been completed too often they were repetitive and ineffective. An example was periodic reviews the registered manager had completed of key parts of nursing care in the service. While the checks covered a lot of subjects they were not sufficiently detailed. This resulted in the serious shortfalls we found going unnoticed and unaddressed. These shortfalls had a significant impact on people.
• Standards in relation to fire safety, risk management and medicines management were poor. There was a lack of competent and knowledgeable staff to meet people's needs which impacted on their health and well-being. Safeguarding concerns had not been identified or acted upon quickly or robustly and there was a lack of insight by both the registered manager and provider into how a Good rated service should operate. When concerns about staff conduct were raised little or no action was taken to address this which placed people at increased risk.
• The registered provider repeatedly failed to deliver safe care and treatment or have a robust oversight of the safety and quality of the service. This had led to continued and new breaches of regulation that should have been identified by effective quality assurance systems and action taken to address. The registered provider has not achieved an overall rating of Good in its last four inspections.
• The registered manager did not fully understand the duty of candour. This requires the service to be honest with people, their representatives and others when things had not gone well. They did not fully know what types of events they had to tell stakeholders about and could not tell us what action they should take to give assurances things had been put right including offering an apology. This increased the risk people with an

interest in the service would not be given the information and assurances they needed
• People and their relatives had not been fully involved in making suggestions about how the service could be improved. The Provider Information Return said people were invited to attend regular 'residents' meetings' to give feedback about their experience of the service. The record of a recent meeting showed only four people chose to attend. Little had been done to engage people in a meaningful consultation exercise. An example of this was the entry in the record summarising a person's contribution to the meeting saying, "When (the activities coordinator) speaks to her she always seems content. She will always smile."
• Records showed the activities coordinator had consulted on an individual basis with each person who had not attended the meeting. However, only seven of the 10 people in residence had either been part of the meeting or had spoken with the activities coordinator. Even when a person had suggested an improvement there was no evidence it had been acted on. An example was a person who wanted a small light to be placed by their bed so they could reach and operate it. The person invited us to speak with them in their bedroom and we noted a bedside light had not been provided.
• Relatives had been invited to give feedback by completing questionnaires but in practice this was poorly managed. Only two relatives had completed a questionnaire when they were last sent out in October 2019. No enquiries had been made to obtain feedback from other relatives.
• Members of staff had also been asked to give feedback through questionnaires but again this process was poorly organised. Although most responses were positive no attempt had been made to identify themes and explore subjects about which members of staff had been less positive. Even when a respondent had declined to answer a question no consideration had been given to the possible reasons for their decision and no further enquiries had been made.
• There was no system to receive and act on feedback from visiting healthcare professionals such as doctors, community nurses and dietitians.
• All the shortfalls identified in this inspection report were readily identifiable and had not been addressed because management arrangements were inadequate. We raised this matter with the registered provider. They did not explain how the shortfalls had gone unnoticed and did not describe how quality checks would be strengthened in the future. We were concerned that there was little realistic prospect that robust steps would be taken to address our concerns to ensure people consistently received safe care and treatment.

Failure to assess, monitor and improve the service by completing robust quality checks and acting on feedback was a continuing breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Services providing health and social care to people are required to inform the Care Quality Commission of important events happening in the service. This is so we can check appropriate action has been taken to keep people safe. The registered manager had not consulted guidance we have published on our website and did not know all the events to be notified to us.
• Since the last inspection the registered provider had not submitted at least two notifications to the Care Quality Commission in accordance with our guidelines.

Failure to submit statutory notifications was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Staff had not been fully supported to understand their responsibilities to meet regulatory requirements. There were written policies and procedures designed to help staff consistently provide people with the right

care. However, staff did not know where to find the documents or what subjects they covered. A member of care staff said, "I not know what you mean. I read care plan after care plan and I know what I need. No read office documents as not need."
• We were told it was important to have detailed handovers between shifts so staff knew about changes in the care to be provided. We were also told these handover meetings were recorded so staff could refer to the information they had been given. Records relating to handover consisted of a single undated sheet of paper with people's dates of birth and dates of admission to the service. There was no information that would have been useful to staff about people's care. Staff did not understand what was meant when asked about their contribution to handover meetings. One told us, "I just come on shift, head down and get on with it. There's so much to do."
• There was no system to receive and act upon updated information from the Department of Health about the correct use of use of equipment including hoists and medical devices. This increased the risk equipment and devices would not be used in accordance with national guidance.
• Nurses, care staff and ancillary staff attended team meetings. The registered manager said team meetings were used to raise and resolve problems in the running of the service. An example given to us was staff whose first language was not English were reminded they could ask for tuition to increase their language skills. Another example was nurses and care staff being reminded about the importance of completing records so they were legible. However, neither of these subjects had been discussed at the most recent staff meeting. This was even though they referred to shortfalls that significantly reduced the service's ability to provide people with safe and responsive care which we had identified.
• It is a legal requirement a service's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about the service can be informed of our judgements. The registered persons had conspicuously displayed their rating both in the service and on their website.

Working in partnership with others
• The registered provider did not work effectively in partnership with other agencies to promote the development of high-quality 'joined-up' care. The service had not complied with all the requirements of the local authority who commissioned most of the care provided in the service. Many of the improvements requested by the commissioner were similar to the shortfalls identified in this inspection report. Some of the improvements had not been actioned over an extended period.
• The registered manager attended various training courses and met with managers of other residential care services in Kent. This was intended to enable the service to share and benefit from best-practice initiatives. However, in practice people living in the service had derived little benefit from these activities as serious shortfalls continued in the care and treatment they received.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to submit notifications to CQC.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to provide person centred care.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to promote dignity and respect.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to provide person centred care.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

	The registered provider had failed to provide safer care and treatment.

The enforcement action we took:

Cancelation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to safeguard people from abuse.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to promote nutrition and hydration.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had failed to receive and act on complaints.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to monitor and evaluate the service.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to operate safe recruitment procedures.

The enforcement action we took:

Cancellation of registration