

Heathfield Healthcare Limited

Heathfield Residential Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection was carried out on 14 November 2017 and was unannounced.

Heathfield Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Heathfield Residential Home accommodates 34 people in one adapted building. Accommodation is arranged over two floors and there is a lift to assist people to get to the upper floor. There were 32 people living at the service at the time of our inspection.

A registered manager was leading the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Potential risks to people's health had been identified and assessed. However, there was not always clear, detailed guidance for staff to follow to mitigate the risks to people. This did not impact on people, as staff knew people and took action to keep them as safe as possible.

There were no environmental risk assessments available for us to see at the inspection. Following the inspection, the provider sent us environmental risk assessments. Potential risks to people posed by the environment had not always been managed to keep people safe. Staff had not identified that people were at risk where a bath had been removed in a bathroom people used leaving pipes exposed. The area had not been cordoned off by staff. During the inspection, action was taken to reduce risk; the bathroom was locked to prevent people entering the room.

Staff completed regular checks and audits on equipment and all areas of the service. The audits had not identified shortfalls found at this inspection, for example, in care plans and risk assessments. When shortfalls had been identified, action plans had not been put in place, with who was responsible and when the action should be completed. Some shortfalls had been rectified but there was no record of how or when this had been completed.

Each person had a care plan, the person's profile contained information about their life, choices and preferences. However, the care plans did not always contain details about how to support people in the way they preferred and reflect the care being given. Staff knew people's preferences and people told us they received support in the way they preferred.

The registered manager met with people before they came to live at the service and carried out an assessment, to ensure staff were able to meet the person's needs. The assessments did not include information about people's equality and diversity needs, this was an area for improvement.

People's care was planned following best practice guidelines. Staff monitored people's health and people were referred to specialist healthcare professionals when needed. People had access to professionals including opticians, dentists and chiropodist to support them to be as healthy as possible. Staff worked with health and social care professionals to ensure people received the support they needed. People were supported to eat and drink enough to maintain a balanced diet.

People were protected from abuse and discrimination. Staff knew how to report concerns and felt confident that action would be taken. Staff knew how to keep people safe and understood their responsibilities for reporting accidents and incidents. The registered manager analysed accidents and incidents, to identify any patterns or trends and took action to mitigate the risk of them happening again. People's medicines were managed safely and people received them on time.

Staff ensured people were protected from the risk of infection, they wore protective clothing and kept the building and equipment clean. The building had been adapted to meet the needs of the people living at the service. However, there were no signs for people to know where the bathrooms and toilets were. This was an area for improvement.

People were supported by sufficient numbers of staff, who had been recruited safely. Staff completed regular training to keep them up to date with guidance and best practice. Staff received supervision and appraisal to discuss their performance and personal development. The registered manager worked with staff to ensure they were competent; however, this had not been recorded.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People were treated with compassion and kindness. Staff had developed caring relationships with people and their relatives. People's confidentiality, privacy and dignity were promoted and maintained by staff. Some people had not discussed their end of life wishes with staff, so everyone may not be aware of people's wishes.

People were encouraged to air their views and were involved in making decisions about their care, support and treatment. People were supported to take part in activities; people told us they would like more activities. The registered manager told us that they had recognised this and would be employing an activities organiser. People told us that they knew how to complain and that any concerns they had would be dealt with immediately.

People, relatives and staff were encouraged to provide feedback on the quality of the service. Regular meetings were held for people to give their views and suggestions, these had been acted on and changes made.

There was an open and transparent culture within the service. Staff told us that they felt supported by the registered manager and they would deal with any concerns they may have. People and relatives knew the registered manager well and told us they were approachable. The registered manager was visible within the service; their office was by the dining room, so people could see them.

The provider had policies and procedures to give staff guidance about how to perform their role, this included equality and diversity. Staff understood their roles and responsibilities, and understood the vision that the registered manager had for the service. The registered manager was changing the staff structure within the service to improve the communication and lines of responsibility for both staff and people. Staff

told us this was a positive step and would improve the support they gave people.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications in an appropriate and timely manner and in line with guidance. The registered manager attended forums and worked with care specialists to ensure that they were up to date with best practice.

Providers are required by law, to display their CQC rating to inform the public on how they are performing. This was the first inspection of the service under the provider and a rating had not been given.

At this inspection a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. You can see what action we have asked the provider to take at the end 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?

The service was not always safe.

Potential risks to people's health had been assessed and mitigated, but there was not detailed guidance for staff to refer to.

Action had not been taken to mitigate all risks associated with the building. The service was clean.

There were sufficient staff to meet people's needs, who had been recruited safely.

People's medicines were managed safely and people received them when they needed them.

People were protected from abuse, and discrimination
The registered manager had made improvements following incidents and accidents.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People's needs were assessed and care planned using best practice guidelines, however, the assessment did not contain specific information about equality and diversity.

The building had been adapted to meet people's needs but there was not sufficient signage to direct people to bathrooms and toilets.

Staff received training appropriate to their role, supervision and appraisal to discuss their personal development.

People were supported to eat and drink enough to maintain a balanced diet.

Staff monitored people's health and worked with other health professionals to meet their needs.

People had access to healthcare services and support.

Requires Improvement ●

Staff understood and worked within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good ●

The service was caring.

People were treated with kindness, respect and compassion.

People were supported to be as independent as possible.

People's privacy and dignity was promoted and respected.

Staff encouraged people to express their views and be involved in decisions about their care.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People received personalised care; however, records did not reflect the care being given.

People were supported to be involved in activities; people told us that they would like more to do.

People knew how to complain and felt that any concerns would be dealt with immediately.

People were not always asked about their end of life wishes.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Checks and audits were completed on equipment and all areas within the service. However, shortfalls found at this inspection had not been identified. When shortfalls had been found, action plans had not been developed to ensure the shortfalls were rectified.

There was an open and transparent culture within the service.

Staff and people told us the registered manager was approachable.

People, relatives and staff were asked to give feedback about the

service.

Staff understood their roles and responsibilities.

Heathfield Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 14 November 2017 and was unannounced. It was carried out by one inspector and an expert by experience who spoke with people and relatives. Our expert by experience had knowledge and understanding of residential services or caring for someone who uses this type of care services.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. We looked at notifications received by CQC. A notification is information about important events which the provider is required to tell us about by law, like a death or serious injury.

We looked around areas of the service, and talked to eight people who live at the service. Conversations took place in people's rooms and the main communal areas. We did not use the Short Observational Framework for Inspection (SOFI) as people were able to talk with us and tell us about their experiences. SOFI is a way of observing care to help us understand the experience of people who cannot talk to us.

We reviewed records including four care plans and risk assessments. We looked at a range of other records, staff rotas, medicines records and quality assurance surveys and audits.

We talked with five relatives who were visiting people, the registered manager, area manager, the provider, deputy manager and four care staff.

This was the first inspection of the service under the new provider.

Is the service safe?

Our findings

People told us they felt safe living at the service, their comments included, "Staff around 24 hours makes me feel safe" and "I feel very safe living here."

Risks to people's health were assessed and identified. Staff knew how to keep people safe, however, there was not always consistent, detailed guidance provided to staff about how to support people to remain as safe as possible. Some people required assistance to move around the service. The information for one person was contradictory about the support they needed and the equipment that was used. The risk assessment was unclear if the person required a sling hoist or a stand aid hoist or a walking frame to walk for short distances. Staff knew the person well and were able to tell us how they supported the person and we saw staff safely move the person.

Some people were living with diabetes; there was no detailed guidance for staff about what action they should take if people's blood sugar levels were too high or too low. One risk assessment stated that the person's blood sugar should be checked at least once daily, records showed that this had not been completed. The registered manager told us staff were not required to take the person's blood sugars each day and only took them when requested. There was information about the signs of low and high blood sugar but not what to do if the signs were observed. Staff were able to describe what signs the person may display if their blood sugar was unstable and what action they would take.

Some people were at risk of developing skin damage and had specialist equipment such as mattresses in place to help reduce the risk. Detailed guidance was not available for staff about how to support one person to change position while they were in bed or how often to check their skin and what to do if damage was seen. Staff told us how they supported the person to keep their skin healthy and the person did not have any skin damage. There was a risk staff who did not know people would not have detailed guidance to follow to help keep people safe.

The provider had failed to monitor and mitigate the risks relating to the health, safety and welfare of service users. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Potential risks within the environment had not always been identified. One bathroom had the bath removed and there were exposed pipes that had not been cordoned off, the pipes were cold but there was a risk people would knock their legs on them. The registered manager told us that only people who required support from a member of staff used the bathroom. During the inspection, the registered manager ensured that the bathroom was locked. Following the inspection, the provider told us that the pipes had been covered. We follow this up at our next inspection.

Environmental risk assessments were not available during the inspection as the registered and area were not able to find them. Following the inspection, the provider sent us environmental assessments assessing the risks within the building, including a risk assessment for the bathroom that had been taken out of use. Checks had been completed on equipment to make sure they were safe. There was a fire risk assessment

and each person had a personal emergency evacuation plan (PEEP), in place to ensure they could be evacuated safely in case of an emergency. Staff understood the emergency procedure and explained how they would support people. Checks had been completed to ensure that water temperatures were at a safe level to prevent the risk of scalding.

People told us that they received their medicines when they needed them. People told us "Medicines are regular," and "They stand and make sure that I take them."

People's medicines were managed safely by staff who had received training and were aware of their roles and responsibilities. Medicines were stored and disposed of safely. Staff recorded the temperature of the room and fridge where medicines were stored; to make sure it was within safe limits. There were appropriate arrangements in place for ordering, administering and disposing of medicines, in line with best practice.

Some people were prescribed medicines on an 'as and when needed' basis. There were guidelines in place for staff to follow about when to give the medicines. Some medicines required additional records to be maintained and these had been accurately completed. We observed people receiving their medicines safely.

People told us that there were enough staff and their bells were answered quickly. People said "Yes, I think there are enough staff," and "Staff come quickly when I use the call bell."

Staff told us that there were enough staff and that they worked as a team to cover any sickness or holidays. The registered manager told us that they assessed the needs of people and adjusted the amount of staff as required. During the inspection, people were supported when they requested, they were not hurried and staff had time to spend with people.

Staff were recruited safely. Recruitment checks were completed to make sure staff were honest, reliable and trustworthy to work with people. These included a full employment history and written references. Each person had proof of identity on file with a photo. Disclosure and Barring Service (DBS) criminal records checks were completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

People were protected from the risks of abuse and discrimination. The registered manager referred to the local safeguarding authority for advice when needed. Staff knew what to do if they suspected incidents of abuse. Staff told us that they were confident that any concerns they raised would be dealt with appropriately and immediately by the registered manager. People were protected from the risks of financial abuse, any monies kept for people was recorded along with any purchases and receipts.

There were policies in place to give staff guidance to recognise people's choices and preferences in the way they wanted to live their lives and support them with their individual needs. Staff spoke to us about how they promoted people's differences and why it was important for people to be treated equally. Staff understood their responsibilities to challenge colleagues and people who discriminated against people.

The registered manager recorded all accidents and incidents. These were analysed and action was taken to reduce the risk of them happening again. The registered manager had changed the way staff were organised during shifts following a recent incident. The incident had highlighted that there was no clear leadership during a shift. The registered manager told us that the staff structure was being altered to ensure that staff, people and relatives knew who was responsible for organising the shift. Staff told us they thought the changes would improve the support they gave people.

The service was clean and hygienic. People told us they were happy with the standard of cleaning. There were sufficient domestic staff to ensure standards were maintained, including laundry staff. Domestic staff followed cleaning schedules to ensure that all areas of the service were cleaned regularly. The registered manager completed an infection control audit monthly to identify any shortfalls and action had been taken to rectify any shortfalls. Staff wore protective clothing such as gloves and aprons when required. There were different coloured gloves and aprons for different tasks, for example, staff wore blue gloves when serving food.

Is the service effective?

Our findings

People told us they were able to make choices about their care and support, people said "I can get up and go to bed when I like," and "I choose to have a shower once a week and staff help me."

Before coming to live at the service, the registered manager met with the person and their relatives to complete an assessment and to check that the staff had the skills and knowledge to support the person. The assessment covered all aspects of the person's needs including their physical, mental and social needs. The initial assessment was used as the basis for the person's care plan. The registered manager understood the need to base people's care and support on best practice. The guidance in the care plans was based on best practice guidelines, for example, nutrition was assessed using the MUST (Malnutrition Universal Screening Tool) and the guidelines were followed.

The assessment used did not specifically address equality and diversity needs such as sexual preference. The registered and area managers told us that this was an area that they would be looking into as it is not something they asked about at the assessment process. They discussed with us how they would make this part of the assessment process and the different approaches they would take. Staff had received training about equality and diversity and the registered manager said they would be discussing the new assessment at the next staff meeting. We will follow this up at the next inspection.

People's care plans were completed on an electronic database. Staff used this to help them record people's daily support and recorded any improvements that people had made. People told us that staff recorded information while they were present including any concerns.

People received care and support from people who knew them well and had received training appropriate to their role. New staff completed an induction when they started at the service. This included shadow shifts, where they worked with more experienced colleagues to get to know people, their needs, preferences and routines. Staff completed essential training such as moving and handling and safeguarding before working with people.

Staff had completed regular training in topics such as fire awareness, moving and handling and how to keep people safe. Updates were arranged regularly to keep staff up to date with the latest guidance. The registered manager told us that following a safeguarding incident additional training had been arranged for staff to answer any questions they may have. Staff received training on specific health conditions such as diabetes, preventing skin damage and dementia. Staff were able to describe how they put their training into practice to support people living with these conditions, people told us that staff were able to support them when they were unwell.

Staff were supported to complete additional training to aid their personal development. This included social care vocational qualifications. Vocational qualifications are work based awards that are achieved through assessment and training. To achieve vocational qualifications, staff must prove that they have the ability to carry out their role to the required standard. Staff received regular one to one supervision and yearly

appraisal with the registered manager to discuss their performance and development.

Staff told us they felt supported by the management team and they were able to approach them about any concerns they may have. The registered manager worked with staff to monitor their standard of work and competency, this was confirmed by staff. However, the registered manager had not recorded these checks. This was an area for improvement.

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 much 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 understood their responsibilities under MCA. They told us how they enabled people to make choices and decisions about their daily care and support, such as when they got up and where they spent their time. We observed staff asking people what they would like to eat and drink or how they wanted to spend their time. Some people had Lasting Power of Attorneys in place, staff were aware of this and involved the advocate in best interest decisions and this was recorded.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked to make sure the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty being met. At the time of the inspection there were no authorisations in place, the registered manager had assessed people to decide if applications should be made.

People were supported to eat and drink to maintain a balanced diet. However, there were mixed feelings about the choice of food available. People told us, "Food is very good, I have a good appetite so I get a larger portion," "Food not great but has got better lately," and "Very nice and well cooked but not a lot of variety."

People told us that the choice of meals had reduced recently and they did not get a second choice of main meal. The area manager told us that they had a new cook in post and were changing the menu, there was a choice of main meal and vegetarian, people were able to choose from the alternatives such as omelette and jacket potato if they did not want the main choices. The cook was made aware of people's dietary needs and these were catered for.

People were able to choose where they ate their meals. We observed the lunchtime meal in the dining room, it was a social occasion. People were chatting and enjoying each other's company. Staff joined people at the table to eat their lunch, this stimulated conversation including reminiscence about the meals people had enjoyed as a child. The meal portions were large, some people told us the portions were too large for them. Staff encouraged people to eat, relatives told us that staff sitting eating with people had really helped their loved one to enjoy their food and they had put on weight. After the meal people said that they had enjoyed it.

People were supported to remain as healthy as possible, staff monitored people's physical and mental health and took prompt action when they noticed any changes. People's weight was monitored monthly and people were referred to the dietician when they had lost weight. The guidance from healthcare professionals was recorded and followed. People were supported to drink any dietary supplements prescribed by the dietician. People told us they received regular visits from the optician, audiologist and

chiropracist.

People and relatives told us that when they were unwell the GP was called quickly. Staff referred people to the district nurse if skin damage was observed and followed instructions given. People were supported by staff to attend appointments at the hospital, if people wanted. Staff supported people to be involved in decisions about their health care, people were present at meetings to discuss their care. When people's health needed to be regularly monitored, for example, blood sugars, people were kept informed and any changes explained to them. Staff attended verbal handovers at the change of each shift so that they remained up to date with people's needs.

When people's needs changed and the service was no longer able to meet the person's needs, the registered manager referred people to the relevant professionals. Staff provided professionals with the information they needed to find a service able to meet the person's needs.

Heathfield Residential Home is a large converted house with a garden. The building was adapted to meet people's needs including a lift and specialist equipment. People were able to move freely around the building. The garden was not easily accessible to people, one person told us that they had not been out in the garden or seen other people out there. The registered manager told us that the provider had plans to open up access to the garden next year. This was an area for improvement.

The building was clean, tidy and well maintained. There was maintenance work being completed to improve the facilities for people, such as developing a shower room. The bedroom doors had numbers on them but these were not in a contrasting colour so they could be seen easily. Bathrooms and toilets did not have signs on them. There was a risk that people especially those living with dementia, would not be able to find their way safely around the building. This was an area for improvement.

Is the service caring?

Our findings

People told us that staff were kind and caring, they said "The carers are nice, caring and friendly," and "The girls are marvellous I couldn't be treated better if I was at home." Relatives agreed with them, one relative told us, "Commend their dedication, they do a good job, 11 out of 10."

Staff knew people well and spoke with them in a kind and compassionate way. Staff had built strong relationships with people. They told us that they ensured people were able to have as much control over their lives as possible, for example supporting people to make choices about their care when meeting with healthcare professionals. People were caring towards other people and were concerned about their wellbeing. At lunchtime one person was worried about someone not eating and spent time encouraging them to eat. The person then expressed their concern to a member of staff who reassured them and asked the person if they would like some support, which was accepted.

Staff spoke about people's backgrounds and what their aspirations were and knew people well. People told us that staff supported them in the way they preferred and enabled them to be as independent as possible. One person told us, "When I came here they did everything for me but gradually with their encouragement I have become more independent. Now they let me walk anywhere. I go for a walk around the home two or three times a day."

Staff responded to people when they were anxious or upset, giving them the reassurance they needed. One person told us, "I woke up feeling depressed and upset, the night carer came in and spent time talking to me and reassuring me and cheered me up. That evening when they came on duty they took time to come and check on me."

People's privacy and dignity was respected. People told us and we observed staff knocking on people's doors and waiting to be invited in before entering. One person told us, "They always knock and draw the curtains during personal care. I have the door open during the day and close it at night." Staff kept people's personal and confidential information about them and their needs secure to protect their privacy.

We observed staff speaking with people in an appropriate way. Staff were patient and gave people time to respond to questions and express themselves. We observed staff explaining to people what they were doing when supporting someone to move around the dining room, so that they knew what the staff were going to do next. Staff were discreet when supporting people to leave the lounge to use the bathroom.

People were encouraged to personalise their rooms with their own possessions such as photos and ornaments. When rooms were decorated people were asked how they would like the room to look and helped choose curtains and wall colours.

People were encouraged to maintain and develop relationships with people that mattered to them. Friends and relatives were able to visit at any time and told us they were always made to feel welcome.

People's religious beliefs were discussed and recorded to enable staff to support people. Members of the local church visited monthly, and, for those who wished to take part, the pastor met with people for prayer and hymns.

Some people were unable to express their views about their care, so staff ensured that decisions were made involving people who were important to them. Some people had nominated a person to represent them, however, some people had not. When this was the case, staff knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Is the service responsive?

Our findings

Relatives told us that staff were responsive to people's needs. One relative told us, "Any problem they sort it out, always phone if there are medical problems and call the doctor straight away."

Each person had a profile in their care plan that included information about their choices, preferences, likes and dislikes. The care plan had details about their past life and family that were important to them. People or their advocate had been involved in writing the care plan. The care plans gave details about people's aspirations, for example, 'would like to be able to stand up'. However, the care plans did not always contain details of people's choices, preferences and how their aspirations would be met.

The service used electronic care plans. The care plans identified people's needs but did not always give guidance for staff to support people in a way specific to them, for example, people's choice of when they wanted to go to bed or get up was not always recorded. One person required assistance with their continence needs, there was no clear guidance for staff about how the person preferred to be supported. Guidance about how people preferred to be supported during personal care was not consistent. There was not always information about the support people needed with their personal hygiene, one plan stated the person needed help with shaving, but did not say what kind of help or if they preferred a dry or wet shave. Staff were informed that people needed assistance with washing and dressing but not how they were to support the person in an individual way.

Staff knew people well and knew their preferences and choices. People told us that they received care and support in the way they preferred, "I choose to have a shower once a week" and "They are very concerned about my appearance." Staff told us about the support they gave to people and described how different people liked things to be done. They knew if people preferred male or female carers to provide their support. There was a risk that new staff who did not know people would not give support as people preferred due to the lack of detail in care plans.

The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans had been reviewed but had not been changed to reflect people's changing needs and personal preferences. Staff had a verbal handover at the change of each shift to keep up to date with any changes. Staff used electronic tablets to record the care and support they gave to people at the time; people were usually present when this was completed so they would be involved.

People were supported to maintain relationships with people who were important to them. Some people had telephones in their rooms, one person told us, "I have a land line it keeps me in touch with the outside world." Relatives and visitors told us they were able to visit whenever they wanted and were always made to feel welcome.

People told us they would like more activities, one person told us, "The afternoon and evening are a bit boring because there is nothing going on." Another person told us, "Would like a bit more action in the afternoon and evening."

The registered manager told us that staff took on the role of providing activities during the day. There were various posters around the service to inform people of entertainers that would be coming in. During the inspection staff spent time with people, either one to one completing a word search or in a group completing a quiz. The registered manager told us that they were looking at the provision of activities within the service. We will follow this up at the next inspection.

Concerns and complaints were investigated in line with the provider's policy. There had been no recent written complaints. People and relatives told us that they knew how to complain if they needed to. There was information about how to complain in each person's room and in the main reception, there was no easy read version of the complaints policy. This was an area for improvement.

People told us they were able to speak to the registered manager and staff if they had any complaints. The registered manager told us about a concern they had received, a person had a light shining into their window and it was annoying them. The registered manager spoke to them and discussed solutions and it was decided that a blackout blind would be provided; this was confirmed by the person. The registered manager had not recorded when they had spoken to people to address any 'niggles' they may have, and they agreed to do this in future to pick up on any trends or themes.

Each person's care plan had a section for end of life wishes. Some people's wishes had been recorded, for example, there was a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place, when people had requested. Other care plans did not have any details about people's wishes, the registered manager told us and it was recorded that people had not wanted to discuss the topic. The area manager showed us a new document that would be given to people or their representatives when they came to live at the service and had been sent to families of people already living at the service. The document asked people about their end of life wishes and why it was important for the staff to know this.

Staff told us how they supported people at the end of their lives and why it was important to them that people were comfortable. One staff member told us, "They are like my family; I only want the best for them." The registered manager told us that they involved the GP as soon as they felt people were becoming frailer and towards the end of their life. People were monitored and when required the staff involved the district nurses to ensure people had the medicines they needed to keep them comfortable.

Is the service well-led?

Our findings

People told us they thought the service was well led, comments included, "The manager is very approachable", "The management are an amazing team" and "The registered manager is a very, very good manager, she has a happy disposition and is very approachable."

The registered manager and staff completed regular checks and audits on all areas of the service including medicines, infection control and the environment. The questions in the audits were closed questions, so the person completing the audit answered yes or no. There were no prompts or guidance about what the person should expect to find and how to identify a shortfall. For example, the infection control audit asked if COSHH information was available, the answer until October 2017 was 'no, products brought at the supermarket'. The audit had not prompted action to ensure that information about the products used was available even though they were purchased from a supermarket. The shortfalls found in the care plans and risk assessments, at this inspection, had not been identified by the audits.

The audits had a section for corrective action; this had been completed on the maintenance audits when shortfalls were found. However, there was no action plan in place, timescale for the action to be completed or who was responsible. Action had been taken; however, there was no record that the action taken to correct the shortfall had been checked to ensure it had been completed.

The infection control, health and safety and medicines audits completed up to and including September 2017 showed that there were shortfalls. However, these had not been recognised as shortfalls by the registered manager. The area manager had identified the shortfalls in October 2017 and taken action to rectify them. Following the inspection, the provider told us that they had made changes to the audit process and documentation to ensure a more robust system is in place. We will follow this up at our next inspection.

Accurate and complete records were not maintained for all people living at the service. Risks relating to some people's care and support had been assessed and documented, but the information was not accurate and contradictory. There was not always guidance for staff about how to mitigate risks to people. Care plans had been reviewed but not updated to reflect the care given and people's changing needs. Accurate information and guidance was not available for staff to refer to and there was a risk that care would not be provided consistently.

The provider failed to maintain accurate records in respect of each service user. The provider had failed to fully assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a culture of openness, staff and the management team spoke to each other and people in a respectful way. The registered manager, supported by the area manager had a clear vision for the future of the service. Staff understood their role in achieving the vision for the service, this included treating people with respect, promoting independence and giving everyone choices.

Staff and people told us that the registered manager was approachable and visible within the service. The registered manager's office could be seen from the dining room, they were able to observe staff practice. People and relatives told us they could go and see the registered manager when they wanted and they would act on any concerns they had.

People, their relatives and staff were asked for their feedback about the service each year. This year's staff survey had been sent out at the beginning of November, staff confirmed they had received the survey and were completing them. Relatives and people had completed a survey in October, the response was mainly positive. The results had not been analysed yet and no action plan had been developed. Stakeholders such as GP's had not been asked for their feedback, the area manager told us this would be done as soon as possible. Including other stakeholders in the survey was an area for improvement.

Regular residents meetings were held and were well attended. People were encouraged to express their views on the service. People had expressed views on the choice of food on the menu. People had asked for more chicken and lamb, also for crumpets to be offered. The menus had been changed and the new menus included roast chicken and lamb twice a month and crumpets were offered at tea time.

Staff attended regular meetings. The meetings discussed all elements of the carer's role and the standards expected of staff. The registered manager encouraged staff to discuss issues that had been raised such as cigarette breaks, so that any difficulties were out in the open. However, there were no action plans following staff meetings to monitor if agreed actions had been taken. The registered manager told us that areas discussed were being monitored but there was no record of this and had not been reviewed at the next meeting. The registered manager agreed that a record should be kept to show what action had been taken and any improvements that had been made. We will follow this up at our next inspection.

The provider had a range of policies and procedures in place to give staff guidance about how to carry out their role safely. The policies had been reviewed and including information and guidance about how staff should promote equality and diversity for people living at the service. Staff knew how to access the information they needed. Records were stored securely to protect people's confidentiality.

The provider was a member of Kent Integrated Care Alliance to keep up to date with current best practice. The registered manager attended care home forums, to keep in contact with other home managers and healthcare professionals.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications in an appropriate and timely manner and in line with guidance.

Providers are required by law, to display their CQC rating to inform the public on how they are performing. This was the first inspection of the service under the provider and a rating had not been given.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. The provider had failed to fully assess, monitor and improve the quality and safety of the services.