Mylan Limited

Wychdene

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 27 and 28 July 2017.

Wychdene is a residential care home providing accommodation and personal care for up to 24 older people some of whom may be living with dementia. The service is built over three floors and has a passenger lift. Nine bedrooms are en-suite and the remainder have a hand basin in them. The service is set in large gardens edged by trees. It is a short walk from Broadstairs town centre and close to Broadstairs beach. On the day of the inspection there were 18 people living at Wychdene.
The service was run by a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Having a registered manager is a condition of the registration of the service. The registered manager was not present on the days of the inspection. The provider and care manager were present. The registered manager resigned after the inspection.

We carried out an unannounced comprehensive inspection of Wychdene in June 2016; the service was rated 'requires improvement'. There were breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 and we asked the provider to take action to make improvements. We issued requirement notices relating to failing to have a registered manager in post, failing to effectively monitor and assess the quality of the service, failing to complete relevant checks to make sure staff were safe to work with people and failing to ensure staff received the appropriate support and training. The provider sent us an action plan. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. Improvements had been made and some of the breaches met. However, we found three new breaches and one continued breach of Regulations.

Risks to people were assessed, identified and monitored. However, not all pressure relieving equipment was set correctly placing people at risk of developing pressure areas. Medicines were stored, and disposed of safely. Staff had not consistently completed the medicines records.

People told us there were generally sufficient staff during the day. However, contingency plans were not in place in the event of an emergency. On the second day of the inspection there was an unexpected shortage of staff. The provider took immediate action to bring in another member of staff and increased the numbers of staff on duty from then on.

The service was tatty and some areas of the service smelled strongly of urine. Some carpets and flooring needed to be replaced. Staff wore personal protective equipment, such as, aprons and gloves when supporting people with their personal care.

The provider had recruitment and selection processes in place, which were followed, to make sure that staff employed were of good character. Staff completed training and had one to one supervision meetings with

the registered manager or care manager. There were some gaps in staff training and refresher courses had been booked to cover these.

Staff knew the importance of giving people choices and gaining people's consent. However, records about people's capacity were inconsistent and contradictory. Staff understood the requirements of the Deprivation of Liberty Safeguards and applications for DoLS had been made in line with guidance.

People were not consistently treated with kindness, dignity and respect. Records did not always contain appropriate language. Staff knew people well including their likes and dislikes and knew their relatives well. People were encouraged to be as independent as possible.
People took part in a variety of activities within the service. However, people's views on the quality of the activities offered varied. People said they were bored and would like to go out. There was a limited variety of activities within the service. People had voiced their wish for more activities at a residents meeting and this had not been acted on.

Some audits of the service were being completed and recorded. Action had been taken when shortfalls were identified. However, shortfalls found during the inspection had not been identified. The provider's website had a link to their last CQC report. However, the rating and last report were not on the 'Home page' where people looking for information about a service would see it.

People were offered a choice of home-cooked meals. People's health was monitored and staff worked with health and social care professionals to make sure people's health care needs were met.

People's confidentiality was respected and their records were stored securely. People told us they felt safe living at Wychdene. People were protected from the risks of abuse and avoidable harm. Staff knew how to recognise and respond to abuse and understood the processes and procedures in place to keep people safe.

People and their representatives were involved in planning their care and support. People's care plans were reviewed by staff to make sure they were kept up to date.

People and their relatives knew how to complain or raise concerns and felt confident to do so. People were asked for their input into the day to day running of the service and their ideas were acted on.

People knew the staff and registered manager by name and told us they could rely on them to provide the right support.

Notifications had been submitted to CQC in line with guidance.

We last inspected Wychdene in June 2016 when a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. At this inspection improvements had been made. However we found one continued breach of regulation and four new breaches. You can see what action we have asked the provider to take at the end of the full report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people were identified and monitored. However, not all pressure relieving equipment was set correctly.

Medicines were stored, and disposed of safely. Staff had not consistently completed the medicines records.

The service was tatty and some areas of the service smelled strongly of urine.

People and staff said there were not enough staff on duty. Contingency plans were not in place in the event of an emergency.

People were protected from the risks of abuse and avoidable harm.

Safe recruitment processes were followed to make sure staff employed were of good character.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff knew the importance of giving people choices and gaining people's consent. However, the provider was not following the principles of the Mental Capacity Act.

Staff understood the requirements of the Deprivation of Liberty Safeguards and applications for DoLS had been made in line with guidance.

Staff completed training and had one to one supervision meetings. There were some gaps in staff training and refresher courses had been booked.

People were offered a choice of home-cooked meals. People were supported to maintain good health and were referred to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not consistently treated with kindness, dignity and respect. Records did not always contain appropriate language.

Parts of the service smelled strongly of urine which did not show respect and promote people's dignity.

Staff knew people and their relatives well. People were encouraged to be as independent as possible.

People's confidentiality was respected and their records were stored securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People said they were bored and would like to go out. There was a limited variety of activities within the service.

People were involved in planning their care and support. People's care plans were reviewed by staff.

People and their relatives knew how to complain or raise concerns and felt confident to do so.

Is the service well-led?

Inadequate

The service was not well-led.

There was a continued breach of Regulations and three new breaches of Regulations.

Audits were being completed and recorded. Action was taken when shortfalls were identified. However, shortfalls found during the inspection had not been identified.

The provider had not displayed the rating for the service conspicuously on his website.

People were asked for their input into the day to day running of the service but their ideas were not always acted on.

Notifications had been submitted to CQC in line with guidance.

Wychdene

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 27 and 28 July 2017 and was unannounced. This inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone in a care home setting.

Before the inspection the provider 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 included in the PIR along with other information we held about the service. We looked at previous inspection reports and notifications received by CQC. Notifications are information we receive from the service when significant events happen, like a death or a serious injury.

We met and spoke with 12 people living at Wychdene and with four relatives. Some people were not able to explain their experiences of living at the service because of their health conditions so 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 talk with us. We spoke with staff, the care manager and the provider. During the inspection we observed how the staff spoke with and engaged with people.

We looked at how people were supported throughout the day with their daily routines and activities and assessed if people's needs were being met. We reviewed four care plans and associated risk assessments. We looked at a range of other records, including safety checks, records kept for people's medicines and records about how the quality of the service was managed.

We last inspected Wychdene in June 2016 when a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. The service was rated Requires Improvement.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Wychdene. People said, "I've got no fears for my safety", "I feel very safe living here" and "I feel safe". A relative commented, "It's a delight coming here, the staff are all very friendly and caring and we think [our loved one] is very safe, well looked after and settled".

When people were at risk of developing pressure areas, the registered manager and staff worked with health professionals to support people to keep their skin as healthy as possible. People had special equipment, including mattresses and cushions, to help prevent pressure areas. Staff told us this was checked regularly to make sure it was working properly. When people remained in bed staff told us they supported them to change position to help protect their skin and this was recorded. During the inspection we found one person's pressure mattress was set incorrectly. The care plan noted, 'The pressure settings were set at the time of the installation according to the person's weight which is currently 50.8kg'. We checked the person's weight chart and their weight was 53.6kg on 16/07/2017. We checked the setting on the mattress and it read 75kg. There was a risk this could have an impact on the person's skin as lying on a mattress that is too firm may not give the person the best protection from developing pressure areas. We raised this immediately with the care manager and they were not aware of it. They spoke with health professionals and the mattress was adjusted to the correct setting.

People told us staff supported them with their medicines. They said, "The staff sort all my tablets for me" and "I get my medicines regularly". People's medicines were stored, managed and disposed of safely. Staff were reminded at staff meetings about the importance managing people's medicines correctly. Staff, trained to administer medicines, made sure people had taken their medicines before they signed the medicines record. They checked people knew what they were taking and why they needed them. People's medicines were reviewed by their doctor to make sure they were still suitable. When we checked people's medicines administration records (MAR) we found there were some gaps where staff had not signed to confirm medicines had been administered. We discussed these with the head of care to check that people had received their medicines correctly and they had. Staff had not consistently noted when a person had refused their medicines. Another person was prescribed their medicine four times a day. On 17 July 2017 there was no signature on their MAR for their dose at 12:30. There were no notes on the reverse of the MAR to explain why the medicine had not been administered which would be best practice.

People told us there were generally enough staff. They said, "There seem to be enough staff, they are exceptional", "The staff change quite frequently, sometimes it's all or nothing" and "Occasionally I think they are a little short staffed". Staff told us they were sometimes short-staffed and rushed. Records of a staff meeting noted, 'It is a struggle with 3 staff in the morning. [The care manager] pointed out that they and [the registered manager] are there to support with the meal times and that covers the need for the 4th staff member during the days. [The provider] said that once we have more residents the staffing levels will increase'. The duty rotas for weeks ending 30 July and 6th August 2017 showed that there were three carers on the morning shifts and three in the afternoons, the registered manager and the care manager. The provider told us that the registered manager and care manager would help care staff if they needed addition help. The registered manager used a 'dependency tool' which summarised the level of support people

needed with specific tasks, such as eating, dressing and their mobility.
On the second day of the inspection a member of staff had called in sick. There was no contingency plan to cover this shortfall. When we raised our concern that the level of staff may put people at risk, the care manager temporarily covered. The provider arranged for an additional relief member of staff to attend the service and gave the Care Quality Commission assurances of adequate staff cover for the weekend. The provider told us they would increase the number of staff on duty and, following the inspection had provided staff duty rotas to confirm the increase.

People told us that staff answered call bells in good time. People said, "If I use my call bell they come quite quickly most times, you have to except you are not the only person here" and "When I press my buzzer someone comes quite quickly, if they are busy they may ask me if can wait five minutes but if I can't I tell them".

The provider failed to ensure care and treatment was provided in a safe way. The provider failed to assess risks to people and do all that was practicable to mitigate any such risks. This was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Other risks to people were assessed and monitored. For example, when people had difficulty moving around there service there was guidance for staff about how much people preferred to do independently. There was also guidance about what level of support staff needed to give and any specialist equipment, such as walking frames and hoists, people needed to help them stay as independent and safe as possible. The service was spacious and furniture was positioned to allow clear movement with walking aids and wheelchairs around the service. Staff supported people to move around the service and we saw that this was done safely. For example, staff observed one person attempting to get up from their chair. They did not intervene immediately and appeared to know the person well. The member of staff gently encouraged the person and suggested they took a moment to get their balance before they began to walk. They then walked with the person until they were happy they were steady.

The service was generally tidy but was in need of decorating in places. Some people's rooms were tatty. In one person's room we noticed the edges of the vanity unit had been worn away and exposed the chipboard making it difficult to keep clean. One person commented, "It's the quality of the materials!" Relatives had noted on the last quality survey, 'Some of the decoration is looking tired and could do with refreshing' and 'The general décor could be improved'. The flooring in the kitchen and the staff area was split and torn. There was a risk that the flooring would not be cleaned thoroughly. On both days of the inspection there was a strong smell of urine in one part of the service. We discussed this with the provider and asked them to take action. Following the inspection the provider told us that new carpets and flooring in two rooms, the kitchen and the staff area had been ordered and would be in place by 28 August 2017. We will follow this up at the next inspection.

The provider failed to ensure the premises were clean, and properly maintained. This was a breach of Regulation 15(1)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) 2017.

People were protected from the risks of abuse and discrimination. The care manager and staff knew what to do if they suspected incidents of abuse. Staff told us they completed training on how to keep people safe and training records confirmed this was done. Staff told us that if they felt anyone was unsafe they would talk with the registered manager and were confident it would be dealt with straight away. Care plans gave staff information and guidance about people's behaviour. This included any known 'triggers'. Staff told us how they distracted and diverted people and reassured them to reduce any signs of anxiety. Some people had advocates or family to manage their finances. When staff supported people with their money, for

example when the hairdresser visited or toiletries were purchased, receipts were kept and a log of any monies spent was completed. A monthly audit of this was carried out by the registered manager and an audit of petty cash was also completed.

Staff carried out regular checks of the equipment to make sure it was safe to use but had not identified when equipment was not set correctly. Staff wore personal protective equipment, such as, aprons and gloves when supporting people with their personal care. Toilets and bathrooms had hand towels and liquid soap for people and staff to use. People's rooms were generally well maintained but improvements were needed to the cleanliness and decor. Bins were lined so that they could be emptied easily. Outside clinical waste bins were stored in an appropriate place so that people could not access them. There were policies and procedures in place for emergencies, such as, gas / water leaks. Fire exits in the building were clearly marked. Regular fire drills were carried out and documented. Staff told us that they knew what to do in the case of an emergency. Each person had a personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical and communication requirements that each person had to ensure that people could be safely evacuated from the service in the event of an emergency.

At the last inspection in June 2016 the provider had not completed the relevant checks to make sure new staff were of good character. We asked the provider to take action. At this inspection improvements had been made. Recruitment checks had been made in line with the provider's policy to make sure staff were honest, reliable and trustworthy to work with people. These included a full employment history, proof of identity and written references. Staff told us that checks were carried out before they started working at the service. Discussions held at interview were recorded. Disclosure and Barring Service (DBS) criminal record 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. The breach in regulation found at the last inspection had been met.

Requires Improvement

Is the service effective?

Our findings

People told us they received support from staff when they needed it and that the staff were trained to provide the right support. One person commented, "I find the staff to be very helpful and do things properly".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Best interest meetings had been held with the relevant people with regard to DoLS applications. DoLS assessments had been completed and the registered manager had made applications in line with guidance.

Some people had been diagnosed as living with dementia and were not able to give their valid consent to care and support. When people were not able to give consent to their care and support, staff did not consistently act in their best interest and in accordance with the requirements of the MCA. Care plans contained an assessment of a person's capacity but this was general and not specific to any decision. These were not always correct. For example, one person was deemed as having capacity by the staff and yet they had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) on which a GP had noted that the DNACPR was in the person's best interest as they had advanced dementia and no capacity.

People had not had their capacity assessed to check they were able to understand about their consent to care. People's capacity regarding different aspects of their care and support had not been assessed. One person's care plan noted that the person had capacity and 'Should be encouraged to make decisions with prompting from staff'. During the inspection staff offered them choices and they made choices. For example, how they wanted to spend their time. Other information in the care plan was contradictory. It noted that the person 'Requires the use of an advocate to raise any complaints within the home'. We asked this person how they would complain if they were worried about something and they pointed to the care manager and told us they would speak to them. It also noted that the person's advocate had 'Given consent to the use of photographs' but the advocate had no legal right to do so. It noted the person 'Is aware it is necessary to share information in their best interest' and 'Has given consent for any regulatory body to have access to their confidential personal information' but their capacity to consent and understand this decision had not been assessed.

Some care plans noted, 'Ensure that decisions made are in [the person's] best interests, and in a way that is least restrictive as possible'. Staff discussed with health professionals and had meetings to make specific

decisions in people's best interest. For example, health professionals advised staff not to use bedrails for a person as they were at risk of trapping their feet in the rails. It was decided the least restrictive option was to not use bedrails and this was followed by staff.

During the inspection people were offered straight forward choices about what they wanted to do and how they wanted to spend their time. People's choices were respected by the staff. People told us they got up and went to bed at a time they chose. People said, "You can get up when you like but I get up between 7.00 and 7.30", "In the evening I stay up quite late and the staff are very considerate if I am watching television they ask if I want to finish watching and they will come back later" and "I like to get up early".

The provider was not working in line with the principles of the Mental Capacity Act. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed an induction when they started working at the service. New staff completed the Care Certificate, an identified set of standards that social care workers adhere to in their daily working life. They shadowed experienced staff to get to know people, their routines and their preferences.

At the last inspection in June 2016 the provider failed to ensure staff received the appropriate support and training. We asked the provider to take action. At this inspection improvements had been made. Staff had regularly met with the registered manager or care manager on a one to one basis for supervision. Staff said they felt supported in their roles and told us what training they had completed. The registered manager monitored staff training and used a schedule to ensure refresher training was booked when needed. Gaps in training were identified and action taken to address this. For example, two staff were due to have their refresher training of moving and handling and this had been booked. Some staff were planning to undertake specialist SSKIN training – this was a five step model of training for pressure sore prevention – the registered manager had been in contact with a health professional to arrange this. They made sure staff were up to date with the necessary knowledge and skills to carry out their roles effectively. When we spoke with staff they were knowledgeable and told us how they provided people with the care they needed and preferred. For example, staff were able to tell us what signs a person might show if they were anxious and how they reduced this anxiety. During the inspection staff put on some music and encouraged a person to sing along and they visibly relaxed, smiled and appeared to enjoy this. When a person put on their coat and said they wished to go out, staff gently took their arm and supported them to walk in the garden and this appeared to settle them. The breach in regulation found at the last inspection had been met.

People told us they enjoyed their meals and that they had plenty to eat and drink. People said, "Good food and large helpings", "I am extremely fussy. I've asked for salads in the hot weather and I've had a couple of good salads" and "The food is good". A relative commented, "We stayed for Christmas dinner, it was excellent". People and their relatives commented on how good the cakes were that were made by the cook. A menu offering the day's choices was displayed and the cook asked people each day what they would like. Some people used special cutlery to support them to maintain their independence. During lunch the staff were attentive and checked that people had everything they needed. Most people chose to eat together in the dining room where they chatted with each other over their meal. Food was well presented. People ate well and told us they enjoyed it. Regular hot drinks with biscuits were served. Cold drinks were freely available throughout the day. There were bowls of fruit for people to help themselves to and in the afternoon a carer went round offering people a choice of fruit and encouraging them to choose one.

Staff checked people's weights and referred people to the relevant health professionals when needed. For example, when a person's weight reduced they liaised with a dietician and the speech and language team and followed the guidance given to them. The cook told us that when people were at risk of malnutrition

they used butter, cream and other high fat products to fortify people's diets. They were aware of people's food intolerances, allergies and diabetic needs.
Staff monitored people's health and took action when they noticed any changes. The care manager told us, "The staff keep an eagle eye on any changes in people's health and let the GP or community nurses know". When they had a concern they contacted health professionals, such as dieticians, community nurses and GPs, for advice. Staff followed guidance given to make sure people stayed as healthy as possible. People told us staff supported them to see doctors, chiropodists, dentists and opticians. People also said that staff supported them to attend appointments and stayed with them if requested. One person said, "The carers accompany me to my hospital appointments".

Requires Improvement

Is the service caring?

Our findings

People told us they were happy living at Wychdene and that the staff were kind and caring. People said, "The staff are excellent, I am well, probably too well fed and I have a comfortable nice size room", "The staff turn up in the morning and help me wash; they wait on me hand and foot", "I'm quite satisfied with what I've got", "It's lovely here" and "This is one of the best for all round care". Relatives commented, "Friendly, comfortable, home from home and very caring", "[Our loved one] gets on well with staff" and "It is very homely". Relatives had noted on quality surveys, 'I have personally met various members of staff and have found them caring and dedicated' and 'We find the staff very helpful and friendly and we are very happy (and so is my loved one) with the care [my loved one] receives'

Staff were not always respectful of people and their belongings. One person told us that when staff needed to go to their handbag the older staff asked first if it was alright to do that and the younger staff did not ask. Some people said that staff could be abrupt and one person told us they didn't like it when a carer said, "What do you want". We told the care manager of this and they agreed this was disrespectful and that they would address this with the staff team. Staff did not always use respectful language when they completed their records. For example, one daily record in July 2017 noted a person as, 'Appears to be disgruntled'.

Staff had been reminded at a staff meeting in June 2017 about recording in a respectful way. A record of a recent staff meeting noted, 'In terms of documenting in care plans, can all staff ensure to document about the service user in a person centred way. For eg: X had tea at 10. Don't just write "tea given at 10"; instead write "X (write the name you call your service users by) had a cup of tea at 10. It is observed that some staff are just doing it ONLY for the sake of doing it, staff must remember that we provide a person centred care and person centred documentation is a part of person centred care'. Despite this reminder staff continued to write in a detrimental way.

During the inspection staff spoke with people in a kind, gentle and patient way. They bent down to speak with people to make eye contact and sometimes held their hand as they spoke with them. All the staff knew people and their relatives well. Staff spoke with people about things that were important to them.

The provider failed to ensure that people were consistently treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how much people could do for themselves and what level of support was needed. People said, "I wash and dress myself and carers help me with the things I can't manage" and "I try and do things myself and the girls help me if I can't do something". People were able to move freely around the service and grounds. Some people chose to spend time in their own rooms whilst others enjoyed each other's company in the communal areas. When people chose to stay in their room this was respected by staff.

People maintained their friendships and relationships. People told us their loved ones could visit whenever they wanted and there were no restrictions. The visitors' book confirmed that friends and relatives visited at various times of the day. Staff knew people and their relatives well. Relatives told us there was "Good

communication between the home and the family". They told us staff kept in touch with them and let them know if there were any significant changes in their loved ones health.

People told us their privacy was respected. We saw staff knocked on people's doors and waited for an answer before entering their room. People were referred to by their preferred names and were relaxed in the company of each other and staff. Staff knew when people wanted their own space and respected this. People told us that they were able to choose if they would like a male or female carer although no-one we spoke with had a preference. Staff were discreet when speaking with people about their personal care. One person commented, "They don't make you feel uncomfortable or embarrassed and are very discreet".

People said they and their families were involved in planning their care and that staff explained things to them and discussed any changes to their care and support. People's confidentiality was respected and personal records were stored securely. Care plans and other records were located promptly when we asked to see them.

People personalised their rooms in line with their particular likes and preferences and this was encouraged by staff. Some people had decorated their rooms with pictures and photographs of things that were important to them such as family members or loved ones.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff were responsive to their needs. People knew how to complain and felt comfortable telling staff about complaints if they needed to. People said, "Every comfort is here", "If you ask for something you get it" and "It is very good, most things if you ask you get". Staff were observant and responsive to people's needs.

People were encouraged to keep active and to help with jobs around the service. One person told us they liked to fold napkins at lunchtime and also to keep their room clean and tidy. Another person said, "I like to go in the garden and potter because I had a garden at home".

The provider had a minibus, however people and staff told us this was only used for shopping. People said they had never been asked if they would like to go out in it. One person commented, "I have been living here for a year and not been out in the minibus yet". Some people had families who took them out. Others said they would like the opportunity to go out. People said, "We used to go out for walks but no longer" and "I'm bored out of my mind".

Care staff took it in turns to organise activities within the service. There was no schedule of planned activities. There was no one employed to lead activities. Activities were dependent on care staff having time to spend doing this. For example, during the inspection people enjoyed playing 'giant snakes and ladders', knitting, singing to old time music and dancing. A relative told us there were barbecues during the nice weather and that a summer fete had been planned. People said, "Sometimes we do singing they come weekly", "We have quizzes, we have entertainers", "Activities are rather few and far between when I first came in there were quizzes", "People bring their dogs in", "Two volunteers come from the library and bring in books" and "I prefer to stay in my room, I've got my TV. They bring me a newspaper". Minutes of a recent residents meeting noted people requesting more activities.

People and their families were initially involved in the planning of their care and support. The registered manager met with people and their representatives before they moved into the service to discuss their needs and preferences. An assessment was completed which summarised people's needs and how they liked their support provided. This helped the registered manager make sure staff could provide the care and support the person wanted. From this information a care plan was developed to give staff the guidance they needed to look after the person in the way they preferred.

People told us that staff provided the care in the way they preferred. Staff spoke knowledgeably about people's care and support preferences. An electronic care planning system was used. Staff were issued with a handheld tablet computer to make changes to people's care plans as they needed to do so. Key workers were responsible for making sure the care plans were kept up to date. A keyworker was a member of staff who was allocated to take the lead in co-ordinating someone's care. Guidance for staff on how best to communicate with people was in the care plans. Care plans noted if people were able to communicate verbally, reminded staff to maintain good eye contact and to stand in front of people, and to speak clearly and slowly. Care plans were reviewed and updated when required.

There was good communication between the staff team and a handover was completed at the beginning of each shift to make sure they were up to date with any changes in people's needs. Staff were allocated specific tasks, such as medication, the tea trolley and activities, so they knew what their priorities were for the shift.

The provider had a policy in place which gave guidance on how to handle complaints and copies of this were displayed in the service. When complaints had been made they had been investigated and responded to appropriately. People and relatives told us they would raise any concerns with the registered manager or staff and felt that they would be listened to and their complaint properly addressed. People said, "If you complain they would do something about it" and "I was told I could speak privately to a senior if I had a problem. I have spoken to one about something. I was told it is being looked into". A relative told us, "We have a good relationship with the staff so we would have no issues in complaining if we needed to".

Inadequate

Is the service well-led?

Our findings

People knew the staff and registered manager by name and told us they could rely on them to provide the right support. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in June 2016 the provider had failed to have a registered manager in post. We asked them to take action. At this inspection a registered manager was in post and the breach in regulation found at the last inspection had been met. However, during the inspection the provider told us they had received the registered manager's resignation. They told us how they planned to replace the registered manager and this will be monitored and followed up at the next inspection.

At the last inspection in June 2016 the provider failed to assess and monitor the quality and safety of the service. We asked them to take action. At this inspection improvements were needed. Systems had been implemented as part of the management audit to check of the quality of the service. However, these systems were not sufficiently robust and the shortfalls found during our inspection had not been identified by the registered manager, care manager or provider. For example, the last management audit completed by the care manager on 19 July 2017 did not identify the inconsistency in care plans regarding people's consent and mental capacity and the shortfalls with the environment. The providers' checks had failed to pick up and act on insufficient staffing levels, equipment not being set correctly, issues with medicines management, poor cleanliness and foul odour in some areas, the attitude and conduct of some staff and the lack of activities. The provider had not taken action when relatives had feedback about the state of the environment their loved ones were living in. The provider had not addressed staff concerns with regard to staffing levels.

Regular quality checks were completed on key things, such as, fire safety equipment, hot water temperatures and infection control.

The provider failed to assess and monitor the quality and safety of the service provided and had not identified shortfalls at the service through effective auditing. This is a continued breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Providers are required, by law, to display their CQC rating to inform the public on how they are performing. The latest CQC report and rating was displayed in line with guidance within the service. The provider's website had a link to their last CQC report. However, the rating and last report were not displayed conspicuously so people looking for information about a service would see it.

The provider had noted on the Provider Information Return that they had 'Employed new full time care services manager in February 2017 to provide office admin services and also carry out regular audits necessary to improve the quality of care'. The care manager said, "I wanted to so shifts with the staff to get

to know the residents. I am here to develop and mentor the staff".

Staff told us the lines of responsibility were unclear. There was a registered manager, a care manager and a head of care. Staff were unclear of each ones roles and responsibilities. We discussed this with the provider during the inspection and they told us they would meet with the staff to ensure roles were defined. There was no clear leadership of the service to coach, mentor and develop the staff and to drive improvements in the quality of the service.

Staff told us, and records confirmed, that regular staff meetings were held and that they were able to openly discuss any concerns. Records were kept of each meeting and a note of any actions and who needed to take action were completed.

People were encouraged to provide feedback and contribute ideas for the service. Monthly residents meetings were held to obtain feedback on the quality of the service. People told us their views were listened to. People said, "We told them it was very hot in the lounge and the owner bought an air conditioning unit" and "I suggested we had lasagne and the next day we had it". People, relatives, staff and health professionals completed quality surveys to give their views. Surveys had been sent and the responses were being collated. The care manager told us they would analyse and review the responses to see if any action was needed.

The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely. Staff knew where to access the information they needed. When we asked for any information it was immediately available and records were stored securely to protect people's confidentiality.

The registered manager and care manager worked with staff each day. They understood their responsibilities in recording and notifying incidents to the Kent local authority and CQC. All services that provide health and social care to people are required to inform CQC of events that happen in the service so CQC can check appropriate action was taken to prevent people from harm. The registered manager notified CQC in an appropriate and timely manner and in line with guidance.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people were consistently treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not working in line with the principles of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure care and treatment was provided in a safe way. The provider failed to assess risks to people and do all that was practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises were clean, and properly maintained.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider failed to assess and monitor the quality and safety of the service provided and had not identified shortfalls at the service through effective auditing. This is a continued breach.