Fort Horsted Care Home Ltd

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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 09 and 13 November 2017. The first day of the inspection was unannounced.

Fort Horsted Care Home Ltd 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. People received nursing and personal care

Fort Horsted Care Home Ltd accommodates up to 30 people in one single storey building. There were 29 people living at the service when we inspected, one of whom was in hospital. A number of people received their care in bed. Some people lived with dementia.

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

At this inspection people told us they enjoyed living at the service. They got on well with staff and we saw that people were comfortable and relaxed.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of the service. Records were not always complete, accurate or securely stored.

People's care plans detailed most of their care and support needs. However, care plans did not all reflect each person's current needs or specific healthcare needs.

The provider followed effective recruitment procedures to check that potential staff employed were of good character and had the skills and experience needed to carry out their roles. Appropriate numbers of staff had been deployed to meet people's needs. It was not clear how staffing levels had been determined as people's dependency information was not used to calculate the staffing required. We made a recommendation about this.

People's care records and assessments did not follow the principles of the Mental Capacity Act 2005. Staff supported people to make everyday choices about their care.

Staff had attended basic training but had not always attended training relevant to people's needs.

Staff had received effective supervision from the registered manager. There was no formal process in place for the registered manager (as a trained nurse) to receive planned and regular clinical supervision. We made a recommendation about this.

Risk assessments were in place to mitigate the risk of harm to people and staff. These had not always been updated when people's needs had changed.

Medicines had not always been well-managed or stored securely. Prescribed thickening powder which was a choking risk was found unattended in the dining room and in some people's bedrooms.

People and their relatives gave us mixed feedback about the activities. Activities took place during the inspection. Some people were enabled to access their local community both with their relatives and with the staff. We made a recommendation about this.

People had choices of food at each meal time which met their likes, needs and expectations. Food was not always prepared to meet people's dietary requirements. People with diabetes were provided with the same meals as others. We made a recommendation about this.

There was a lack of signage around the home to direct people to communal areas such as the lounge and dining room. We made a recommendation about this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had systems in place to track and monitor applications and authorisations.

Staff knew and understood how to protect people from abuse and harm and keep them safe. The service did not have a copy of the local authorities safeguarding adults policy and procedure. We made a recommendation about this.

People were supported and helped to maintain their health and to access health services when they needed them.

Maintenance of the premises had been routinely undertaken and records about it were complete. Fire safety tests had been carried out and fire equipment safety-checked.

Staff were cheerful, kind and patient in their approach and had a good rapport with people. The atmosphere in the service was calm and relaxed. Staff treated people with dignity and respect.

People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were welcomed at the service at any reasonable time.

People and their relatives had opportunities to provide feedback about the service they received. Compliments had been received from relatives.

People and their relatives knew who to talk to if they were unhappy about the service. Complaints had been effectively managed. The complaints procedure required some updating. We made a recommendation about this.

Relatives and staff told us that the service was well run. Staff were positive about the support they received from the management team. They felt they could raise concerns and they would be listened to.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks had not been appropriately assessed and mitigated to ensure people's health and safety.

Medicines were not always managed safely.

There were enough staff deployed to meet people's needs, however the provider had no system in place to ensure people's assessed dependency levels were collated to review the numbers of staff deployed. The provider had followed safe recruitment practices.

Staff knew what they should do to identify and raise safeguarding concerns.

The service was clean, tidy and equipment had been properly checked.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff supported people to make choices about all elements of their lives. However, people's care records and assessments did not follow the principles of the Mental Capacity Act 2005.

Staff had received basic training relevant to their roles. However, staff had not all completed training relevant to people's needs and health conditions. Staff had received supervision and good support from the management team.

People had choices of food at each meal time which met their likes, needs and expectations. Food was not always prepared to meet people's dietary requirements.

People received medical assistance from healthcare professionals when they needed it.

There was a lack of signage around the service to direct people to communal areas such as the lounge and dining room. Some

doors to bathrooms and rooms were signposted as one thing but were found to be something else.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People were involved with their care. People were treated with kindness and compassion.

People were able to contact their relatives when they wanted to and were supported to maintain contact with their relatives. Relatives were able to visit their family members at any time.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans required improving to ensure they were person centred. Care plans were not in place for all people's known and assessed needs. Some people's care records evidenced that advanced care planning had taken place to record their wishes and preferences around the end of their lives.

People we spoke with knew how to complain. Complaints information was not accessible for those living with dementia. Complaints had been dealt with appropriately.

Some people gave negative feedback about the activities. Activities for some people were taking place to ensure people could keep active and stimulated when they wanted to be, both in the service and the local community.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audits had not always been totally effective in identifying shortfalls in the service. Additional improvements to policies, procedures and practice were identified. Records had not always been maintained to ensure they were complete and accurate.

The registered manager had reported incidents to CQC. The provider had displayed the rating from the last inspection in the service.

Staff were aware of the whistleblowing procedures and were

confident that poor practice would be reported appropriately.

People and staff felt the registered manager was approachable and would listen to any concerns. Staff felt well supported by the management team.

Fort Horsted Care Home Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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.

This inspection took place on 09 and 13 November 2017 and the first day was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete 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 also reviewed the information we held about the service including previous inspection reports. These inspection reports related to the same service but the provider's previous legal entity. We considered the information which had been shared with us by people and relatives and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We spent time speaking with 10 people who lived at Fort Horsted Care Home. Some people were unable to tell us about their experiences, so we observed care and support in communal areas. We also spoke with five relatives and one person's friend to gain their feedback about the service. We spoke with a visiting GP and a visiting community nurse to the service.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority care managers and commissioners. We spoke with nine staff; including care staff, registered nurses, kitchen staff, housekeeping staff, activities staff, the registered manager and the provider.

We looked at eight people's personal records, care plans and medicines charts, risk assessments, staff rotas, staff schedules, three staff recruitment records, meeting minutes, policies and procedures.

We asked the registered manager to send us additional information after the inspection. We asked for copies of policies and procedures and legionella check records. These were not received in a timely manner.

The service had been registered with us since 23 December 2016. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. Comments included, "There's always someone around, including at night"; "If I ring the buzzer, they come quite quickly" and "There is always somebody about. I don't like being on my own at night".

Relatives also told us their family members were safe. One relative told us, "There seems to always be enough staff. They don't seem rushed". Another relative said, "I am very impressed about safety here. With infections, they know the signs. Dad was getting poorly and I spoke to Matron. They had already ordered antibiotics".

Each person's care plan contained information about their support needs and the associated risks to their safety. This included the risk of a person falling, of malnutrition, aspiration, developing pressure areas and of deterioration in their health or medical condition. Guidance was in place about any action staff needed to take to make sure people were protected from harm. For people who were at risk of falling, guidance was in place about any specialist moving and handling equipment they required when moving around the service, transferring, when moving in bed and bed rails to prevent a person falling out of bed. However, care plans and risk assessments did not have all the information staff needed to keep people safe. One person was diagnosed with epilepsy. They had a risk assessment in place which detailed that staff should stay with them when they had a seizure and to check this person hourly during the day and night. There was no care plan or risk assessment in place to detail to staff how they should meet this person's needs and what the person's seizures may look like and what action they should take if they had a seizure. The person received their care in bed, there was no electronic monitoring taking place such as epilepsy alarms to alert staff if the person was having a seizure. The person was unable to use the nurse call bell. Although people's risk assessments and care plans recorded that some people required hourly checks, the room charts and records for each person had gaps of much longer than this. For example, one chart for a person who required hourly checks stated; '08:00 sat up, 10:30 personal care attended and another entry was made at 11:00. We checked this person's chart at 13:00 and there were no further entries. This showed that the person had not been checked as frequently as they should have been which put them at risk of harm.

Risks in relation to people's pressure area care were not always well managed. During the inspection we heard beeping sounds coming from some people's rooms. A nurse told us that this was the pump for the air mattresses. We asked them to check that it the mattresses were correctly inflated. The nurse told us that the pump was not working correctly. We asked to see records in relation to pressure relieving mattresses to evidence that staff were checking they were correctly inflated. The nurse told us that there were no records to evidence that these checks were taking place. We reported these concerns to the registered manager. Other risks to people's safety had also not been considered. We found that some rooms which should have been locked to prevent unauthorised access were not locked. The wheelchair store room which also contained hot water tanks and pipes was unlocked as was the cleaning materials cupboard. These areas could cause harm to people through contact and ingestion of chemicals and from burns.

The failure to take appropriate actions to mitigate risks to people's health and welfare is a breach of

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Medicines were not always managed safely. Most medicines were stored safely, however we found that two people's Insulin medicines were kept in their rooms. We raised this with the registered manager as a concern to people's safety. A number of people were prescribed fluid thickener, which is used to thicken drinks to help people who have difficulty swallowing. We found this was left unattended in the dining area on a trolley which was used to make drinks for people. We also found prescribed thickener in some people's bedrooms. Prescribed thickeners should be kept locked away to prevent accidental ingestion of the powder. A patient safety alert had been cascaded by NHS England in February 2015 which warned care providers to the dangers of ingesting thickener. The home did not know about this safety alert and had not kept the thickener out of reach. The registered manager and the provider agreed to change where fluid thickener was stored in order to keep people safe. The temperature of the room where medicines were stored was often high and had exceeded the recommended maximum temperature. Cooling fans were in place and used when temperatures were high, however these were not cooling the temperature down sufficiently. We spoke with the registered manager to suggest that they review the effectiveness of the fans. An air conditioning unit may be more suitable to keep the temperatures lower. Medicine fridge temperatures were monitored appropriately.

Controlled drugs (CDs) which are medicines with potential for misuse, requiring special storage and closer monitoring were stored and recorded in line with legislation. Nurses carried out regular balance checks of CDs and we found these to be correct. Staff were suitably trained to ensure people received their prescribed medicines. People's records contained up to date information about their medical history. However, people's records did not detail how, when and why they needed the as and when required (PRN) medicines prescribed to them. This meant that staff administering these medicines may not have all the information they need to identify why the person takes that particular medicine and how they communicate the need for it.

People were given medicines at the appropriate times and people were fully aware of what they were taking and why they were taking their medicines. There were good systems in place to manage the administration of pain patches which were administered daily. However, this practice had not been incorporated for people who required pain relief patches on a weekly basis. We reported this to the registered manager and they agreed to amend the recording of the weekly pain relief patches. The dispensing pharmacy had carried out an audit of medicines on 22 March 2017 and identified a few small areas which could be improved on. These included ensuring that handwritten entries added on to the medicines administration record (MAR) must be signed by two people and topical cream were not being consistently recorded that they had been administered. During the inspection we found a number of MAR charts which had hand written entries that were not double signed and also found that people's records did not show that they had their prescribed creams and lotions administered as prescribed. This meant people were at risk from unsafe medicines practice.

The failure to manage medicines safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider followed safe recruitment procedures to ensure that staff employed to work with people were suitable for their roles. The provider followed safe recruitment procedures to ensure that staff employed to work with people were suitable for their roles. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Employer references were also checked. Nurses were registered with the

Nursing and Midwifery Council and the registered manager had made checks on their PIN numbers to confirm their registration status.

There were suitable numbers of staff on shift to meet people's needs. Staffing rotas showed that at least one nurse was allocated on each shift. The registered manager worked four days on shift as a nurse each week. Allowing one day working in the office carrying out their management duties. The deputy manager and registered manager worked alternate weekends which meant there was always a member of the management team available. People's nursing and care needs were met in a timely manner. However, it was not clear how the staffing levels were determined in the home. Each person was assessed to record what level of dependency they had. For example, those people cared for in bed who required assistance with all of their personal care needs, eating and drinking needs were assessed as very high dependency. Each person's dependency level had been reviewed on a monthly basis. However, the information was not then collated by the provider and registered manager to review whether there were sufficient staff deployed to meet people's needs.

We recommend that registered persons review systems and processes to evidence that staffing levels meet people's assessed needs.

Staff understood the different kinds of abuse to look out for to make sure people were protected from harm. Staff knew who to report any concerns to and had access to the whistleblowing policy. Staff all told us they were confident that any concerns would be dealt with appropriately. Staff had access to the providers safeguarding policy. This policy did not link to the local authority safeguarding policy. The policy also conflicted with the local authority policy as it detailed that that registered manager would decide whether alleged abuse constituted criminal action. The service did not have a copy of the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse.

We recommend that registered persons review and amend their policy and ensure that a copy of the local authority's safeguarding policy, protocol and procedure is obtained.

Maintenance records evidenced that checks had been completed by qualified professionals in relation to legionella testing, asbestos, moving and handling equipment, electrical appliances and supply, gas appliances, the lift and fire equipment to ensure equipment and fittings were working as they should be. Weighing scales had been calibrated to make sure they were working correctly to enable staff to monitor people's weight effectively. However, general maintenance tasks such as decorating needed improving. Some corridors and door frames were scuffed and marked. A number of bedrooms required redecoration. One person's bedroom had a large hole next to the bed with bare plaster. The provider's maintenance team were working in the home on the day we inspected to redecorate one bedroom. The provider had a maintenance plan and explained that some of the areas we had showed them had already been decorated.

Each person had a personal emergency evacuation plan (PEEP). PEEPs set out the specific requirements that each person had, such as staff support or specialist equipment, to ensure they could be evacuated safely in the event of a fire. However, these PEEPs were not all in one place such as in the emergency grab file. The emergency grab file had a list of people which was out of date, newer people had not yet been added and some people who no longer lived at the service were listed. We reported this to the provider and the registered manager. On day two of the inspection they showed us an updated file to evidence this had been completed. Visual checks and servicing was regularly undertaken of fire-fighting equipment to ensure it was fit for purpose.

Fire drills had been carried out to ensure people and staff knew what to do in the event of a fire. Three drills had been carried out in 2017. The fire drills records had not recorded how long the drill had taken to evacuate the service, so it was difficult to evidence that the process was robust. Regular fire alarm testing had also taken place; the last test had taken place on 06 November 2017.

The service looked and smelt clean and fresh. Housekeeping staff carried out cleaning tasks. There were suitable supplies of personal protective equipment available and these were used appropriately by staff. There were clear procedures in place to deal with soiled laundry, which all staff knew about. Washing machines washed soiled clothing at the required temperature to ensure it was clean and hygienic.

The service had undergone an infection control audit on 18 November 2016 by the Infection Prevention Specialist at the local authority. The audit identified a number of actions. All but one of the actions had been completed in a timely manner. The only outstanding action was to ensure that people who required the use of hoists to enable them to safely transfer had a sling for their individual use. This would reduce the risk of cross infection. We spoke with the registered manager and the provider about this. They explained that a list of slings had been put together and a list of people. We checked this and found that this listed what size sling a person should use. The slings had not been labelled for individual use.

The registered manager shared how the service had learnt lessons from when practice had gone wrong. They shared how one person had rolled out of bed whilst being supported with their personal care. They explained what action was taken immediately to address the situation. Care plans and risk assessments had been updated to ensure that staff knew how to safely support the person. The registered manager had met with the person's family and reported the incident appropriately to the safeguarding team within the local authority.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were.

People's care records and assessments did not follow the principles of the MCA 2005. For example, one person's 'mental capacity care plan' stated 'Does not have mental capacity and is unable to make choices and decisions' this was not decision specific. Another person's care file contained detailed that they lacked capacity, but again did not detail what decision this related to. Another person had moved into the service several weeks before we inspected. Their care records detailed that they had varying capacity because sometimes they were not aware of their surroundings. We checked whether capacity assessments had been completed for specific decisions in relation to their care and support. The registered manager told us, "We are a bit behind and need to put those in place".

People's right to consent to their care and treatment was respected by staff at a verbal level day to day. People or their relatives had been asked to sign a consent form agreeing to care and treatment and photos. However, in many cases the consent form had been signed by relatives rather than the person themselves, even if the person was capable of doing this. The registered manager said they did not ask the person to sign this as moving into the home can be emotional and stressful. Consent should always be agreed to by the person whenever possible, they do not need to complete on the first day. Staff should go through the areas of consent so people have an understanding of what they are being asked to sign up to, as is their right.

The failure to follow the principles of the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood the requirements of the Deprivation of Liberty safeguards (DoLS), and documents seen demonstrated that the appropriate procedures had been followed.

Staff explained they helped people to maintain some self-care also promoted there feeling of self-worth by promoting independence. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. However, we found that some people had not had their care re-assessed for more than a year even when their care needs had changed in that time. The care being given was also seen to be different from that described in the care plan. We found that care plans were not detailed enough to detail how staff should meet people's health needs. For example, one person had epilepsy. Their care plan did not detail what type of seizure the person had and how long their seizures

usually lasted and what action staff should take if the seizure last longer than normal.

We recommend that registered persons review and amend people's care plans with them as their needs change.

The cook had devised a four week menu that met people's likes and dislikes. The cook said menus provided balanced and nutritious diet, using fresh foods when in season. The cook asked people what they would like to see on the menu as the seasons change. They explained, that now it is winter some people had asked for steak and kidney pudding. People like the meals offered and told us, "The food's quite good. It's dished up well to look nice" and "There's a choice for lunch and you're asked in advance". People were able to have their meals in their bedrooms if they wished. Most people had their breakfast in their rooms but came through to the lounge or dining area the rest of the day. One person said, "I like to have my breakfast in bed. It's my choice. It's my one luxury". Another person told us, "We can have drinks when we want. You get everything as you like it as long as you tell them in advance".

The cook explained that they catered for people who had different diets. When asked, the cook and staff said that they knew that people who were of the Muslim faith do not eat pork. They said that they made sure people had foods they liked. We asked staff about people who were having a diabetic diet, they knew who were diabetic but that they had the same meals as everyone else. This was confirmed by the cook, who said they have the same as everyone else, its ok if everything is in moderation. After the inspection, the registered manager told us this was not the case and said that people living with diabetes were offered an appropriate diet to meet their needs.

We recommend that the provider and registered manager review the catering arrangements for people with different diet needs.

Some people needed help to eat their meals, staff explained that some people needed their food cut up or pureed. A relative said, "They feed her and make sure she's fed. She's fussy but her appetite is coming back". We asked how staff had managed to get their family member to eat and they told us, "The staff kept asking her what they could get her until they found something she would eat". Staff sat with people who needed assistance and checked that they were happy with the meal they had chosen. They then assisted people to eat at each person's pace, offering a drink at times.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The nurses on shift told us they had received training to carry out their roles. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Nurses had received further training to validate their NMC nursing qualification, one nurse said, "They provide me with training as a nurse; I recently undertook venepuncture as part of the revalidation process". Venepuncture is the collection of blood from a vein which is usually done for laboratory testing. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of their training and development needs. The training records confirmed that all staff had received the training needed to give them the skills and knowledge to care for people. However, there was no evidence that staff had undertaken training that matched some of the conditions the people they cared for had. For example, dementia, stroke, diabetes and epilepsy were not covered but were relevant as people they cared for had these conditions. Staff received supervision from their line managers. The registered manager utilised the other registered managers with the provider's other services for support at any time. They also made links with visiting healthcare professionals. There was no formal process in place for the registered manager (as a trained nurse) to receive planned and regular clinical supervision.

We recommend that registered persons review the training requirements for staff to ensure that staff have the right skills and knowledge to work with people who had specialist health conditions. We also recommend that the provider reviews the arrangements for clinical supervision.

New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. Two new staff confirmed with us that they had started with an induction. These staff had worked in care previously and had completed vocational training so did not need to undertake The Care Certificate standards. Copies of the previous training certificates were on file. The Care Certificate is a course that gives staff just starting in care the basic knowledge of how to care for people. The course includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised and provide care appropriate and safe.

Staff were knowledgeable about people's health needs and medical history, which were recorded in people's plans of care. People's day to day health needs were managed by the staff team with support from a range of health care professionals. A health care professional told us the service was, "Good at referring to the dietician and GP when people were not eating or had weight loss" and "They pick up on problems with new patients such as pressure areas". Another health care professional told us they visited the service on a weekly basis. They went on to say, "The girls [staff] ring or email me in between if they need to. It works really well, they are good".

Nursing staff supported people's day to day nursing needs in relation to managing diabetes and other healthcare conditions. Community nurse practitioners visited people on a weekly basis and when required to meet people's nursing needs. Staff had sought medical advice from the GP when required. Records demonstrated that staff had contacted the GP, nurses, local authority care manager, occupational therapist, ambulance service, nurse practitioners, respiratory team, chiropody, palliative care nurses, tissue viability services, hospital and relatives when necessary. Records also evidenced that referrals had been made to speech and language therapist (SaLT) when people had difficulty swallowing. Advice given by the SaLT team was being followed by staff providing care and treatment. People had seen an optician on a regular basis to check the health of their eyes. People told us, "The doctor will come here as and when you need it. If you're ill, he might come more" and "If I need a doctor, they will bring the doctor in".

During the inspection, we observed that there was a lack of signage around the home to direct people to communal areas such as the lounge and dining room. Some doors to bathrooms and rooms were signposted as one thing but were incorrectly labelled. For example, one room was labelled bathroom, however there was no bath. The room was the hair dressing salon. There was a toilet in the room and a mattress had been stored in there. Another room which was labelled as a toilet was found to be a cleaning cupboard. The service provided care and support for people with a variety of needs including those people living with dementia. Inaccurate signage and lack of dementia friendly signage could cause people to be disorientated in the environment. Doors mostly looked the same, some doors had numbers on and some had names. The corridors were mostly painted cream, which meant that they all looked the same. The provider and registered manager had not followed recognised guidance issued by The National Institute for Health and Care Excellence (NICE) to help and support people living with dementia.

We recommend that the provider seeks advice and follows good practice guidance to support people with dementia to orientate themselves in the service to enable them to live well.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. Comments included, "The staff are very good. I couldn't have had better care if I had been in a top hospital"; "The staff are fine. I'm happy"; "I've been treated well"; "I really like it here"; "It's alright living here. I'm happy here" and "The carers are a nice group of people. I'm treated alright. They are kind to me. If I'm feeling poorly, they make sure you're alright".

Relatives and friends told us their family members and friends received good quality care and staff were friendly and caring towards them and their family members. One relative said, "The staff are fairly good. They seem kind and friendly". One person's friend told us, "I'm very pleased with his care. I have friends with relations here who spoke well of it". Relatives gave examples of good practice in nursing care. One relative detailed that their relative was cared for in bed, the person had no pressure areas which indicated to them that the care was good.

We observed that staff respected people's privacy. Staff were seen to knock on doors before entering. We spoke with staff who said that they would ensure privacy by making sure that the door was closed when they gave personal care, one staff member said they would ask personal questions such as do you wish to go to toilet in hushed tones rather than making an announcement. Some people shared bedrooms with other people. We observed that curtains and screens were fitted to ensure people's dignity whilst they received personal care in bed. Some people told us their experiences of sharing rooms, "It's nice to have someone to chat with. I usually stay in the room with the lady I share with. She's a lovely lady and I get on well with her. It's a small room but we get along ok"; "It makes no difference to me [sharing a room]. At first there was a lady who had had a stroke and couldn't speak. We get along alright". A relative detailed how they were given privacy to have family time together. They said, "They give us space when we're visiting".

There were many examples of staff understanding people's individual needs and attending to them with a caring attitude. People were treated with dignity and respect and staff clearly knew people well. Some staff had worked at Fort Horsted Care Home for many years so knew people very well as well as their relatives. We saw staff chatting and having a joke with people and their relatives when they were visiting their family members.

People told us their relatives were able to visit at any time. We observed relatives visiting from early in the morning through to the evening. People said, "My family come to see me. My son comes every Sunday"; "Visitors pop in. There's always someone around me. My family come in my room and they're offered a cup of tea" and "I get lots of visitors". Friends and relatives said they were made to feel welcome. One person's friend explained, "Staff make me feel welcome when I come. They make me a drink or I can help myself to a drink". We observed a staff member taking a birthday card to a person; they explained that they had selected the card for the person to write as it was the person's relative's birthday coming up. Whilst this supported the person to keep in contact and be involved in their relatives life, further improvements could be made to support people to go out of the home to purchase cards of their choosing for their relatives or making use of internet based shopping to help people choose.

Staff knew people well and were able to identify if people were upset or quiet. One person told us how they had been given some sad news about a close friend. They had been very upset. They said, "The staff sat and had a chat and then I felt better" and "The staff are very good. Nothing's too much. They know my position. If I get upset, they give me a cuddle".

Staff were gentle with people and talked through what they were doing when there was a need to use the hoist in the lounge. Staff approached people using their chosen name and spoke with them at their level much of the time rather than standing over them. When one person became upset, a member of staff immediately went over and sat next to the person to hold their hand and comforted them. This helped the person to relax. The staff were kind, patient and compassionate. They spoke in a respectful way about the people they were supporting.

There was a policy and procedure in place relating to people's rights. It stated that people had the right be included, right to dignity and respect, protection from abuse, to be addressed as they wished, to recognise a range of statutory and specialist services. They should have an advocate if they have no one to speak on their behalf, privacy in their room and have visitors of their own choice. They should also be able to vote in elections. On the first day of our inspection someone from the electoral roll visited the service to check all the names of the people at the service, to make sure that they were on the electoral roll. The nurse in charge went through this with them to ensure everyone was included.

People had opportunities to feedback about the service they received. The registered manager held a 'Tea with Matron' event on a regular basis which enabled people to sit and have afternoon tea with the registered manager. This helped people to relax and feedback about the service they receive in a relaxed manner. The provider told us that 'Tea with Matron' helped iron out small issues. The registered manager and deputy manager also carried out 'comfort checks' with people every three months. These comfort checks check that people are happy with the length of time it takes for their buzzers to be answered, how staff respond, whether they are disturbed by other people pressing their buzzers. We observed staff responding to people's questions throughout the inspection.

People told us that they were the decision makers in their own lives. People chose what they wanted to do to keep themselves active, what to eat, drink and wear. We observed this in practice. One person told us, "It's my choice to stay in my room. I like to watch TV. They've got one out there but I might not agree with what's on". Another person explained that they did not like either of the choices on the menu at lunchtime. This was respected and the cook made them something they did like. A relative shared how it was their family member's choice to stay in bed and rest.

Requires Improvement

Is the service responsive?

Our findings

Some people told us the service was responsive to their needs. One person said "There's no pressure about anything. It's like being in a home from home".

Relatives told us they had been involved in planning their family member care and support needs. One relative said they had been, "Consulted and involved" in their family member's care plan and was "Always informed" about matters relating to their family member.

People did not always receive the care and support they needed. Care plans were in place for each person which detailed how staff should meet most people's care needs. However, care plans were not in place for each element of a person's needs. For example, one person had a catheter fitted; there was no catheter care plan in place to detail how staff should safely meet their needs. One person's religious needs meant that they had specific cultural requirements regarding their food. There was no care plan in place to detail their requirements and why it was important to them. One person was diagnosed with epilepsy; there was no care plan in place to detail how epilepsy affected this person and what staff should do to safely support them. Elements of this person's care plan conflicted with other parts. A care plan was in place in relation to maintaining a safe environment, this detailed that the person was unable to use a call bell to summon help and they had bed rails in place. The care plan stated they needed checking every two hours. However, a risk assessment showed because of their epilepsy they should be checked every hour. One person's care plan detailed that they were diet controlled diabetic however our observations showed us and a nurse confirmed that the person's diabetes was managed through insulin injections. Care plans gave information about people's preferences and wishes in relation to times they liked to get up and go to bed and their past hobbies and interests. Information within care plans did not always tally with people's wishes and preferences. For example, one person's care plan detailed they liked to have their bedroom door open, however they told us they preferred it to be closed. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. However, we found that some people had not had their care re-assessed for more than one year even when their care needs had changed in that time. The care being given was also seen to be different from that described in the care plan. We checked the daily records to check that people had received care as detailed in their care plan. The records did not evidence that people had received mouth care, teeth cleaning or showering as detailed in their care plans. There was no record to show that people had been offered this care and that they had declined.

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

People gave us mixed comments about the activities within the home. Comments included, "I like to keep busy otherwise I'm at a loss"; "There are no activities here I like. I used to read and knit but I'm waiting for my cataracts to be done"; "We went to Hempstead Valley. There were only four of us and each one of us had a carer. I really enjoyed that day"; "I used to listen to music, but don't listen now. I used to like music"; "I'm happy with my TV" and "No one comes and visits me. Sometimes a lady from the church comes. Sometimes

I go shopping when I want something". One relative said they were "dubious" about the activities. They explained that their family member would like to do some exercises to build their strength. They also liked gardening and kept asking about their garden in the family home. Another relative told us they thought there was a problem of lack of stimulation for their family member who was cared for in bed. They detailed that the staff were trying to do something about this to improve this because the issue had been raised at a recent relatives' meeting. They shared that some relatives had raised they were concerned about the fact that people could stay in bed all day if they said they did not want to go in the day room. They would like more to be done to keep their relatives occupied.
We recommend that registered persons review the activities to ensure there are activities available to meet people's individual needs.

We observed that activities took place in the home during the inspection. The activities staff member made handmade Christmas decorations with each person; they visited people in their bedrooms and assisted those people who wanted to take part in making a candle holder. Activities information was displayed in several places around the service; however it was not current and related to old dates. The activities staff told us they worked at the service three full days and two half days each week to support people to engage in activities. They said that activities were designed to meet the needs of the people. Activities included, talking about current affairs on a one to one basis, quizzes, crafts, singing and outside entertainers visited on a monthly basis. The service held a sherry morning, with puzzles and brainteasers at the end. Activities staff shared how they encouraged people to reminisce about their past. Such as talking about things like weddings past and present about how they are different now. They had collected food packaging and discussed how food packaging had changed in size and style, this usually sparked further conversations and discussions. The activities staff member also spent time with people on a one to one basis such as reading current affairs or a book based on people's interests, some people choose their own book. The activities staff also provided hand massages for people if they wanted it. A staff member shared how they often went to chat with people in their own rooms to prevent them becoming socially isolated.

There were a number of visitors who visited people in the home to meet their religious needs. Representatives from a Catholic church visited weekly. A representative from a Christian centre visited twice a month. They held a service in the lounge area for people to attend if they wished. The staff shared how a person who was of Muslim faith was also supported to meet their religious needs. The activities staff member explained that the service had been selected by a local church to receive an award for being friendly, showing kindness and providing a welcoming environment.

The provider's care planning records asked people about their end of life wishes and whether they had made any advanced decisions. Some people had consented to do not attempt resuscitation (DNAR) with their GP or consultants. Some records held detailed if people had a pre-paid funeral plan and basic information about people's preferences and wishes to ensure that their wishes were documented in preparation for when their health deteriorated further. The registered manager was sensitive to people's end of life needs. We observed them discussing in a king and caring manner one person's deteriorating needs with the person's friends. The friend was upset and the registered manager helped to reassure them and to make a plan about how they should approach the person to discuss their wishes and preferences. One relative told us there had been no discussion about end of life wishes since their family member had moved into the home. They explained they welcomed the discussions and said, "If clinically possible, I would like [family member] to stay here. It's more restful". Further work was required by the registered manager to ensure people's end of life wishes were discussed with people in a planned way so that wishes were captured in case people's health suddenly changed. The registered manager recognised that this would be a difficult subject to approach with people and planned to do this in a sensitive manner.

People knew who to complain to if they needed to. One person said, "I can't see a thing I can complain of". They went on to say that if they did have a complaint they would tell the activities staff member. A relative said, "I have raised issues. They have responded and I have been happy with the response". Another relative told us, "I know the matrons. I can ask them anything. I would feel comfortable about raising a complaint. I feel they would respond and be prepared to discuss it". The provider told us that the complaints and compliments procedures were kept by the visitors signing in book in the hall way. They detailed that each person was given a copy of the procedures when they moved into the home. They made people aware of the procedure as best as they can. Lessons are learnt from complaints received. The provider explained that complaints are discussed with staff in meetings and handover meetings as well as in supervisions. They said, "We are here to make the residents happy. We take it positively to learn from that. We have an open door". Complaints had been managed effectively by the registered manager and provider. We identified that the complaints policy required some updating as one policy gave people incorrect information about which external agencies they could contact if they were unhappy with the response they received from the provider. Complaints information was not in an accessible standard to help people living with dementia understand.

We recommend that the provider reviews their policy and procedures to ensure people and their relatives have clear information about how to raise and escalate complaints should they need to.

Requires Improvement

Is the service well-led?

Our findings

People knew the registered manager. We observed that people and their relatives felt confident in speaking to the registered manager about things. One person took their room charts to the registered manager to show them that they hadn't been written on. One person told us that the registered manager had said to them, "Come to me if you have any concerns". They went on to explain that they did not have any concerns at all.

Relatives and friends had confidence in the management of the home. Comments included, "Things have improved since [registered manager] has been here. She asked me if I was happy and I told her I was not happy with the food. [The registered manager] dealt with it straight away"; "I am happy with it here" and "[Registered manager] is very approachable. She's lovely. [Person] likes [name of staff], his carer. She took him out in the wheelchair". One relative told us the registered manager "Has good control of everything".

Audits and checks were carried out by the registered manager. The registered manager carried out a quarterly comfort checks, weekly room checks, monthly accidents and incidents audit, monthly observations of care provided by staff, checks of uniforms, shoes, medicines, wounds, charts, weights and filing. We also found that a bed rails audit had been done 18 April 2016 and a mattress audit on 01 February 2017. We checked with the registered manager whether there were more up to date mattress and bed rails audits. They said that the mattresses and beds were checked regularly but these checks were not always recorded.

The registered manager spent four days per week on shift as a registered nurse and one day per week carrying out management duties. This was because there was a vacancy for a nurse and they were being utilised by the provider to fill this gap. Whilst this meant they had a good understanding of what was happening in the service on a day to day basis, it also meant that management tasks, audits, checks and records were delayed.

Despite the quality monitoring systems in place further improvements were still required to drive the service forward to ensure people were receiving safe, effective, responsive and well led care. Quality assurance processes had not been successful in recognising all of the issues we identified in this inspection; such as risk assessments, medicines management, mental capacity assessments, care planning and records accuracy and storage.

Records were stored securely in the office. However, the office was left unlocked and unattended at regular intervals. Records relating to people's care were not always accurate and complete. Dates were not written in full which meant it was not always clear whether the record was old or current. Room charts recording people's care and support such as repositioning and checks on people's health and safety were not always completed.

The failure to operate effective quality monitoring systems and failure to make accurate, complete and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The registered manager met with the other registered managers of the provider's other services on a regular basis. The registered manager felt welt supported by the provider and said they could access them at any time. The provider visited the service on a regular basis. We observed staff chatting to the provider and asking questions which evidenced they knew them well.

The provider's statement of purpose stated; 'Fort Horsted Nursing Home aims to provide a high standard of individualised care to all its residents at all times whilst striving to ensure that residents live in a clean, safe environment. Dignity and respect of residents is to be maintained by staff and visitors at all times. Staff are well trained, following an extensive induction period to ensure that sensitivity and person centred care is shown to all residents regardless of why they are here'. We observed that people were supported to live in a clean, comfortable and safe environment. Staff treated people with dignity and respect and did their upmost to ensure that people had the best quality of life. There was a relaxed and homely atmosphere at Fort Horsted Care Home. Each staff member we spoke with told us how much they enjoyed working at the service and providing care and support to the people living there.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had not always been updated by the management team in a timely manner. We discussed this with the registered manager during the inspection and they updated some following our feedback, such as the supervision policy. The registered manager and provider told us they were committed to reviewing care documentation and policies to ensure that the service meets future people's equality, diversity and human rights.

Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported. Staff told us that they had confidence in the registered manager taking appropriate action such as informing the local authority and CQC. Effective procedures were in place to keep people safe from abuse and mistreatment.

Staff meetings were held quarterly to ensure that staff had opportunities to come together, share information and gain information from the management team. The registered manager and provider attended provider forums which are run by external agencies in the local area. This enabled them to keep up with changes and updates in practice as well as building links with other organisations. As an outcome of attending one of these the service will be taking part in a pilot scheme to ensure faster discharge for people from hospital. The registered manager shared how they were looking forward to being part of this and were planning to talk with staff about this at the next scheduled staff meeting. The registered manager kept themselves up to date with regulation by receiving newsletters from CQC. The registered manager also kept up to date with nursing practice by attending events and training sessions. They had attended one the week before we inspected, we observed them sharing information with other nurses.

Staff told us they had lots of support from the management team. One staff member said, "[Deputy manager] and [registered manager] are very helpful with courses and are very helpful regarding personal matters". Another staff member told us, "

Relatives were able to feedback about the service their family members received. One relative told us that there were relatives meetings held and "I can put my views to any of them and discuss. There is a comments book. I feel listened to". The service had received compliments about the service. One thank you card read, 'A big thank you for caring for mum'.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The registered manager and the provider had notified CQC about important events such as deaths and safeguarding concerns that had occurred.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating for their last inspection (under the old legal entity) in the reception area. It was not displayed on their website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Registered persons had failed to plan care and treatment to meet people's needs and preferences. Regulation 9 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Registered persons had failed to follow the principles of the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Registered persons had failed to operate effective quality monitoring systems and failure to make accurate, complete and contemporaneous records. Regulation 17 (1)(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Registered persons had failed to take appropriate actions to mitigate risks to people's health and welfare and failed to manage medicines safely. Regulation 12(1)(2)

The enforcement action we took:

We served the provider and the registered manager a warning notice and asked them to meet the regulation by 19 January 2018.