GCH (South) Ltd

Kent House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 5 and 8 December 2017 and was unannounced on the first day and announced on the second day.

Kent House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission [CQC] regulates both the premises and the care provided, and both were looked at during this inspection. Kent House is registered to accommodate a maximum of 40 people with dementia. At the time of our inspection 28 people were living at the home.

There was no registered manager in post at the time of our inspection. The current manager was in the process of applying to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was the first comprehensive inspection of Kent House since it was re-registered under the provider, GCH (South) Ltd in May 2017. Prior to this the service had been inspected in May 2017 under the previous provider, GCH (Kent) Ltd, at which time it was rated 'Requires Improvement''..

At our last inspection in May 2017, we found two breaches of regulations. We found medicines were not managed safely and that the provider did not effectively assess, monitor and improve the quality and safety of the service provided. At this recent inspection we found improvements had not been made and we identified further areas of concern.

Prior to this inspection CQC had received intelligence from external sources, including professionals, raising concerns for the safety of the people residing at Kent House. We looked into these concerns as part of our inspection.

We found the leadership of the home to be weak and inconsistent. Kent House has had four managers since 2016. People's relatives expressed concerns about the constant changes of managers. They told us there was a general lack of continuity. We also found there was a general low level of staff satisfaction because the absence of a stable management team meant that staff did not always receive consistent support.

There was no evidence of learning, reflective practice and service improvement. Although there was an internal audit system in place, we found this to be unreliable and irrelevant because shortfalls were either not addressed or identified. This meant we could not be assured that the audit process was effective.

Risks to people had not always been identified and managed appropriately. There was limited action to assess, monitor or improve the safety of the service. Where risks had been assessed plans were not clear or

coordinated. In other examples, there were no plans in place to instruct staff on how to safely manage those risks. At times information about risks to people was not passed on to the staff and others who needed it. A few staff members were not aware of specific risks to people.

The service did not regularly review its staffing levels to make sure that it was able to respond to people's changing needs. Although the levels of staffing described by the provider were mostly maintained during the week, this was less so during the weekends. We saw records of people who now had higher needs since moving to the home, but this had not been taken into account in staffing decisions.

People were at risk because staff did not administer medicines safely. In some examples we found people did not receive medicines as prescribed. This was a repeated breach, as we saw no improvements since our last inspection in May 2017.

Accidents and incidents were not competently managed. We found the approach to reviewing and investigating causes to be insufficient and slow. We found people with documented history of falls but no effective action had been taken to improve their safety. There was little evidence of learning from these occurrences.

The provider did not always make referrals for appropriate care and treatment at the right time. In some examples we found that recommendations for care and treatment by other professionals were not always carried out as directed.

Whilst we saw that staff asked for people's permission before carrying out care, people's care records did not always reflect how decisions had been reached in their best interests. We also found some staff were unclear about the requirements relating to consent.

People's relatives told us people were treated with kindness. We observed that generally people were treated with dignity, respect and kindness during all interactions with staff. However, we noted that some did not always respond to the needs of people in distress or discomfort in a timely way.

People's care needs were not regularly reviewed. We found some care plans did not sufficiently inform staff on people's current care, treatment and support needs. We also found that the care needs of people who had recently moved to the home were not always fully assessed and planned for.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review. If we have not taken immediate action to propose to cancel the provider's registration of the service, they will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe and a rating of inadequate remains for any key question or overall, we will take action in line with our enforcement procedures. This could be to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report. We are currently considering what action to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people had not always been identified and managed appropriately. Where risks had been assessed there were no comprehensive plans in place to instruct staff on how to safely manage those risks.

Staff had been recruited safely. However, there were insufficient staff employed by the service to ensure people's support needs could be met.

Medicines were not managed safely.

There were checks to make sure people lived in a safe environment and that equipment was safe to use.

Is the service effective?

Inadequate

The service was not effective.

When people were unwell assistance was not always sought in good time

Consent was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.

People were not always supported to maintain their health and wellbeing.

Staff were supported through an induction and on-going training, but they had not consistently received supervision.

Is the service caring?

Requires Improvement

The service was not always caring.

Relatives told us staff were kind and caring. However the provider had failed to address matters, which had been raised at

previous inspections. People had continued to be at risk.

We observed people's dignity and privacy being respected by staff during the inspection.

People were supported to meet their religious needs.

Relatives told us they were able to visit their loved ones at any time if they wanted to.

Is the service responsive?

Requires Improvement

The service was not safe.

Risks to people had not always been identified and managed appropriately. Where risks had been assessed there were no comprehensive plans in place to instruct staff on how to safely manage those risks.

Staff had been recruited safely. However, there were insufficient staff employed by the service to ensure people's support needs could be met.

Medicines were not managed safely.

There were checks to make sure people lived in a safe environment and that equipment was safe to use.

Is the service well-led?

Inadequate

The leadership and management of the service was inadequate and placed people at risk of harm.

A new manager was in post and had applied to become registered with CQC. However, there was a lack of a stable management team since 2016. There had been four managers since 2016.

The provider did not effectively assess, monitor and improve the quality and safety of the service provided.

Kent House

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.

This unannounced inspection took place on 5 December 2017 with a further announced visit on 8 December 2017. The inspection team consisted of one inspector and a specialist advisor. The specialist advisor was a qualified nurse and pharmacist who had experience of working with older people living with dementia and/or mental health needs.

As part of the inspection process we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications. We checked if the provider had sent us notifications in order to plan the areas we wanted to focus on during our inspection. We also contacted the local authority for information they held about the service and reviewed the Healthwatch website, which provides information on care homes. This helped us to plan the inspection.

We had received concerns from partner agencies that related to keeping people safe from the risk of avoidable harm. We looked into these concerns as part of our inspection.

We spoke with seven relatives, the new home manager, the regional manager, operations director, head of care, senior care worker, deputy manager and eight staff members. People were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people who lived at the home. 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 also looked at records in relation to 13 people's care and medicines records to see how their care and treatment was planned and delivered. Other records looked at included seven staff recruitment files to check suitable staff were recruited. We also looked at the provider's training records. We looked at records

relating to the management of the service along with a selection of the provider's policies and procedures, to ensure people received a good quality service.

Inadequate

Is the service safe?

Our findings

At the last inspection in May 2017, we identified a breach of regulation in relation to keeping people safe and we rated the service as 'Requires Improvement' under the key question of 'Is the service safe?' The breaches were in relation to the management of medicines and risk management. At this inspection these issues remained and we also found new concerns in other areas.

Although some people's relatives told us of repeated incidents of falls at the home, generally all relatives spoken with were happy with the quality of care. One relative told us, "I am pleased with the care [my relative] is receiving. [Kent House] is doing well under the circumstances (shortages of staff and constant changes of managers)."

We found that risks to people had not always been identified and managed appropriately. Where risks had been assessed there were no comprehensive plans in place to instruct staff on how to safely manage those risks. We reviewed 13 care records of people using the service. In one example, a hospital discharge letter stated that one person was at risk of seizures. However, several months after moving into the home, there was no care plan or risk assessment or instruction of action staff would take to keep the person safe.

A second person had diabetes and was taking medicines to control blood sugar levels. Their diabetes care plan instructed staff to check blood sugar levels three times a day. However, the plan to address relevant risks was not clear or coordinated. There was no instruction of the action staff should take if the person became hypo-glycaemic (low-blood sugar) or hyper-glycaemic (high-blood sugar).

A third person had a mental health assessment, which highlighted they were prone to displaying behaviours that challenged the service. Their daily logs repeatedly recorded incidents of aggression to staff, and other untoward behaviours. However, there were no risk assessments or management strategies around this person's behaviour.

We also reviewed the pre-admission assessments and care records of people receiving care, which stated they were at risk of falls. The accidents and incidents records documented repeated falls for some individuals. However, there were no risk assessments or care plans to instruct staff on how to safely manage those risks.

We also found out that medicines were not managed safely. On the second day of inspection we observed two staff administering medicines, a senior care worker and an agency worker on his first shift at Kent House. The senior care worker prepared the medicines and passed this to the agency worker who then took the medicines to individual people. We identified that the agency staff was not given a MAR (medicines administration record) or a profile with a picture for respective individuals for reference. The senior care worker told us she had told the agency worker who the recipients of the medicines were. We were not confident that this method of administering medicines was safe as it presented a risk to people of receiving the wrong medicines.

People who were on anticoangulant medicines were at risk of receiving unsafe care or treatment because risks to their health and safety in relation to warfarin had not been assessed and action had not been taken to mitigate the risk. There is need for extreme care because of the effects of this medicine. For example, regular blood tests are required to make sure the levels of warfarin are always in a safe range and risk assessments to monitor any side effects such as haemorrhaging, bruising, nosebleeds and clots in legs and chest. We looked at the records of two people who were on anticoangulant medicines. Both individuals did not have risk assessments in place. We also confirmed from their medicines records and from speaking with staff that both individuals had missed doses in the last month. One person had also missed their anticoangulant medicines monitoring test. These shortfalls were discussed during this inspection. We recommended that both individuals were referred to their GPs immediately and for the new home manager to make sure there were risk assessments in place for all people who were on high risk medicines.

Another person was on a medicine for rheumatoid arthritis. We read the summary of the product characteristics (SPC). The SPC state how the medicine was to be used for a specific treatment. The SPC for this medicine stated, 'Patients should be aware of the importance of adhering to once weekly intakes. Daily or more frequent administration can result in severe toxicity'. However, there was no risk assessment to support staff's understanding of the need for extreme care with the dosing of this medicine. We also saw evidence that this medicine was not administered as prescribed. We identified that a dose had been missed in December 2017.

The provider did not always have protocols in place to guide staff when medicines prescribed as and when required (PRN), should be administered. For example, a MAR identified one person to be on paracetamol, to be administered as PRN for pain relief. However, there was no written protocol for paracetamol. There were no written guidelines to inform staff when the person might have needed the medicines and what signs to look out for to assess when and how much they needed. This lack of guidance may have led to the risk of the person receiving too much or too little pain relief.

The above is evidence that the provider was failing to provide safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Safe care and treatment

Staff were not always available to meet people's needs and keep them safe. We observed throughout the inspection that staff were rushed and were not able to spend any significant amount of time with people in the lounge areas, which meant people, were left unsupervised for long periods.

We received consistent feedback from relatives regarding staffing levels. One relative told us, "There seems to be a lack of experienced staff at weekends." Another relative said, "There are shortages of staff. There is generally no staff looking after people in the lounge. We brought this up in the last meeting and the [new home manager] promised to rectify." A third relative told us, "There is a high turnover of staff. There is quite a lot of new staff." A fourth relative told us, "Staff are good. Unfortunately they change too often."

There were a few occasions during this inspection that we identified that staff were not present in the lounge. Some people in the lounge were at risk of falls. One of the people in the lounge had a history of multiple falls in the home. This person had sustained various injuries during these falls, several of which had resulted in emergency admissions at a local hospital. Twice we observed this person attempting to walk and it was evident they were unsteady on their feet and therefore at risk of falling. On both instances we alerted the management as there were no staff around to assist.

Staff also expressed concerns about staffing levels. One staff told us, "You hardly have the required levels of

staffing during weekends." This was confirmed by a sample of rotas we looked at. The head of care had advised us there were four care workers and a senior care worker on duty each day, including weekends. However, this was not consistent with the information on the rotas. Although the levels described by the head of care were mostly maintained during the week, this was less so during the weekends. During weekends staffing varied between three and four. The head of care told us, "We know we have been short-staffed. At times staff cancel shifts in the last minute."

There were insufficient staff to support people's needs. A staff member told us, "Some people who previously required less support now need two staff to assist with personal care." We saw records of five people who now had higher needs since moving to the home, but this had not been taken into account in staffing decisions.

On the second day of the inspection we observed the new home manager had taken immediate action to address staffing concerns. She told us, "We feel there is need to increase staffing levels." She had increased staff to five and added an extra senior care worker per day.

We found the provider was not always able to provide enough staff to support people to stay safe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked with people's relatives about their views about people's safety at the home. One relative told us, "From the care point of view, we have never had any problems with staff." A second relative told us, "We are very happy with care." A fourth relative told us, "My relative is safer than he would be if he was at home." Staff explained to us how they would report any suspicion of abuse and the signs they would look for to indicate a person was being abused. They were also aware they could report to the Commission or local authority if management did not respond to concerns. There was a safeguarding policy and procedure together with contact details of the local authority.

Safer recruitment procedures were in place. Staff told us pre-employment checks were completed before they commenced working at the home. We confirmed this from the records we reviewed. Disclosure and Barring Service (DBS) checks had been completed prior to their employment. The DBS check helps employers to make safer recruitment decisions and reduce the risk of employing unsuitable staff. We also saw, at least two references were in place for all staff.

There were checks to make sure people lived in a safe environment and that equipment was safe to use. Water temperatures throughout the home had been regularly checked to make sure it was within safe limits. Fire systems had been checked. People had personal emergency evacuation plans in place which gave staff guidance about the support they would need to leave in case of an emergency.

The provider had an infection control policy. Staff explained how they used protective wear such as aprons and gloves to ensure people were protected from the risk of infection. Staff understood their responsibilities around minimising the risk of infection. Each person's room had a liquid soap dispenser and paper towels, which is recommended good practice for infection control.

Inadequate

Is the service effective?

Our findings

At the last inspection in May 2017 we rated the provider as 'good' under the key question of 'Is the service effective?' At this inspection we found that this had not been sustained. The management had not taken action to ensure effective support was continually provided.

People were not always supported to maintain their health and wellbeing. Whilst we saw that people were referred to health and social care professionals, including GP, speech and language therapists (SALT), and dietitians, this was not consistently followed through. We found out that when people were unwell assistance was not always sought in good time. For example, a body map of one person recorded a bruise and broken skin. However, there was no information relating to how the wound would be managed. The regional manager confirmed the expectation would have been for a district nurse or GP referral but this had not been carried out.

In another example, we identified that one person had been experiencing a symptom of bowel infection for 'some time'. A senior care worker told us she had taken advice from NHS 111 on 3 December 2017 who had recommended that the person stayed in their room and to have a diet of steamed vegetables. Further advice was given to contact the person's GP if the symptoms had not resolved in 48 hours. However, this information was not recorded in the person's care records and at this inspection no referral had been made to the person's GP.

There were other examples where the provider had not made referrals for appropriate care and treatment at the right time. One person had a wrist fracture for days before receiving medical input. The head of care advised us when the provider noticed the swelling they had called the GP, who prescribed medicines and to monitor for three days. During this time the swelling did not subside, but it was not until the fourth day that further medical input was sort. Another person had sustained a hip fracture but there was no medical input sought for days. Both incidents are subject to current safeguarding investigations.

One person's nutritional assessment identified them as having a MUST score of two (The Malnutrition Universal Screening Tool). The tool recommends once a score of two or more is reached the individual must be referred to the nutritional support team, dietician or implement local policy. However, at this inspection the provider had not taken action to support this person.

The failure to meet people's needs is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA) and found that improvements were required. The 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 people lack mental capacity to make particular decisions, any made on the person's behalf must be in their best interests and as least restrictive as possible.

Staff asked for people's permission before carrying out any care, however, people's care records did not always reflect how decisions had been reached in their best interests. For instance, in one file we noted that consent to care document had been signed by one person, even though their mental capacity assessment showed they did not have capacity to understand. In another file, we noted that consent to care documents were signed by a relative who only had the person's Lasting Power of Attorney (LPA) for property and financial affairs. In other records we found the provider had not carried out assessments of people's capacity to make certain decisions. The head of care told us that the assessments had been carried out but were misplaced by the last home manager. One more file contained a photocopied DNAR (Do Not Attempt Resuscitation). This showed the person had capacity. However there was no discussion recorded as having taken place with the person.

We also checked whether any conditions on authorisations to deprive people of their liberty were being met. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Most people at Kent House had dementia and were under continuous supervision and control and were not free to leave. However, only two people were subject to DoLS authorisation, which meant other people who may have lacked capacity to consent to these arrangements, may not have been deprived of their liberty in a safe and correct way. Following this inspection, the new manager informed us that she had submitted further applications to the local authority to deprive 19 people of their liberty in order to keep them safe.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We examined the systems in place to ensure staff were supported in their roles. We found staff had not consistently received supervision since June 2017. The new home manager explained the service had not managed to maintain regular supervisions since the departure of the last registered manager in June 2017. We saw evidence the new home manager had resumed staff supervisions and there was a supervision schedule in place. Staff who had been employed for over one year had completed a yearly performance appraisal of their work with the previous registered manager. However, the absence of a stable management team had ensured staff received consistent support. A staff member told us, "The [new manager] is good but the constant changes put pressure on us." Another staff said, "We have only had one staff meeting in the last six months."

New staff completed an induction using the Care Certificate framework before starting work. The Care Certificate is a method of inducting care staff in the fundamental skills and knowledge expected within a care environment. We looked at the training matrix and saw that generally staff had access to a range of essential training, mental capacity and DoLS, safeguarding, infection control, moving and handling, and health and safety.

Relatives were complimentary about the competence of staff. One relative told us, "Staff are reasonably efficient". Another relative said, "Staff are good but they are overworked." A third relative said, "I am very happy with staff."

We observed lunch time. There was a pleasant atmosphere. People were supported to sit where they preferred. Although staff looked busy, people received support that met their needs. Where assistance was required we saw this being provided.

People's dietary needs were met and their choices respected as far as possible. Relevant information about people's dietary needs was passed to the kitchen staff. In some examples, we saw that where there were concerns about nutritional intake advice had been sought from relevant health professionals such as SALT and dietitians who provided guidance.

Relatives were complimentary about the quality of food. Their comments included, "My relative thinks the food is really good"; "My [relative] likes the food"; "My relative likes his food. From what I see the food is appetising. There is no lack of food" and "The food is okay. My [relative] eats everything he is offered."

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in May 2017, we rated the provider as 'good' under the key question of 'Is the service caring?' At this inspection we found the provider required improvement.

Relatives told us that staff were caring. Their comments included, "We are happy with the care that our [relative] is receiving. We can see that some people are born to care"; "Staff are all very pleasant"; "I am pleased with the care that my [relative] gets"; "Staff are very good. They reassure us"; "We have a good relationship with staff"; and "Staff are friendly and very helpful."

Even though the feedback relating to the staff approach was positive, the concerns we found at this inspection did not demonstrate a caring approach. People had continued to be at risk related to medicines, falls, and other medical conditions. We also found leadership and management of the service was inadequate and placed people at risk of harm. Furthermore, the shortage of staff at the home meant that staff may not have had enough time to get to know people and offer them compassionate support. Staff were not aware of people's specific medical needs, which meant they may not have been sensitive to the needs of people.

The interactions between staff and people were warm and friendly. People were given sufficient time to eat their meal. We observed staff supporting people with personal care, and transferring them using hoists. In all instances, staff explained each step to people and offered comfort, whilst doing so. However, there were also some examples where staff had to leave people to attend to other duties. For example, we saw that at times people were left in the lounge on their own whilst staff attended to personal care of others.

People's relatives were involved in care. Relatives told us that they could visit the home at any time and were given sufficient time and space to catch up with their loved ones. One relative told us, "Staff always phone when there is a problem." Another relative told us, "Staff have kept us updated of any changes." A third relative told us, "I am always informed of any changes and my feedback is taken on board.

During the inspection we observed people's dignity and privacy being respected by staff. We saw staff knocking on people's doors before entering their rooms and referring to people by their preferred name. Personal care activities were carried out in private to respect people's dignity. Staff told us they would knock on people's doors before entering bedrooms and close the curtains if necessary, which we observed during the inspection. People told us they were able to stay in their rooms if they preferred privacy and we observed people were able to go to their rooms at any point during the day should they wish to.

We checked whether the provider complied with the Accessible information Standard. We found the provider was not following the standard. All organisations that provide NHS or adult social care must follow this standard by law. This standard sets out how organisations how they should make sure that people who used the service who have a disability, impairment or sensory loss can understand the information they are given. The new manager told us that they were going to develop the policy.

We looked to see if the provider supported people's cultural and religious needs. Staff told us they did support people to continue to practice their religious beliefs. Records showed that clergy from local churches visited the home regularly.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in May 2017, we rated the provider as 'good' under the key question of 'Is the service responsive?' At this inspection we found the service required improvement. We found that their care needs were not always fully assessed and planned for. At this inspection we found that the provider had not made improvements.

The care needs of people who had recently moved to the home were not always fully assessed and planned for. For example, there was a letter from a healthcare professional in a person's file, which highlighted behavioural strategies for managing their behaviours. However, this information was missed at the pre-assessment stage. The pre-assessment had not included information about their mental health. The daily logs of this person repeatedly recorded events of untoward behaviours. Despite this, the provider had not carried out a full assessment of this person and did not have a care plan setting out specific behavioural needs and how to address them.

In another example, a pre-assessment document of one person detailed a history of frequent falls. This person had complex medical issues which meant they were prone to increased frequency of falls. The falls records showed that this person had unwitnessed falls on 9 August 2017, 17 October 2017, 7 November 2017, 25 November 2017, 29 November 2017, 29 November 2017, 1 December 2017 and two falls on 3 December 2017. We identified that the risk assessment of this person was incorrectly completed as it had scored the falls risk for this person as 'medium' instead of high. This meant their care plan, was not appropriate or able to be used to meet their needs.

Care plans were not always updated as people's needs changed. The head of care told us that the mobility of one person had deteriorated such that they now required a wheelchair. However, their mobility care plan showed that they were able to mobilise using a walking aid. During this inspection we observed the person using a Zimmer frame. As this equipment was not stipulated in the mobility section of their care plan, we asked the head of care about this. The head of care advised us that the Zimmer frame belonged to a different person. This meant there was no sufficient information to enable staff to support the person safely and effectively.

We also saw that people's care needs were not regularly reviewed. Their care plans were out of date and did not sufficiently guide staff on their current care, treatment and support needs. The head of care told us that care plans were reviewed every six months. However, we saw care plans of people who had moved to the home in the last six months had not been reviewed. The regional manager confirmed a new care plan should be reviewed and signed off by management within 24/48 hours but this had not happened. The provider's computerised care monitoring system (CMS) documented no care plan review had taken place.

All this demonstrates the provider is failing to ensure that the care and treatment of people is appropriate and meets their needs. This is a breach of Regulation 9, Person-centred care, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Generally the service took into account people's needs in relation to maintaining interests and hobbies, and maintaining relationships. Some care plans included information on people's preferences, including the activities they liked to take part in. For example, one care plan showed one person enjoyed watching TV and reading a particular newspaper. We saw evidence staff provider this newspaper to this person each morning. An activity coordinator was employed in the home and we saw an activity schedule on display. During the inspection we saw people participating in games and puzzles.

There was a complaints policy and procedure on display. This described what people could do if they were unhappy with any aspect of their care and support. Staff told us they needed to take all complaints seriously and report them to the manager. Relatives were aware they could raise any issues with staff and felt confident these would be addressed. One relative told us, "If I ever say anything it is sorted." Another relative said, "If I see anything that is not right I complain and its put right." A third relative told us, "If we are concerned about our [relative's] welfare, he wouldn't be here."

Inadequate

Is the service well-led?

Our findings

At the last inspection in May 2017, we identified a breach in regulation regarding how the service was managed and the well-led domain was rated as 'requires improvement.' This was because the provider did not effectively assess, monitor and improve the quality and safety of the service provided. At this inspection we found improvements had not been made and we also identified further areas of concern.

The leadership and management of the service was inadequate and placed people at risk of harm. We found the home to be inconsistently managed. Kent House has had four managers since 2016. The last registered manager left the organisation in June 2017. She was replaced by a manager who commenced work in July 2017 and left the organisation in September 2017. This manager left without giving notice. The head of care told us the manager told staff that he was attending a meeting and did not return. He was then replaced by the current manager. However, when the current manager commenced employment there was no senior manager to give her a handover. The head of care and the regional manager who were overseeing the management of the home were both on annual leave.

The registered provider is required to have a registered manager as a condition of their registration. 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, we found there was no registered manager in post. However, there was a new manager who commenced employment on19 October 2017.

We asked relatives of people receiving care what they thought of the management of the home. The relatives we spoke with expressed concerns about the constant changes of managers. One relative told us, "Unfortunately management changes a lot." Another relative told us, "I have not seen any senior management since May 2016." A third relative told us, "Since [my relative] moved here, there has been three changes of managers. There is a general lack of continuity."

We found that since the previous registered manager's departure in June 2017, there has been a lack of management oversight. Whereas, in the last inspection of May 2017, improvements had been made to keep people safe, at this inspection we found that risks to people's health and safety had not been assessed and action had not been taken to mitigate the risks. We identified that people who had moved into the service since June 2017 did not have risk assessments or if they had, the risk assessments and care plans did not provide sufficient information to instruct staff on how to safely manage those risks.

Since June 2017 we saw there was also a lowering of standards in other areas of the general management of the home. For example, regular staff supervisions, staff meetings, and the carrying out of mental capacity assessments came to an end following the departure of the previous registered manager.

We also found the provider did not effectively assess, monitor and improve the quality and safety of the service provided. Although there was an internal audit system, this had not identified gaps that were picked

up during this inspection. Moreover, where gaps were identified action had not been taken to address the shortfalls.

We identified that 13 people were at risk of falls but that there were no risk assessments in their files in relation to this. One person had epilepsy but the provider did not have a care plan or risk assessment for epilepsy. Another person had diabetes but there was no risk assessment on the file in relation to this. The provider's audits had not identified these matters.

An audit that was carried out on 10 November 2017 had concluded that pre-admission assessments were completed to a good standard. However, at this inspection we identified evidence to the contrary. The medical sections of most assessments were blank. Therefore we were not assured that the audit process was effective because this audit had not identified these shortfalls.

Where the provider had identified shortfalls, we established action was not always taken to improve or mitigate the risks. For example, an audit that was carried out by the provider on 10 November 2017 identified that: no risk assessments for people had been reviewed since July 2017; a file of a new person had no care plans in place; one falls risk assessment had been completed but no care plan was in place to reduce risk; and, that people at risk of pressure ulcers did not have care plans in place. These shortfalls had been identified in previous audits by the provider. However, at this inspection, we identified that the provider had not taken action to address these shortfalls.

The provider did not maintain accurate, complete and contemporaneous records relating to care delivery. Where care plans were completed, we found these were not consistently and accurately completed and at times contained incorrect information about people. For example, an assessment stated that one person managed their own special needs such as stoma care and diabetic injections. However, we found out that this person did not have diabetes and stoma. People's daily care logs did not always record how people were supported.

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

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 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff employed by the service to ensure people's support needs could be met.