Mr Bidianund Jaunky and Mrs Vindoo Jaunky

Bracknell House Residential Care Home

Inspection report

26 Helena Road
Capel-Le-Ferne
Folkestone
Kent CT18 7LQ
Tel: 01303 254496
Website:

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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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We undertook an unannounced inspection of this service on 16 and 17 July 2015. Bracknell House is registered to provide accommodation and support for up to 22 older people. There were 13 people living at the service during our inspection. Accommodation is provided over two floors with communal lounge, dining/conservatory areas.

Our previous inspection on 17 and 22 December 2014 found breaches of 10 regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These now correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015.

We took enforcement action and required the provider to make improvements. We issued four warning notices in

Summary of findings

relation to care and welfare; management of medicines; records and quality assurance. We told the provider they needed to meet the terms of the warning notices by 30 January 2015.

At the previous inspection on 17 and 22 December 2014 we also found six further breaches of regulations. We asked the provider to take action in relation to safeguarding people from abuse, staff recruitment processes, staff training and induction, consent to care and treatment, nutrition and respecting and involving people. The provider gave us an action plan and told us the work needed to meet these requirements would be complete by the end of April 2015.

Mr & Mr Jaunky are the providers who work in the service and Mrs Jaunky is also the registered manager. We met with the provider on 23 January 2015 to make sure they understood their responsibilities and explained possible further action, should appropriate improvement not be made. The provider voluntarily agreed not to admit any more people to the service until they met the requirements of the regulations.

At this inspection we found that some improvements had been made, but the provider had not met all elements of each warning notice. Where the provider had sent us action plans telling us what they were doing to improve in other areas, all of the actions they told us they had completed were not completed. As a result, we found the service continued to breach regulations relating to fundamental standards of care.

People remained at risk of not receiving appropriate care and support because guidance about how people should be supported was not always in place where needed.

Risk assessments did not reflect people's changing needs and reviews of incidents and accidents did not result in action for staff to take to try to prevent people being at risk again.

People suffered repeated falls. Insufficient and ineffective action to address the cause meant people were not safeguarded from abuse and improper treatment. The service failed to recognise their lack of activity to respond to the concerns appropriately represented neglect of the people to whom they should have provided care and support.

Medication was not safely managed and shortfalls previously pointed out had not all been addressed.

People's safety was at risk because checks of fire detection and prevention equipment were not up to date. Equipment, enabling people to access some parts of the service, had not been maintained or certified as fit and safe to use.

Care plans were contradictory and not specific about the support people needed, including the number of staff required to safely support people.

Principles of previous enforcement action had not been adopted as best practice at the service where reasonable to do so; including ensuring personalised information was available to support different healthcare needs.

Mental capacity assessments did not always meet with the principles of the Mental Capacity Act 2005, as they are required to do so.

Training had not been delivered where identified as needed and administrative processes to support training, staff supervision and appraisal were inaccurate and incomplete.

Care plan records did not always reflect that people were involved or had agreed to decisions and changes made about the care and treatment they received.

Care plan reviews did not identify or address contradictory information or effectively cross reference people's support needs from one area to another.

People and visitors felt activities were infrequent and those which took place could be improved.

A complaints policy was in place, but it did not provide all of the information it was required to and some of the information provided was contradictory.

Leadership at the service had not ensured that all enforcement and requirement actions issued following our last inspection were met. The service lacked an effective quality assurance framework and management action plan for ongoing improvement and development.

People and visitors felt the quality of food had improved at the service and there was a better choice.

Staff felt supported in their roles and that the service and moral had improved. People and visitors told us that staff were supportive and caring.

Summary of findings

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 and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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.

As not enough improvement had been made within this timeframe so that there is still an overall rating of inadequate, we have taken action in line with our enforcement procedures, which has led to cancelling their registration.

Summary of findings

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

Risk assessments were not always in place when needed and, some of those in place, did not always record the measures required to keep people safe or respond to their changing needs.

The service failed to take sufficient or effective action to safeguard people from abuse and improper treatment caused by falls.

Medicines were not always suitably managed or recorded and risk assessments and instructions about when some people received medicine were not always in place.

Incidents and accidents were not suitably investigated to reduce the risk of them happening again.

Some equipment was not serviced when required. Records of some key safety checks were incomplete or had not taken place.

Is the service effective?

Inadequate

The service was not effective.

Processes were not in place to make sure each person received appropriate person centred care and treatment that was based on an assessment of their needs and preferences.

Training had been identified as required but not completed. Staff did not have the necessary knowledge and skills to support some people effectively.

People did not have mental capacity assessments in place that were decision specific or showed the steps taken to support them to make decisions themselves. This did not meet with the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always involved in planning their care.

Staff showed kindness and patience in their interactions with people and promoted their independence.

Staff demonstrated an understanding of the principles of privacy and dignity and practiced this in their everyday interactions with people.

People said their families were made welcome when they visited.

Summary of findings

Is the service responsive?

Inadequate

The service was not responsive.

Care plans contained contradictory information which presented a risk of inappropriate care.

Care plan reviews did not ensure they fully reflected people's needs or that errors and omissions were identified and corrected.

A complaints process was available, but did not contain all required information and some information was contradictory.

People were asked their views about the service delivered and some changes were made.

Is the service well-led?

Inadequate

The service was not well led.

Action had not been taken to fully address breaches of regulations identified during the last inspection.

Checks and audits had not identified shortfalls found during this inspection or enabled the provider to meet regulatory requirements.

The service lacked a management plan to ensure continuous improvement and development.

Statutory notifications required by CQC were not always submitted.

Bracknell House Residential Care Home

Detailed findings

Background to this inspection

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

We undertook an unannounced inspection of this service on 16 and 17 July 2015. The inspection was undertaken by three inspectors.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for and interacted with by staff. We looked in detail at care plans and examined records which related to the running of the service. We looked at six care plans and seven staff files as well as staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed such as audits, policies and risk assessments. We also pathway tracked some people living at the home. This is when we look at care documentation in depth and obtain people's views on their day to day lives at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked around most areas of the home including bedrooms, bathrooms, the lounge and dining room/ conservatory as well as the kitchen and laundry area. During our inspection we spoke with nine people who live at the home, four visitors, four care staff, the home's cook and the deputy and registered managers as well as the provider. Mr & Mr Jaunky are the providers who work in the service and Mrs Jaunky is also the registered manager.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority, relatives and healthcare professionals such as a social worker. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Inadequate

Is the service safe?

Our findings

At our last inspection on 17 and 22 December 2014 we identified breaches of Regulations 9 (care and welfare of people who use services), 10 (assessing and monitoring the quality of service provision), 11 (safeguarding vulnerable people who use services), 13 (management of medicines) & 21 (requirement relating to workers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These Regulations now correspond respectively to Regulations 9 (person-centred care), 17 (good governance), 13 (safeguarding service users from abuse and improper treatment), 12 (safe care and treatment) & 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued warning notices in January 2015 in respect of Regulations (2010) 9 (care and welfare of people who use services), 10 (assessing and monitoring the quality of the service provision) & 13 (management of medicines). This was because proper steps were not in place to ensure people were protected against the risks of receiving care or treatment that was inappropriate or unsafe; effective systems were not in place to assess the quality of the service provided; and people were not protected against the risks associated with the unsafe management of medicines. We also asked the provider to take action under Regulations (2010) 11(safeguarding vulnerable people who use services) & 21 (requirements relating to workers) to make improvements to their safeguarding guidance as well as staffing and recruitment procedures.

At this inspection, although people and visitors spoke positively; telling us they felt care was safe and we found some improvements had been made, the requirements of each warning notice had not been fully met. We found the provider had met the original requirement actions under Regulations (2010) 21 (requirements relating to workers).

People were at risk of unsafe care and treatment because guidance about how they should receive their care was not in place. For example, our last inspection identified one person's behaviour presented risks of self-harm and there was no guidance to show staff how to safely support the person with these behaviours. Guidance was required to be in place by 30 January 2015, this was not done until 16 July 2015 after being identified as still outstanding during the first day of this inspection. No action had been taken in the interim period to provide guidance about risks to ensure the person received consistent, appropriate and safe care. We found other instances where information in care plans and people's assessed needs were contradictory. These included the number of staff needed to safely support people with their personal care and mobility. This introduced confusion and a risk that people would not be safely and appropriately supported.

Risk assessments did not reflect people's changing needs or always record the measures required to keep people safe. For example, one person sustained 18 falls, 17 were unwitnessed. After six falls the person was referred to their GP and subsequently moved to a downstairs bedroom, so they would be more visible to staff. A physiotherapist visited three months later in June 2015 and gave advice. Throughout this period and despite further falls, the risk assessment was reviewed and annotated 'no change'. Advice received was not been followed through into risk assessments and practical measures, which had been discussed within the management team, such as the provision of a pressure mat, had not taken place. A pressure mat placed beside the bed or chair would have alerted staff when the person mobilising; this was the time they were most susceptible to falls.

Medicine management was not safe. Some people self-administered medicines, such as inhalers for asthma or sprays for angina, but it was of concern that risk assessments were either not in place or lacked required detail. For example, where some people used inhalers, there were no risk assessments to ensure they were able to do this safely. Where another person used two different inhalers, although risk assessments were in place, they did not make clear which inhaler was to be taken when. One inhaler was to be used in emergencies, discussion with staff found they were unable to tell us which of the two inhalers was for emergency use. This placed the person at risk if they were in a situation where they were reliant on staff to administer the inhaler. In addition, there were no records about how many inhalers were given to the person for their use, introducing uncertainty of stock control and potential risks of over or under use. There was no information about which eye one person's eye drops should be placed in and staff gave differing account of how they administered another person's medicines covertly. These shortfalls raised concerns about inconsistent administration of medicines.

Where people were prescribed gels and creams for their skin, there was, in some cases, no guidance for staff about

when, where or how these should be applied. This placed people at risk of inconsistent treatment and care. We saw medicine administration records (MAR) were not always completed by staff when topical products such as skin foams and cleansers were used. The MAR is a part of a person's care records, staff are required to sign the record at the time that the medicine is administered or code the MAR correspondingly if medicines are not given or are refused. Some prescriptions on MAR charts had been updated and overwritten by hand; the new entries were not always dated to know when they came into effect or double signed as an indication of a double check to make sure the new information was correct. Where medicines were given to people when needed (PRN), there was often no guidance in place to support this and records were incomplete. For example, in the case of variable amounts, the amount of medicine given was not always recorded. Recording of how much was administered would help to make sure that too much was not taken within suitable timeframes. There was also a lack of guidance, particularly for the application of topical medicines. Records of medicines to be returned to the pharmacist were not up to date. The normal method for disposing of medicines should be by returning them to the supplier. The supplier can then ensure that these medicines are disposed of safely, this also forms an audit trail for disposed of medicines; we found a bag of different medicines had not been entered into the returns register.

Some of the concerns about the management and administration of medicines identified during this inspection were also identified during the last inspection. For example, no risk assessments for the self administration of some medicines, no records of quantities of medicines handed over to people for self administration, no information about the application of eye drops, handwritten MAR chart entries not dated or signed and a lack of PRN guidance for medicines given when required.

The provider had failed to ensure risk assessments were in place where needed; that they were appropriately reviewed; reflective of people's changing needs and did all that was reasonably possible to mitigate risks. People were at risk associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding policies and procedures were in place, accessible to staff and had been updated as needed. Staff spoken with told us they understood about keeping people safe from harm and protecting them from abuse. However, one person had suffered repeated falls, 18 in total. The service failed to recognise their lack of effective activity to respond to these incidents appropriately represented neglect, a form of abuse. The failure of the service to take sufficient and effective action to address causes of falls meant people were not safeguarded from abuse and improper treatment.

The provider had failed to ensure care or treatment of service users was not provided in a way that significantly disregarded their needs and resulted in neglect. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to ensure that the premises and any equipment used are safe. We found weekly fire alarm and fire door guard checks were not recorded beyond 2 June 2015. The service did not undertake any checks of emergency lighting, but were instead solely reliant on twice yearly service contractor checks. The stair lift, which provided access for people accommodated on the first floor, required service and safety checks in March 2015. The provider was unaware this had not happened until pointed out during the inspection.

The provider had not ensured safety critical fire detection and prevention equipment was appropriately tested and equipment provided to enable people to access areas of the service was not checked when needed or certified as fit and safe to use. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were 13 people living at the service at the time of our inspection. Day shifts ran from 8am to 2pm and 2pm to 8pm, they consisted of four staff including the registered manager and deputy manager, the provider was also on site most of the time. Night cover, from 8pm to 8am, was provided by two wake night staff. People, staff and visitors told us they thought there were enough staff on duty to meets people's needs. However, we found care plans were not always specific about how many staff people needed to support them with certain tasks, such as getting up and going to bed, dressing, washing, bathing, support with continence and mobilising. Most care plans said people needed the support of one or two staff. The provider told us

Inadequate

Is the service safe?

staffing levels were determined according to the dependency levels of people, although no specific dependency tool was used. Since most people's dependency needs were not specific about the number of staff required to support them, we were uncertain about the provider's method to determine if there were enough staff to meet people's needs. This is an area we have identified as requiring improvement.

Adequate recruitment practices were in place. Required checks were completed before new staff started work to safeguard people. Proof of identity had been obtained and files contained evidence that disclosure and barring service (DBS) checks had been carried out. These checks help employers make safer recruitment decisions. Application forms had been completed; two references had been received in each case. However, we found some enquires about gaps in employment were addressed verbally and not recorded in writing. It was therefore difficult for the provider to substantiate that these checks had taken place. This is an area we have identified as requiring improvement.

Fire drills were held in January and April 2015 to ensure staff were familiar with actions to keep people safe in the event of an emergency. Staff were provided with information about what to do in an emergency. Each person had a personal emergency evacuation plan detailing the support they needed to evacuate the building safely. Staff were aware of fire assembly points.

Inadequate

Is the service effective?

Our findings

At our last inspection on 17 and 22 December 2014, we identified breaches of Regulations 9 (care and welfare of people who use services), 14 (meeting nutritional needs), 18 (consent to care and treatment) and 23 (supporting workers) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 9, 14, 11 & 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued a warning notice in January 2015 in respect of Regulation (2010) 9 (care and welfare of people who use services). This was because care plans did not show if appropriate action was taken to meet people's health care needs with conditions such as diabetes and epilepsy. We also asked the provider to take action under Regulations (2010) 14 (meeting nutritional needs), 18 (consent to care and treatment) & 23 (Supporting workers) to make sure people's health and nutritional needs were met and that staff were suitably trained and understood their responsibilities under the Mental Capacity Act 2005.

At this inspection we found the element of the warning notice referred to above had been met in relation to people specifically identified within the warning notice. However, the principle had not been applied to other people who had healthcare needs. Information and care requirements were not specific to individuals, making it difficult to know if their health care needs would be effectively managed. For example, there was no information provided to staff about how and when one person's catheter bag should be emptied, how the catheter tube should be positioned to prevent risk of skin damage or compression of the tube, which may prevent adequate drainage. We saw that the person needed prompting with hydration; there was no information for staff about the colour of urine in the catheter bag which may indicate dehydration. Catheters can also make people susceptible to urinary tract infections (UTI), leading to a greater risk of falls; there was no information about any UTI signs or symptoms for staff to be aware of. Where people required support to look after the site of stomas, there was no specific and individual guidance about how this should be done.

Processes were not in place to make sure each person received appropriate person centred care and treatment that was based on an assessment of their needs and preferences. A lack of individual health care information placed people at risk that their health care needs may not be effectively managed. Information available did not make use of potential signs of infection, which if known may allow for early interventions and treatment. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. We found, where needed, a DoLS application had been made to the local authority for a person. We saw approximately half of the staff, including the registered manager and deputy manager had received training about MCA and DoLS. However, we found mental capacity assessments did not meet with the principles of the MCA. This was because they did not set out the specific decision requiring assessment of people's mental capacity; record the steps taken to reach a decision; or any measures taken to help people form their own decisions.

Sample checks of mental capacity assessments did not show an embedded understanding or practices which met the principles of the MCA 2005. This is a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously the induction training staff undertook did not meet with the recognised induction standards training of Skills for Care. We looked at the induction training for a new member of care staff; it was divided into eight sections and provided basic information about the running of the home. The induction required the registered manager or deputy manager to check and sign the various modules when they were complete. We saw this last occurred on 23 April 2015. The staff member had dated and signed the induction as being complete on 18 June 2015; no further management checks after 23 April to validate this had taken place. There was no record that any knowledge tests had taken place at any stage to ensure the induction was understood and could be applied in practice. We saw despite their induction not being signed off as complete, the member of staff had supported people while unsupervised. The registered manager told us they had signed up all staff to

Is the service effective?

receive a recognised training standard provided by Skills for Care. However, we found staff were provided with access to Skills for Care training material but there was no evidence that these had been completed or even started.

Our last inspection found that specialist training to meet people's individual needs, such as diabetes and epilepsy had not been provided. Therefore we could not be confident that staff had the necessary skills and experience in order to meet people's needs. We found since the last inspection staff had still not been provided with either diabetes or epilepsy training. Safeguarding training had also been identified as required, but only four staff out of the 16 staff had undertaken this since the last inspection. The provider told us in their action plan that they had identified that staff also required training in challenging behaviour and dementia to meet people's needs. This training had not been delivered.

Staff had not received appropriate training to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager was an accredited food hygiene, moving and handling and health and safety trainer. Training had been delivered to most staff in these areas since our last inspection.

Staff told us they felt morale had improved among the staff team, they were supported by the registered and deputy managers and received regular supervision. Staff supervision was a one to one meeting with their manager. We looked at supervision records. Most staff had received one if not two supervision meetings since the last inspection. During their supervision staff had an opportunity to discuss their learning and development. There was conflicting information about the frequency of supervision. The registered manager told us the policy stated every six to eight weeks and a recent team meeting stated every three months. In addition there had also been two team meetings held where procedures and practices were discussed. Only three staff had received an appraisal although others at worked at the home for longer than 12 months. This is an area that requires improvement.

People's weights were recorded when they moved to the home and then monthly. Any significant weight gains or losses were reported to the registered manager and GP referrals made. We saw some people were referred to dieticians and speech and language therapists for advice about nutrition and eating difficulties. Each person had a nutritional assessment, showing any concerns about weight and any specific dietary needs. Where needed, some people received fortified meals and supplement drinks. The cook regularly discussed meals and food with people, so that they were aware of people's preferences.

People and visitors spoke positively about the improvements in the food, telling us, "I really enjoy the food," "There is a new cook who can cook" and "The food is much better, there is a very good choice and it tastes nice." People received a wide variety of homemade meals, fresh fruit and vegetables. Home baked cakes and desserts were also particular favourites. People were provided with menu choices and the cook catered for people's dietary needs. A menu planner showed lunch and supper time meals and choices of desserts and we heard staff reminding people what there was to eat. Where people benefited from the use of picture reference cards, we saw they were used and helped people decide what they wanted to eat. People told us breakfast was usually cereals or toast and snacks were available at any time. Mid-morning and mid-afternoon drinks were served with a choice of biscuits. The food served was well presented, looked appetising and was plentiful. People were encouraged to eat independently and supported to eat when needed. Staff asked people if they enjoyed their meal and if they wanted any more. Drinks were provided during meals in accordance with people's choices.

Requires improvement

Is the service caring?

Our findings

Our last inspection on 17 and 22 December 2014, identified breaches of Regulation 17 (respecting and involving people who use services) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to make sure people's privacy and dignity was respected. During this inspection we found that the provider had taken steps to improve the service and had met the previous shortfall. However, we identified other areas of concern which meant that the service was not always caring.

Although staff interactions were compassionate and well-intended; knowledge levels and a lack of awareness did not always enable staff to respond quickly enough and in a meaningful way to some people's needs. For example, where people had experienced a high level of falls, action taken had not effectively addressed falls prevention. Consequently, this impacted negatively on the level of care some people experienced.

Our last inspection made the service aware that guidance was required to support a person with behaviour that challenged, including their self injurious behaviour. This would have ensured staff provided consistent and safe care for the person, alleviating their distress. The required action was not taken. This did not demonstrate the ethics or behaviours of a caring service.

We identified other concerns about how involved people were enabled to be about the care and support they received. For example, care plans did not reflect that people were able to express their views and be actively involved in making and reviewing decisions about their care. Although reviews were up to date and had been completed when required, most people had not signed their care records to show that staff had discussed their planned care with them or that they had agreed to changes. Some people told us they did not know what their care plan was and were not aware if it had been discussed with them, but told us they were happy with the support they received. People felt happy they could discuss their care and support with staff if they felt they needed to. Some people told us they had done this, however, other people felt they had not had the opportunity or did not know that they could. The deputy manager explained new format care plans were being introduced and the practice of recording discussions and asking people to sign in agreement of their care was not yet embedded. This was evidenced by the care plans we viewed.

The provider had failed to carry out, collaboratively with the relevant person, an assessment of their needs and preferences for care and support of the service user. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were treated with dignity and respect. We saw practices previously in place, which did not promote people's dignity, no longer happened. People confirmed staff made sure doors were closed when they helped them with personal care and screens were positioned to afford privacy if people needed support in a communal area. People were positive in their comments about the care staff. People told us, "Staff are helpful and caring"; "They are all very nice, helpful people here. I have a good laugh with them all. People are friendly here"; "I think they look after me. They are very helpful here" and "They've been awfully good to me here. They have always looked after me".

We observed staff were kind, caring and patient in their approach with people and supported people in a calm manner. We observed people smiling and laughing during interactions with staff.

Staff knew people well and demonstrated a high regard for each person as an individual. Staff spoke with us about the people they cared for with genuine affection and were able to tell us about people's lives prior to living at the home; including what was important to people. During the inspection staff talked about and treated people in a respectful way. People were able to move around the service freely and chose where they preferred to spend their time.

Staff promoted people's independence, and allowed them to carry out tasks for themselves if they wished to do so. For example, one person helped to lay the tables for lunch and made drinks for other people. Where some people could manage some aspects of personal care, staff prompted them to do this for themselves, helping people to maintain elements of independence. One person told us, "I like being able to do things for myself. But if I do need help I will ask." Another person spoke about being able to go to bed when they wished and said, "I can get up at a reasonable

Requires improvement

Is the service caring?

time, which is not too early". This helped to demonstrate that staff listened to and respected people's wishes. People's religious needs were met; a local church group visited the service regularly.

Relatives told us that they felt welcome at the home at any time. They told us, "We are all very welcome"; "They make us feel welcome and offer drinks" and "We are all welcome, it's an open door here and we come at all times". Relatives described the care as positive and felt staff genuinely cared about the people they supported. A relative told us they thought their family member looked "Well turned out."

Inadequate

Is the service responsive?

Our findings

At our last inspection on 17 and 22 December 2014 we identified a breach of Regulation 9 (care and welfare of people who use services) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This Regulation now corresponds to Regulations 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued warning notices in January 2015 in respect of Regulations 9 (2010). This was because care plans were not always person centred, some information in them was inconsistent and care plan reviews were not always effective.

At this inspection, although most care plans contained more personal information about people, such as their preferred daily routines, what people could do for themselves and the support they needed from staff; information remained inconsistent and contradictory. Reviews of care plans were ineffective because they had not identified or rectified areas of inconsistency; therefore staff did not have accurate information to ensure that people's needs and preferences were clearly represented.

The service was in a transitional period between care plans and had not decided upon a finalised layout or content. Most people's files contained two different types of care plan, both of which were subject to regular reviews. There were various assessments including people's health, their dependency, mobility, risk of falls and fluid and nutrition needs. We found care plans contained contradictory information about people. For example, the continence assessment in one care plan explained that the person required skin care on alternating days; the second did not mention this skin care. Both care plans were updated on 7 July 2015 and the inconsistency was not noticed. Another care plan for a person with an ileostomy stoma stated that the person should avoid 'certain types of food', but no specific list was given. A second care plan listed the foods to be avoided. An ileostomy is where the small intestine is diverted through an opening in the abdomen. The opening is known as a stoma. A further care plan for another person stated that they needed 'regular' repositioning to safeguard against damage to their skin, but there was no clear guidance or definition of 'regular.'

Care plans did not cross reference mobility difficulties with washing and bathing, for example, if people needed to use a bath hoist or shower chair. Most care plans were non-specific about the amount of support people needed with different tasks, for example, saying people needed the support of one or two staff, but not differentiating when or why so this was done safely and consistently. Where people had specific medical conditions, some general guidance was available in care plans, but it was not personal or tailored to individual needs. For example, stoma site care assessments told staff that they needed to follow infection control procedures, but did not say what they were; similarly there were no step by step instructions about how stoma care should be delivered or reference to people's preference of care. Where a person experienced epilepsy, seizure records were not maintained. This would have helped to identify any changes in the frequency or type of seizures and provided information in anticipation of medicine reviews.

Reviews of care plans were not effective, they did not identify inconsistencies in care or ensure care and treatment reflected individual needs and preferences. The provider had not ensured that the care and treatment was person centred to meet with people's needs and reflect their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and visitors told us they did not have any complaints and did not wish to make any. They told us they knew the staff, the registered manager and provider by name and were confident that, if given cause to complain, it would be resolved quickly. The complaints procedure had been updated since the last inspection. A copy provided by the registered manager did not include the contact details of the local authority or the Local Government Ombudsman. Another displayed complaints procedure for people and visitors was similarly incomplete. In addition it contained contradictory information to the copy provided by the registered manager, advising people complaints would be responded to in different timescales.

The provider had not established an effective system for dealing with complaints. Information about who complaints could be made to was incomplete and details

Inadequate

Is the service responsive?

about when complaints would be responded to was contradictory. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In house activities were delivered by care staff and the provider in addition to their normal duties. The provider told us activities at the service included occasional outings, hand massage, nail care, quizzes, bingo, ball games and going into the garden. A local church also visited the home as well as a pat dog, brought along by a volunteer. People told us they enjoyed the activities provided, but felt they were limited. One person told us, "There's not much happening most of the time," another person told us "I can't see the television, it's too small." We asked another person if there were any activities at the service that appealed to them, they replied, "No, bugger all." On one day of our inspection, the advertised activity was 'nostalgia' but people weren't able to tell us what this entailed and didn't appear engaged in an activity. The provider explained that nostalgia was intended to prompt discussion and reminiscence, however, the session observed was not supported with objects or reference materials that may have made it more focused and engaging for people. While care plans noted people's interests, they did not explore alternatives. For example, a care plan noted a person could no longer read because of their deteriorated eyesight, however, no consideration was given to sourcing talking books or newspapers. A visitor told us they rarely saw any activities. This is an area we have identified as an area requiring improvement.

People, their relatives and visiting health care professionals had completed questionnaires to give their feedback about the service provided. Resident and relatives meetings also took place. Responses to questionnaires were positive, with people commenting favourably about the friendly atmosphere of the service and the kindness of staff. Where people had made requests or suggestions we saw these had been acted upon. Examples included rearranging personal care routines, provision of a shower, staff wearing name badges and people's general agreement about improvement in the food provided.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 17 and 22 December 2014 we identified breaches of Regulation 9 (care and welfare of people who use services), 10 (assessing and monitoring the quality of service provision) and 20 (records) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These Regulations now correspond to Regulations 9 (person-centred care) and 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We issued warning notices in January 2015 in respect of Regulations (2010) 9 (care and welfare of people who use services), 10 (assessing and monitoring the quality of service provision) & 20 (records). This was because staff were not adequately aware of emergency fire procedures and fire drills had not been completed since 2013. In addition, People were not protected against the risks of inappropriate or unsafe care and treatment through effective quality assurance, improvement planning and risk management systems. We also met with the provider to make sure they understood their responsibilities and explained possible further action, should appropriate improvement not be made.

At this inspection, the requirements of each warning notice had not been fully met. Systems were not effective in assessing, monitoring and mitigating the risks relating to people's health, safety and welfare. For example, tests of safety critical fire prevention and detection equipment had not been kept up to date. There was no system was in place to regularly test emergency lighting. The stair lift had not been serviced. This meant people were placed at risk of unsafe equipment through a lack of effective audit and checking processes. Other shortfalls highlighted during this inspection had not been identified within any quality monitoring processes. The quality assurance framework was ineffective because the provider failed to have effective systems and processes to ensure they were able, at all times, to meet requirements in other parts of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Leadership of the service was poor. The provider and registered manager did not show all the necessary skills and knowledge to provide a service and manage it effectively. They were not fully aware of their responsibilities as registered persons. They did not ensure that care was safe, that staff were trained effectively or that care was person centred. They did not have appropriate knowledge in relation to the requirements of safeguarding or the law on the Mental Capacity Act.

The provider and registered manager had failed to ensure effective management action took place to fully meet the requirements of each warning notice, issued following our last inspection. Where warning notices identified transferable best practices, for example risk assessments and care planning for specific health needs, management had failed to ensure these were embedded as best practice in all applicable areas. Accidents and incidents were recorded, but lacked management oversight to ensure that they formed part of the quality assurance systems to identify trends and mitigate risks. Learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews. Care documents were not accurate and continued to contain contradictory information, but this was not identified during audits. These shortfalls exposed people to unnecessary on going risk. The provider had not demonstrated that they had the necessary insight to recognise the shortfalls in the care they provided. Consequently they had failed to develop suitable systems to continually evaluate and seek to improve their governance and auditing practice.

Leadership and planning had failed to ensure that all requirement actions issued following our last inspection were fully met. Action plans submitted, by the provider's, particularly in relation to training, did not accurately represent the training delivered. The provider failed to effectively engage with stakeholder organisations such as Kent Community Health NHS Foundation Trust, training was offered but take up by the service was poor.

The service lacked management action and a plan to ensure continuous improvement and development and, although the home had developed a philosophy of care, the provider was unable to explain how this was adopted into working practices and driven forward.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and keep complete and accurate records of was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes when a home makes applications under Deprivation of Liberty Safeguards to local authorities where restrictions are needed to help keep people safe in the home. Registered managers must also notify us about the result of the applications. While a relevant application had been made and was pending decision, a statutory notification informing us about the application had not been made.

The registered person had not notified the Commission of events which they had a statutory obligation to do so. This is a breach of Regulation 18 (4)(A)(a) of the Care Quality Commission (Registration) Regulations 2009.

Staff told us that they attended regular staff meetings and felt the culture within the home was supportive and enabled them to feel able to raise issues and comment about the home or work practices. Staff felt their suggestions were listened to, for example, following suggestion; the service was considering introducing armchair exercises for people. Staff felt confident about raising any issues of concern about practices at the service, including using whistleblowing process if needed.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 The registered provider had not taken steps to ensure that care and treatment was provided in a safe way for service users including assessing risks to their health and safety, doing all that is reasonably practicable to mitigate any such risks and ensuring the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(c)(d)(e)(g)

The enforcement action we took:
The Care Quality Commission has closed this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure care or treatment of service users was not provided in a way that significantly disregarded their needs and resulted in neglect. Regulation 13(4)(d)(6)(d)

The enforcement action we took:
The Care Quality Commission has closed this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured that fire detection and prevention equipment was operationally safe equipment used at the service was not maintained. Regulation 15 (1)(e)

The enforcement action we took:
The Care Quality Commission has closed this service.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured appropriate person centred care and treatment based on assessment of their needs and preferences. Providers must ensure people have the opportunity to be involved in the assessment of their needs and preferences as much or as little as they want to be and give people relevant information and support when they need it to make sure they understand the choices available to them. Regulation 9(1)(a)(b)(c)(3)(a)(b)

The enforcement action we took:
The Care Quality Commission has closed this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users must only be provided with consent of the relevant person; the registered person must act in accordance with the Mental Capacity Act 2005. Regulation 11(1)(2)(3)

The enforcement action we took:
The Care Quality Commission has closed this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure persons employed in the provision of a regulated activity received appropriate training as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)

The enforcement action we took:
The Care Quality Commission has closed this service.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had not established an effective system for dealing with complaints. Regulation 16 (2)

The enforcement action we took:
The Care Quality Commission has closed this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Providers must operate effective systems or processes to ensure they are able to meet all requirements; assess, monitor and improve the quality and safety of services; mitigate against risks; maintain accurate and complete records; evaluate and improve their practice. Regulation 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:
The Care Quality Commission has closed this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission of requests to a supervisory body for standard authorisations under the Mental Capacity Act 2005. Regulation 18 (4A)(a)

The enforcement action we took:
The Care Quality Commission has closed this service.