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Alexandria's Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 23 May 2018, it was unannounced.

At the last inspection on 11 January 2018 we rated the service Requires Improvement overall. The service remained rated as Inadequate in well led, which meant the service remained in special measures. We found breaches of Regulations 12, 15, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of section 33 of the Health and Social Care Act 2008. The provider had failed to operate effective recruitment procedures.
The provider needed to make further improvements to ensure the premises and equipment were suitably maintained, appropriately located and clean. The provider had failed to ensure that medicines were suitably stored according to the manufacturer's instructions. The provider had failed to provide training and support for staff relating to people's needs. The provider had failed to operate effective quality monitoring systems. The service did not have a registered manager. The provider had failed to apply to register with CQC the manager they had employed.

We served the provider a warning notice for the breach of Regulation 12 and told the provider to meet this Regulation by 20 March 2018. We also served the provider a warning notice for the breach of Regulation 15 and told the provider to meet this by 03 April 2018. We served the provider a fixed penalty notice for having no registered manager in post. We imposed a condition of registration in relation to the breach of Regulation 17 and served the provider requirement actions relating to the breaches of Regulations 18 and 19. We also made recommendations. We recommended that the provider reviewed systems and processes to evidence that staffing levels met people's assessed needs. We recommended that the provider reviewed and amended practice at meals times to ensure that reasonable adjustments were made to meet people's nutritional needs and preferences taking into account people's communication preferences. We recommended that the provider reviewed practice to ensure that people received the care and support according to their wishes and preferences. We recommended that that provider sought guidance from a reputable source to review and amend policies, procedures and documentation to ensure people's equality diversity and human rights (EDHR) needs were met. We also recommended that the provider reviewed the complaints information to ensure that it was in an accessible format to meet the needs of people living in the service.

The provider did not submit an action plan within agreed timescales and was formally chased for this by letter. The provider submitted documentation to detail that they had met the warning notices. Following the last inspection, we met with one of the providers to discuss our concerns about the ongoing non-compliance with regulations and to ask the provider to complete an action plan to show what they would do and by when to meet the regulations under each of the five. An action plan was received eventually on 25 April 2018.

Alexandria's Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the

premises and the care provided, and both were looked at during this inspection. The service was not registered to provide nursing care. Any nursing care was provided by community nurses.

At the time of our inspection 10 people lived at the service. There was a through floor lift fitted in the home to enable people to use the first floor. There were a small number of bedrooms on the second floor which were accessible using a stair lift, these rooms were not in use. The service accommodated up to 18 older people. Some people lived with dementia.

The service did not have a 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. The provider was in breach of their registration by not having a registered manager in post.

Medicines had not been managed effectively. Medicines records were not complete; stock had not always been counted and recorded appropriately. Medicines were securely stored. Some storage areas had not been temperature checked the ensure that medicines were being stored at safe temperatures. We reported this to the local authority.

There were enough staff deployed on shift to meet people's care and support needs. The provider had reduced staffing levels. One staff member had been removed from the morning shift and one staff member had been removed from the afternoon shift. The housekeeper's hours had also been cut back. The provider had not carried out an assessment of people's care and support needs when reviewing staffing levels.

The provider did not follow safe recruitment practices. Essential documentation was not available for all staff employed. Gaps in employment history had not been explored to check staff suitability for their role.

Risks to people's safety and wellbeing were not always managed effectively to make sure they were protected from harm. Risk assessments had not always been reviewed and updated when people's health needs changed. The provider had failed to take action when accidents and incidents had occurred. Lessons had not been learnt from accidents and incidents to prevent further concerns and to strive for improvement.

Staff had a good understanding of what their roles and responsibilities were in preventing abuse.

Several areas of the home smelt of stale urine. The home was dirty and required redecoration and maintenance. Fire drills had not taken place within six months as detailed in the provider's policy. The emergency evacuation chair was not easy to get to as the medicines trolley was fixed the wall in front of it.

Decoration of the home did not follow good practice guidelines for supporting people who lived with dementia.

Staff had not received all the training, support and supervision they needed to meet people's assessed needs. The provider had not followed good practice guidance to ensure that new staff received a comprehensive induction.

People's healthcare needs had been met in a timely manner. People who were at risk from developing pressure areas had been referred to community nurses and were supported to reposition regularly. Barrier creams and sprays had consistently been used to protect people's skin.

The provider did not have good systems in place to monitor the quality and safety of the service provided. The provider had no evidence to show they had undertaken quality audits. Accurate records were not kept to ensure good communication and the safety of people being supported.

The provider did not offer staff the support and help they required. Staff meetings had not been held.

The provider had failed to notify CQC of important events such as deaths and safeguarding allegations.

People were treated with dignity and respect by the staff. Staff respected people's privacy. Staff were kind and caring towards people and offered plenty of reassurance. However, the provider had failed to treat people in a kind and caring manner and had failed to treat people with dignity and respect.

People were not provided with sufficient, meaningful activities to promote their wellbeing.

People's care plans detailed their care and support needs. Staff knew people well and provided personalised care. Some people had not had baths or showers for some time.

People had not had opportunities to voice their views and opinions about the service through surveys and through meetings.

The provider's complaints procedure did not give people all the information about who they could raise concerns with. There was no accessible and easy to understand complaints information in place. The provider had not followed their complaints policy.

People had choices of food at each meal time. People were offered more food if they wanted it. Food choice was restricted to chicken or pork/gammon. Food stocks were low and staff were purchasing food to ensure people had choices.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Staff had a good understanding of the MCA 2005 to enable them to protect people's rights.

The provider did not have an understanding of when people's Deprivation of Liberty Safeguards (DoLS) authorisations had expired, no action had been taken to reapply to legally deprive people of their liberty.

Staff working in the kitchen were unable to follow 'Safer Food Better Business' guidance provided by the Food Standards Agency. We reported this to the Food Standards Agency.

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

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a number of breaches 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 this report.

The overall rating for this service is 'Inadequate' and therefore the service remains in 'Special measures'. This is the third consecutive time the service has been 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. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures 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.

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.

There were enough staff to meet people's needs. The provider had made changes to the staffing rota without knowing and understanding people's care and support needs. The provider had not always followed safe recruitment practices.

Risks to people's safety had been assessed. However, one person's risk assessment had not been updated following a fall. The provider had not taken action in relation to accidents and incidents and as a result had not learned lessons from accidents and incidents to prevent them from happening again.

Medicines practice had declined since we last inspected the service. Medicines were not always managed safely.

The service was in a poor state of repair. Repairs had not been fixed in a timely manner. Most equipment had been maintained. However, the call bell system had not been, we found it to be faulty. There were a number of areas in the service which smelt of urine, some carpets were dirty and sticky.

Staff understood the various types of abuse to look out for to ensure people were protected.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received the training and support they needed to meet people's needs. Staff had not received a comprehensive induction to ensure they had the skills and knowledge to carry out their roles.

Deprivation of Liberty Safeguards (DoLS) applications had not been made to the local authority by the provider. People confirmed they made their own decisions.

Food safety within the service was poor. Fridges and freezers were not checked to ensure they were working effectively. Meat had not been checked to ensure it was cooked correctly.

Alexandria's Residential Care Home was not decorated effectively to support people living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The staff treated people with dignity and respected and were kind and caring to people. Staff offered reassurance and support to people who were distressed and anxious.

The provider had not treated people with dignity and respect. The provider had not communicated effectively with people about closing the service and had not treated people in a kind and caring manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not have access to activities to meet their needs.

People were provided with personalised care. Some people had not been supported to bath or shower for some time.

People had not been given opportunities to feedback about the service they received.

Information was on display about how to complain, however this did not give people all the information they needed to raise a complaint with external organisations and was not in an accessible format. The provider had failed to follow their complaints policy when handling complaints.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor the quality of the service were not in place.

Records relating to people's care and the management of the service were not well organised or complete.

The provider had not reported incidents to CQC.

Alexandria's 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.

Since the last inspection the local authority had informed us they had placed an embargo on the provider which meant that the local authority would not be placing any new people at the service. The provider had written to people and their relatives on 14 May 2018 to tell them they planned to close the service. The provider had detailed in the letter to people and their relatives that they could not guarantee people's safety. We brought forward our planned comprehensive inspection to check that people were receiving safe care. The local authority had sent in a team of care managers and health and social care professionals to reassess people's care and support needs. The local authority commissioners had met with people and their relatives on 22 May 2018 to explain processes for helping them find new care services to meet their needs because the provider was closing the service.

This inspection took place on 23 May 2018 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, we reviewed the information we held about the service including previous inspection reports. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information of concern that we had received.

We spent time speaking with four people who lived at Alexandria's Residential Care Home. We observed care and support in communal areas.

We contacted health and social care professionals including the local authority commissioners and safeguarding coordinators and Healthwatch to obtain feedback about their experience of the service. There is a local Healthwatch in every area of England. They are independent organisations who listen to people's views and share them with those with the power to make local services better.

We spoke with eight staff; including a housekeeper, cook, care staff, senior care staff and one of the provider's.

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

We asked the provider to send us additional information after the inspection. We asked for confirmation that the staffing rota had been covered, confirmation that servicing and repairs had been completed, one staff members file and the answers to queries we had raised before the inspection about a person's death. We did not receive all the information in a timely manner.

Inadequate

Is the service safe?

Our findings

At the last inspection on 11 January 2018 we found breaches of Regulations 12, 15 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to operate effective recruitment procedures. The provider needed to make further improvements to ensure the premises and equipment were suitably maintained, appropriately located and clean. The provider had failed to ensure that medicines were suitably stored according to the manufacturer's instructions. We also recommended that the provider reviewed systems and processes to evidence that staffing levels met people's assessed needs.

At this inspection, we found that the provider had still not carried out sufficient checks on all staff to ensure they were suitable to work around people who needed safeguarding from harm. We checked the files of three employees, one of whom had been employed since the last inspection. One staff member's file contained all the relevant information and evidence that all checks had been carried out. One staff member's employment records had an unexplained gap of employment from 1985 to 2003 which the provider had not explored. The interview record dated 15 March 2017 evidenced that the gap in employment had not been discussed and explored. This staff member also only had one written reference. The provider had not followed their own policy of ensuring that two written references were obtained and that a full employment history was obtained. The third staff member's file was missing. Records showed that two staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Photographs were in place for one of the three staff members.

The provider had failed to operate effective recruitment procedures. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance records evidenced that repairs and tasks were not always completed quickly. Areas of the home that had been damaged had not been repaired in a timely manner. The fireplace in the dining room had cracked and missing tiles at ankle height. This was present at the last inspection in January 2018. The provider had told us at the time they would fix this immediately. Electrical sockets in a ground floor room were smashed and broken. The call alarm system throughout the home was not working correctly. Several bedrooms we checked had broken leads which meant that when we tested the call system the call bell was not activated. One bedroom's call bell consistently sounded at intervals during the day, when nobody had pressed the alarm and one call bell to a ground floor toilet was not working at all. The provider was not able to produce records to evidenced that the call bell system had been serviced and maintained. We checked directly with the contractor that the provider told us about and there was no maintenance contract for the call bell system. We found a door which detailed that it should be kept locked shut. The door could not be locked as the lock with visibly broken. This broken lock was not listed in the maintenance records.

Checks had been completed by qualified professionals in relation to legionella testing in December 2017, moving and handling equipment in December 2017 and follow up work had been completed 24 January

2018, electrical appliances July 2017 and electrical supply July 2014, gas appliances August 2017. The stair lift had been serviced in August 2017 and had not been serviced since so it could no longer be used. The provider confirmed that no one used this lift as people had been moved to bedrooms located on the lower floors. The passenger lift had been serviced on 03 April 2018 and fire systems, emergency lights and equipment had been checked to see if they were working as they should be. The service records for the cooker within the main kitchen showed that new gas interlock fittings were required. The provider confirmed that this work had not been completed. We checked the cooker following reports that the oven was broken. We found that the oven door was broken and did not close, this meant that food took longer to cook, food was cooked at the wrong temperature and that staff using the kitchen were at risk of harm. An asbestos survey on the property in 2015 highlighted low levels of asbestos outside of the service under the roof. The survey detailed it should be checked annually for signs of deterioration. There were no records to evidence that this had happened. The provider told us that this had not been redone and they would have to contact a contractor who had a long enough ladder as the asbestos was contained within the soffits and facias of the building.

The provider employed a housekeeper to carry out cleaning of people's bedrooms and communal areas. We observed the housekeeper maintaining the cleanliness of these areas to the best of their ability. The provider had cut the housekeepers hours to reduce costs, which meant they were not able to clean all areas of the home. The carpet shampooer had been removed from the building which meant that carpets had not been cleaned. They had become soiled with food, drink and bodily fluids. Some areas of the service smelt of stale urine. Some carpets in some bedrooms were sticky as was the carpet in the hallway upstairs. We spoke to the provider about this and they told us they had removed the carpet shampooer and put it in the shed. Staff had access to personal protective equipment (PPE) such as gloves and aprons to carry out their roles safely and minimising the risk of cross infection. There were adequate stocks of PPE in place. We checked this as whistle blowers had alerted us to concerns that the provider had not paid bills including the supplier of the PPE and they were now refusing to deliver further stocks.

The service had not undergone any further redecoration since the last inspection, despite the provider telling us at the last inspection that it was being done. The service remained looking tired and scruffy.

A fire drill had not been conducted since 03 October 2017, despite the provider's fire policy and risk assessments stating that it would be done at least every six months. We spoke with the provider about this and they confirmed they knew it was overdue. They advised us that they were seeking help from a management consultant within the next fortnight and that the drill would be conducted by them.

The medicines trolley had been fastened to a wall which blocked access to the evacuation chair which should be used in an emergency to evacuate people from the first floor to the ground floor. This blocked the evacuation chair from clear sight and could delay staff accessing the equipment in an emergency.

The provider had not fully met the warning notice that had been served in relation to the premises and equipment. The premises and equipment had not been suitably maintained and cleaned. This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we reported that temperatures of medicines storage areas were not effectively monitored. At this inspection we found that medicines storage had been amended. The medicines trolley had been moved to another area of the home. Additional stocks of medicines had been moved to another area of the home. However, we found additional medicines located in the same area downstairs as the last inspection. Medicines temperatures had not been consistently monitored and recorded. The temperature

records showed that the temperatures had not been checked between 05 May 2018 and 14 May 2018. The temperatures on the days where staff had monitored the temperature showed that these were in the correct range. There was no temperature record for the cupboard downstairs which we had found medicines in. Storing medicines outside of the manufacturers recommended range for a long period of time will affect the efficacy of that medicine and might mean they were not effective.

Medicines practice had declined since we last inspected the service. Medicines were not always managed safely. Seven staff had been trained to ensure people received their prescribed medicines. However, their medicines training had expired and they had not received update training. People's records contained up to date information about their medical history and how, when and why they needed the medicines prescribed to them. Most people were in receipt of as and when required (PRN) medicines. There were no PRN protocols in place to detail how each person communicated that they needed their PRN medicine, why they needed the medicine and what the maximum dosages were.

Medicines had not been checked and signed in correctly. Some medicines administration records (MAR) evidenced that the stock at the end of the previous month had been counted and carried forward, some MAR charts showed the amount of medicines received in the new delivery. However, there was inconsistent practice. Some people's MAR charts showed that no stock had been carried forward and no stock had been counted in. For example, one person had a prescribed nutritional supplement, Proshield skin protection as well as Movicol sachets, which had not been signed in, all of which we found in stock. Another person had Proshield foam and spray as well as Movicol sachets which had not been signed in. One person had been prescribed Adcal D3 tablets, one tablet twice a day. Their MAR showed that staff had not given these at 08:00 and 17:00 on 21 and 22 May 2018 and at 08:00 on 23 May 2018. A staff member told us they had not been given because they were not in stock. The MAR for 17:00 on 23 May 2018 had been signed to show they had been given. The staff member explained that the person had some medicines delivered during the day. We checked the new delivery and found that 56 Adcal D3 tablets had been delivered, however none were missing from the box. We asked staff how they administered the person's medicines. We tried to investigate this further to check if another person's Adcal D3 tablets had been used for this person. We found that we were unable to verify if this had happened because medicines records were poor. The other person taking this medicine should have had 86 Adcal D3 tablets in stock at the start of the medicines cycle according to the medicines records. Records showed they had been administered six Adcal D3 tablets since then which should have left 80 tablets. However, there were only 76 in stock. The staff member then showed us further medicines stock which had not been recorded anywhere showing that 112 Adcal D3 tablets had been received, these did not have a prescription label on and someone had hand written the person's name on the box. The staff member said that the person had returned from hospital with the medicines.

We found one person's Laxido medicine in stock which should have been taken with the person when they moved out of the service 12 days before we inspected. We reported this to the provider and advised them to deliver the medicine to the person at their new service.

We reported our concerns about medicines practice to the provider and to the local authority. The local authority told us they were arranging for an external pharmacist working for the clinical commissioning group to visit the service to provide medicines advice and look at the issues we had found.

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

Medicines were given at the appropriate times and people were fully aware of what they were taking and why they were taking their medicines. Photographs were in place on all MAR charts to assist staff to identify

people when giving medicines. Body maps were in place to detail where prescribed creams should be applied on the body.

People had been served notice by the provider to move out of the service and were worried and anxious. Staff provided reassurance and support to help people feel safe and secure. They explained what was going to happen and listened to their concerns. We observed staff promoting people's independence as well as reminding them about their safety.

There were suitable numbers of staff on shift to meet people's needs because the number of people living in the service had fallen and one person had recently moved out. On the day of the inspection the deputy manager had gone off sick, which meant there was no management team at the service. The provider had contacted staff to arrange staff cover to ensure that two staff were on shift. The provider was not contactable by telephone to offer staff guidance and support. We telephoned the provider on their mobile phone from the service's telephone. The provider switched their off their phone and made no contact with the service to check why they were calling. Later in the day we managed to contact the provider through an off-shift member of staff. The provider arrived at the service at lunchtime. The staffing rotas showed that there had been a reduction in staffing to two care staff per shift during the day and night. The provider had reduced the staffing levels down and dismissed the activity member of staff because of financial difficulty and not through an assessment of people's needs.

The provider's accident and incident policy stated that all accidents and incidents would be reviewed by the registered manager. The service did not have a registered manager so the provider should have taken responsibility to do this. Accidents and incidents had not always been recorded. The staff communication book evidenced that one person had fallen on 15 May 2018. There was no accident or incident report relating to this. Staff had recorded the accident in the person's daily records. The provider told us they were unaware that this had taken place. We found a number of other accidents and incidents that had not been reviewed by the provider. One of which related to a needlestick injury to a staff member who had been pricked by a needle whilst supporting a person to check their blood sugar levels. The provider told us they were not aware of this incident and whether the staff member received appropriate first aid. The provider confirmed that staff had not received training in relation to testing people's blood sugar levels, we advised that this practice should stop immediately and trained community nursing staff should carry out the tests if they are required. Suitable systems and procedures were not in place to enable the provider to learn lessons from incidents and accidents to ensure that these did not happen again.

Each person's care plan contained information about their support needs and the associated risks to their safety. This included the risk of a person falling, behaviour that others may find challenging, medicines administration, nutritional risks, developing pressure areas and of deterioration in their health or medical condition. Guidance was in place about any action staff needed to take to make sure people were protected from harm. For people who were at risk of falling, guidance was in place about any specialist moving and handling equipment they required when moving around the service, transferring and when moving in bed. The local authority employed occupational therapist visited the service whilst we were inspecting and reviewed everyone's moving and handling risk assessments. They found that people were generally protected and were safe. However, they assessed one person as needing a larger size sling for hoisting them in an emergency situation. The person was known to occasionally put themselves on the floor and the safest way for staff to help them up was through using a hoist and sling. They informed the provider of the requirement to meet the person's assessed needs under the Manual Handling Operation Regulations (1992) and Provision and Use of Work Equipment Regulations (1998). They supported the provider to source a suitable sling and helped them to make a telephone call to purchase the equipment. However, the provider declined to make the payment over the telephone and has not purchased the equipment to meet the

person's needs.

One person's care plan and risk assessments showed they were at risk of falling. The person had fallen on 15 May 2018. The care plan and risk assessment had not been updated or reviewed since 10 April 2018 to evidence that the person had a recent fall and what additional action staff should take.

The failure to manage risks appropriately was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All other risk assessments had been regularly reviewed to ensure actions to minimise risks were still effective and appropriate. People 's care files had been reviewed and updated in April 2018 by the previous manager of the service. Staff told us that one person was at increased risk of developing pressures areas on their skin because they chose to spend all their time in bed. Risk assessments detailed that the person should be repositioned two hourly. Records evidenced that staff had consistently done this. We also observed that the person could reposition themselves from a laying position to sitting up to enable them to eat and drink.

Seven out of 13 staff had received training in fire safety. Each person had a personal emergency evacuation plan (PEEP). PEEPs set out the specific requirements that each person had, such as staff support or specialist equipment, to ensure they could be evacuated safely in the event of a fire. The PEEP in each person's care records was clear and detailed. Visual checks and servicing was regularly undertaken of fire-fighting equipment to ensure it was fit for purpose. The fire exits were clear of debris. Weekly fire alarm testing had also taken place, the last one had been recorded on 21 May 2018.

Staff understood the various types of abuse to look out for to make sure people were protected from harm. They knew who to report any concerns to and had access to the whistleblowing policy. Staff all told us they were confident that any concerns would be dealt with appropriately. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 11 January 2018 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to provide training and support for staff relating to people's needs. We recommended that the provider reviewed and amended practice at meals times to ensure that reasonable adjustments were made to meet people's nutritional needs and preferences taking into account people's communication preferences.

At this inspection the provider and staff confirmed that staff had not been provided with any training in 2018. Staff training records evidenced that experienced staff were overdue a number of training courses including; first aid, safeguarding people from abuse, fire safety, medicines safety, and infection control. Six staff had received moving and handling training in 2017 which was due to expire in July 2018. One staff member told us they had not had any moving and handling training since being employed at the service but they had knowledge of safe moving and handling through their previous roles in other services. The provider's training records did not list all staff, four staff were missing. No staff had completed epilepsy, Parkinson's disease or stroke training despite providing care for people who live with these conditions. Only three staff had completed training in relation to food safety. We observed staff cooking meals for people in the kitchen that had not undertaken the food safety training. The provider told us some staff had completed training in relation to monitoring people's blood glucose levels. There were no records to evidence this. The provider said that staff had not done this training for some time. We advised the provider that staff should cease to test people's blood glucose levels and request a trained community nurse to do this. The provider confirmed this would immediately stop.

Staff were not provided with support and supervision, there was a lack of management structure to provide this support which meant staff had contacted CQC and the local authority for advice, support and help when they were unable to get support from the provider. This included seeking advice on discharge procedures when a person was moving from the service. The provider told us that they had not provided any supervision sessions to staff but they planned to do this.

New staff had not been provided with a suitable induction. They had not received training, information and support to carry out their roles.

The failure to provide training and support to staff to enable them to meet people's needs was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

(DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any DoLS authorisations were in place.

People's consent and ability to make specific decisions had been assessed and recorded in their records. Where people lacked capacity, their relatives or representatives and relevant healthcare professionals were involved to make sure decisions were made in their best interests. Training records showed that four out of 13 staff had received training in MCA 2005 and DoLS. We observed staff clearly providing people with choices and respecting their decisions. The provider did not have an understanding of when people's DoLS expired and what action had been taken to reapply to legally deprive people of their liberty. The provider referred us to a member of staff. The staff member confirmed they knew the DoLS had expired and said they had reminded the manager about this before they left, however the applications had not been made. One person had a DoLS authorisation that was in date, it was due to expire on 29 May 2018. Two people's DoLS had already expired. We observed one person walking around the service and frequently trying to open the front door which indicated they were trying to leave the service. There was no record of a DoLS application having been made for this person.

We recommend that the provider seeks guidance from a reputable source to ensure they are adhering to the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Kitchen staff were unable to follow 'Safer Food Better Business' guidance provided by the Food Standards Agency. Fridges and freezers had not been monitored to ensure they were working correctly. Staff told us they were unable to do this as the thermometers were no longer in place. Although a meat probe thermometer was in place, meat cooked by the service had not been checked to see if was cooked thoroughly since 14 April 2018. This was an increased concern because the oven was broken. We reported this to the Food Standards Agency. Kitchen staff had not been supplied with personal protective equipment (PPE) specific for their roles in the kitchen such as gloves, aprons and a hat.

Failure to follow food safety regulations puts people at risk of harm from food poisoning. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At meal times staff provided encouragement and support to people. Staff gave people praise when they had eaten their food. Each person was served their meals in a bowl, staff explained that people tended to find it easier eating from a bowl because they tended to move their food to the side. Staff offered people aprons to cover themselves up at meal times and respected their decisions. However, one staff member did not ask a person and just placed one over the person's head, this caused the person to immediately take it off. The other staff member working helped the person to remove it.

We checked food stocks within the service because staff (including staff that had left) told us that food stocks were low and they were buying items out of their own money to ensure that people had food to eat. Staff confirmed that they continued to buy items to ensure people had variety. One staff member had bought the ingredients to make cakes. Milk stocks within the service were very low. At 10:00 there were six pints of milk in the fridges and four litres of UHT milk in the stock room. Staff informed us that the milk bill had not been paid and so the milk supplier had stopped delivering. Staff told us they would have to purchase milk to bring to the service for the following day. The provider confirmed the milk bill had not been paid. Staff informed us that the daily menu consisted of mainly chicken or pork and gammon. Beef and Lamb had not been purchased by the provider for some time.

People were given a choice of meals at lunchtime. The menu board in the hall way had been written up to show that the meal choices were Gammon, mashed potatoes and green beans or cheese omelette. Fresh

fruit salad and cakes were also listed on the board. The meal choices were not available in an accessible manner to help people make an informed choice. The menus were printed in text only. Photographs were not available to help people identify what was on offer and what they liked the look of. We observed staff checking with people what they would like to have for their tea, each person was offered different sandwich choices. We observed staff encouraging people to drink a variety of drinks. The kitchen contained information about people's likes and dislikes, specialist diets and preferences. The cook explained that one person was diabetic. The person was offered small portions of dessert and plain biscuits. No sugar was added to their drinks. The cook shared how they fortified one person's meals because they were at risk of malnutrition. The person had additional calories added to their food, such as milk powder.

People were able to choose to eat their lunch in the dining room, the lounge or their bedroom. Nobody was rushed, people sat and ate at their own pace.

People referred to the service had their needs assessed prior to coming to live there. These assessments had not always been carried out by staff that were experienced and trained to do so. Since the last inspection a concern was raised by healthcare professionals who had been called to the service. The concern was that the service had taken on a person that required specialist help and support due to the behaviours they displayed towards others. The person was moved out of the service and this was treated as a failed placement. The 10 people living at the service had all lived at the service prior to the last inspection in January 2018.

When we last inspected the service one person was visibly distressed and anxious about every aspect of their life. At this inspection we found that the person had moved bedrooms and was now in a shared bedroom, they were calm, relaxed and happy. They were smiling, chatting and joking with the person they shared with, staff and the inspectors.

People received medical assistance from healthcare professionals when they needed it. Staff knew people well and recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff had sought medical advice from the GP when required. One person had become unwell on the 22 May 2018 overnight. Staff contacted the person's GP and arranged for them to visit the person. The GP visited during the inspection and prescribed the person antibiotics for a chest infection. The person had chosen to stay in bed during the day. Staff carried out frequent monitoring and checks to ensure they were okay as well as offering pain relief. Another person was visited by the community phlebotomist to collect a blood sample. Staff sat with the person and reassured them, they person was calm and relaxed and hummed which the staff also did, this enabled the blood sample to be taken and the person was not distressed or anxious. After the bloods had been taken the staff gave the person praise, the person smiled.

Records demonstrated that staff had contacted the GP, mental health team, district nurse, ambulance service, hospital and relatives when necessary. People had seen a chiropodist on a regular basis. Where people had lost weight, this had been addressed with support, food supplements and referrals to GP's and dieticians as required. People's weight records had been regularly maintained to enable staff to monitor people effectively. Staff had not always followed the advice of health care professionals. One person's care records evidenced that the GP had telephoned on 11 May 2018 to advise that staff no longer needed to take the person blood glucose levels and stated that the district nurse will do this. Staff detailed they had spoken to the community nursing team and decided they would continue to record the person's blood sugar levels. However, as staff had not been trained to carry out this task they had been taking the person's blood glucose levels after food rather than before food.

The provider had not carried out any further improvements to the service since we last inspected in January

2018. Memory boxes that had previously been fitted to the outside of people's doors were not in use for each person. Doors had posters with names and items on as a temporary solution. Further improvements were required; there were no signs in the communal lounge, or the dining area to help people find their way to other areas of the home such as the lift or bathrooms and toilets.

Requires Improvement

Is the service caring?

Our findings

We observed staff treating people with kindness and compassion, taking time to allay their fears about moving from the service and providing reassurance. Staff were visibly upset and sad that the provider had decided to close the service and wanted to stay working there until each person had been moved somewhere else which was able to meet their needs. One staff member said, "I care for service users and then need to worry about myself. I think about the families who are depending on me."

Staff had forged great relationships with people. One person told us, "She is very kind and helpful. She saved my life. I wasn't eating and now I am." Another person had built up a good relationship with the housekeeper, they pointed them out and said, "They smile a lot."

It was clear that staff knew people well and were sensitive to their needs. Staff initiated conversation with people in a friendly, social manner. Staff asked if they were okay and whether they needed anything. This included those people who were receiving their care in bed. One person carried a doll around the service and held on to this whilst they were sitting. They enjoyed their baby and staff supported the person to look after their baby whilst the person used the toilet or had their meal. The staff spoke gently with the person, which they responded well to.

Staff recognised that one person may become distressed whilst a visiting occupational therapist assessed them to use equipment such as the hoist and sling. Staff sat with the person and reassured and made it clear what was going to happen which supported the person to be calm, relaxed and to enjoy being hoisted up in the air. They were laughing and smiling.

We observed that staff continued to respect people's privacy. Staff knocked on doors before entering. We spoke with staff who said that they would ensure privacy by making sure that the door was closed when they gave personal care, closing curtains in bedrooms when assisting people to wash and dress.

Although staff treated people with kindness, compassion, dignity and respect the provider had failed to do so. The provider had evidenced this through their actions, such as writing to relatives telling them to find alternative care homes for their loved ones, without giving people notice. The provider had not met with people or their relatives to discuss their intentions and had not helped people to find more suitable accommodation to meet people's needs. The provider had not respected that people had a right to receive good quality care, in a safe, well maintained, clean environment, from well trained staff and to have access to activities to meet their needs. People had consistently received poor care and support. The provider had caused people to be anxious and distressed about their future.

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

Staff supported people to be as independent as possible with their personal care. One person was sat in the lounge area unshaven with their pyjamas during the morning. Staff explained this was the person's choice

and daily routine as they liked to take their day slowly because they had been up and awake during the night. The person's care records reflected this.

Staff knew people's likes, dislikes and preferences. Each person had a 'This is me' document which detailed key information about the person. Such as jobs the person had held, where they had lived, important people in their lives, what routines and choices were important to them as well as what caused the person anxiety.

Personal records were stored securely in the office to make sure they were accessible to staff. Staff files and other records were securely locked in cabinets within the offices to ensure that they were only accessible to those authorised to view them. Staff had a good understanding of the need to maintain confidentiality.

Relatives were able to visit their family members at any time. One relative visited during the inspection. The visitors book evidenced that people had regular visits from relatives, friends and professionals.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 11 January 2018 we recommended that the provider reviewed practice to ensure that people received the care and support according to their wishes and preferences. We recommended that that provider sought guidance from a reputable source to review and amend policies, procedures and documentation to ensure people's equality diversity and human rights (EDHR) needs were met. We also recommended that the provider reviewed the complaints information to ensure that it was in an accessible format to meet the needs of people living in the service.

We observed people had little to do to keep themselves occupied. The provider had reduced the staffing levels down which meant that no planned activities took place to keep people active. Staffing levels were at a minimum which meant that staff did not have time away from providing care, administering medicines and preparing tea to facilitate activities. During the morning we observed six people sitting in the lounge with music playing, two people were actively listening to the music and tapping their hands and feet to the rhythm of the music. The four other people were watching a television programme with the sound switched down low. Staff told us they do sing and dance with people when they have time to do so. We observed staff doing this during the inspection. One person took themselves into the garden during the inspection to get some fresh air and enjoy the warm weather. Activity records evidenced that activities were taking place until 04 May 2018.

There was bunting around the dining room and lounge, staff told us they had supported people to celebrate the royal wedding the previous weekend. There had been a party, buffet food and wine. Staff had brought the items for the party themselves.

Care plans were in place for each person which detailed how staff should meet people's care needs. Care plans gave information about people's preferences and wishes in relation to times they liked to get up and go to bed. Care plans detailed people's preferences about their personal care. One person's care plan detailed they would like to have a daily body wash and weekly bath. The person's bathing records evidenced that they had not had a bed bath since 11 April 2018, however records also showed that the person had frequently refused to have any support with their personal hygiene. One person had a strong body odour and smelt of stale urine. Their personal care records evidenced that they had not had a bath since 29 April 2018, the records showed there had been some support with personal care as well as the person independently completing their personal care. The person's care plan detailed they were independent with their personal hygiene needs. The person's care plan had not been reviewed and amended when their needs increased.

At the last inspection we recommended that the provider sought guidance from a reputable source to review and amend policies, procedures and documentation to ensure people's EDHR needs were met. This action was still outstanding.

At the last inspection we recommended that the provider reviewed the complaints information to ensure that it is in an accessible format to meet the needs of people living in the service. This action was still

outstanding. The complaints information was not available to people in different formats or accessible versions to help them understand the information. There had not been any complaints since our last inspection. The complaints policy was on display in the service, this provided people and their relatives with information about how to complain to the manager, provider and to external organisations such as the local authority should they want to take their complaints further. The complaints information did not include information about how to contact the local government ombudsman. We spoke with the provider about this. The provider had not maintained adequate records of complaints. The provider had received a verbal complaint from a relative "Four to five days ago" about an item of jewellery that had gone missing in January 2018. The provider had not recorded this complaint in their complaints log and had not followed their own policy. They had not sent an acknowledgment of the complaint to the relative within two days. The provider also told us that there had been a verbal complaint that £60.00 of a person's money had gone missing. Again, this was not documented and recorded. The provider had not reported this to the relevant authorities. The provider told us they had taken action by paying the person £60.00 back.

The provider had failed to establish and operate an effective system for identifying, receiving, recording, handling and responding to complaints received. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the last inspection on 11 January 2018 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to operate effective quality monitoring systems. The provider had failed to apply to register with CQC the manager they had employed. This was a breach of section 33 of the Health and Social Care Act 2008.

There was no evidence that audits and checks had been carried out by the provider. The provider told us they had completed audits of the service as had the previous manager. The provider said, "Unfortunately my audit file has gone missing." We observed that the provider's filing system in the office was a mess, loose papers and documents were discarded on the desk and on top of cupboards, as well as in drawers. The provider was unable to find a number of documents we requested to see during the inspection. During the inspection we asked the provider questions about a number of key areas such as accidents and incidents, care plans, risk assessments, and medicines. They had little to no knowledge of practice within the service which indicated that they had not undertaken suitable and sufficient audits and checks. They also had a lack of knowledge about the care and support needs of people living in the service. When we challenged the provider about their lack of suitable systems to assess, monitor and improve the service they said, "That is the reason I am getting a consultant to help me out. When she comes I will focus on the audit."

Following the last inspection we met with the provider to discuss our concerns. The provider submitted an action plan which we went through with them in the inspection. Items and tasks they said they had addressed in their action plan had not been completed. For example, staff had not received training in 2018, but the action plan said they would receive this immediately. The action plan listed that staffing numbers had been increased. However, since the action plan had been submitted the provider had decreased them without assessing the level of need each person had. The action plan stated that staffing files will be reviewed and contracts will be in place for each role. The provider said, "This is still to be done" and confirmed that senior care staff were still being paid same as care staff. The action plan listed that there was going to be a two week rotating menu in place as well as a picture menu to help people living with dementia make informed choices about the food they wanted. The provider confirmed this had not been done. They went on to say, "People are happy with their food." The provider had carried out informal checks with people regarding their satisfaction levels with their meals. The provider said they had spoken to people and their relatives. This feedback had not been documented.

Following the last inspection we served the provider warning notices for breaches of Regulation 12 and Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to meet these notices within the timeframe set.

Policies and procedures were in place; however, they were not being followed by the provider. For example, the complaints policy, accident and incident reporting policy, fire safety policy, recruitment and selection policy and staff supervision policy had not been adhered to.

The provider had not carried out any questionnaire or surveys for more than one year. There had been no

meetings to enable people and their relatives to meet with the management team to enable them to provide feedback about the care and support they received. This meant people did not have opportunities to express their views and help shape and improve the service. The provider had not attended a meeting on 22 May 2018 with people and relatives which the local authority had arranged. The provider had not spoken with people or their relatives directly about their plans to close the service.

The provider made it clear to us in the inspection that they were having financial difficulties. They had stated this to relatives within their letter to them dated 14 May 2018. Staff told us that they had received letters to tell them that the provider had failed to pay their tax and had failed to pay in to their pensions. The provider had a number of outstanding bills owed to contractors.

The failure to operate effective quality monitoring systems was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had no manager. At the last inspection a manager was in place which the provider had failed to register with CQC. We took action against the provider in relation to this.

Staff told us they had no support from the provider. They had found ways of getting support by making contact with the local authority and CQC. Staff meetings had not taken place.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The provider had failed to notify CQC about important events. During the provider meeting held on 18 April 2018, the manager alerted us to a death that had occurred five days prior to the meeting. The provider had not informed CQC of this death. During the meeting the provider was advised to send a notification through to CQC and to advise the local authority. The provider eventually notified CQC on 14 May 2018. The information was not clear so the provider was contacted to provide additional information. They failed to do this. The provider had also failed to report an incident of suspected financial abuse to CQC. During the inspection the provider told us that relatives of a person had complained that money had gone missing. Another relative had complained that jewellery had gone missing. The provider had not recognised that this could constitute abuse had had not reported it to CQC or the local authority. The provider had failed to notify CQC without delay about important events.

The failure to notify CQC without delay about a person's death was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. The failure to notify CQC without delay of any abuse or allegation of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating in the reception area.

The service had a compliment card from a relative which read, 'To [deputy manager, cook] and all staff [relative] and myself would like to thank you for the care and kindness you have shown to mum since she has been in your care.'

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The provider has failed to notify CQC without delay about a person's death. Regulations 16 (1)

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC without delay of any abuse or allegation of abuse. Regulation 18 (1) (2) (5)

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to treat people with dignity and respect. Regulation 10 (1) (2)

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to medicines safely. The provider had failed to manage risks appropriately. The provider had failed to follow food safety regulations. Regulation 12 (1) (2)

The enforcement action we took:

We cancelled the provider's registration.

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 fully met the warning notice that had been served in relation to the premises and equipment. The premises and equipment had not been suitably maintained and cleaned. Regulation 15 (1)(2)

The enforcement action we took:

We cancelled the provider's registration.

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 failed to establish and operate an effective system for identifying, receiving, recording, handling and responding to complaints received. Regulation 16 (1) (2)

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective quality monitoring systems. The provider had failed to assess, monitor and improve the quality and safety of the service and failed to maintain accurate, complete and contemporaneous records. Regulations 17 (1)(2)

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider has failed to operate effective recruitment procedures. Regulations 19 (1) (2) (3)

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide training and support to staff to enable them to meet people's needs. Regulations 18 (1) (2)

The enforcement action we took:

We cancelled the provider's registration.