GCH (Harrow) Ltd

Kent House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 20, 21 & 24 August 2015 and was unannounced. At the time of the inspection the registered manager was on long term sick leave. She had been off since May 2015. 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 and associated Regulations about how the service is run.

The provider had notified us that arrangements had been put in place so that the deputy manager would be managing the home with support from the regional manager. We were informed the regional manager was going to spend at least two days per week at Kent House and also having daily contact with the service. At this inspection we found the provider had appointed a general manager.

Summary of findings

Kent House is part of Gold Care Homes Limited and provides accommodation and support with personal care for up to 40 older people, some of whom have dementia. At this inspection there were 25 people using the service.

At our previous inspection of 9 and 10 November 2014 we had found eight breaches of legal requirements. We issued five warning notices. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the five warning notices. We carried out a focused inspection on 27 February 2015 to check that they had followed their plan and to confirm that they now met legal requirements. We found the provider had met the legal requirements of the warning notices served.

At this inspection we found the provider had not sustained the improvements we noted in the last inspection in February 2015. We found that people's safety was being compromised in a number of ways. There were inadequate plans in place to assess and manage risks associated with medicines management; pressure ulcers, nutrition, falls and staff deployment.

Assessment plans of care for people who were at risk of pressure damage were not being followed. In some examples, the recording of pressure care was not accurate and did not always reflect the care people needed.

People were at risk of malnutrition and dehydration. Dietary assessment plans were not always followed. People were not always supported adequately to eat and drink enough to meet their needs. The recording of food and fluids was inaccurate. It was not always clear whether people were having enough to meet their needs.

People's dependency levels were not always calculated correctly and as a result the provider could not demonstrate staff deployment always reflected the level of care needs and support required to safely meet people's needs. We found that the deployment of staff required improvement.

Not all staff had received training relevant to people they cared for. For example, staff looking after people receiving end of life care had not received relevant training.

The standard of record keeping was not fit for purpose. We found in some examples that records had not been fully completed. Some care records did not accurately reflect the care being provided or required.

People did not receive care that was tailored to their needs. Staff were focused on tasks and working through these rather than providing care that responded to each individual person. We observed that staff were caring, kind and respectful towards people but we also observed that they were stretched because of work overload.

Staff told us they did not feel well supported or listened to, and morale at the service was low. The absence of an effective arrangement for supporting staff, either through supervision, appraisals or by other means, meant the management were not aware of issues of concern and therefore were not able to adopt plans to boost morale.

There were safeguarding and whistleblowing policies and procedures in place which provided guidance to report concerns. Staff had received training in safeguarding and whistleblowing to protect people from abuse and training records confirmed this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that where required, DoLS applications had been made and the service manager understood when an application should be made and how to submit one.

Overall, we found significant shortfalls in the care provided to people. We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. We will publish what action we have taken at a later date.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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.

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. The arrangements for "as required" medicines were not sufficient.

There were shortfalls in pressure area care, catheter care and inadequate recording keeping.

The provider did not deploy sufficient numbers of staff to meet the needs of people receiving care. We observed staff to be stretched, rushing their work in some examples and we found some staff worked beyond their shifts to clear work backlog.

The provider had maintained improvements in managing infection prevention and control.

Is the service effective?

Inadequate

The service was not effective.

People were placed at risk of malnutrition and dehydration. This is because guidance about people's diets was not being followed and the recording of food and fluids was inaccurate in some examples.

Staff had not received training to be able to safely support people receiving End of Life Care.

Staff had not received regular supervision and appraisal.

Although people had access to external health and social care professionals, there was evidence this did not happen consistently.

Is the service caring?

Requires improvement

The service was not always caring. Although we saw some caring in practice; the needs of people receiving end of life care were not recorded and kept under review. We found variation in the standard of records in relation to Do Not Attempt Resuscitation documentation.

People's privacy was respected. Staff were aware of the importance of ensuring that people's privacy was protected.

Is the service responsive?

Requires improvement

Aspects of the service were not responsive to people's needs. People did not always receive the care they required at the time they needed it. In some examples, delivery of care suited staff routine, rather than people's individual preferences and choices.

Care plans were limited and did not always adequately guide staff to enable them to respond to people's requirements. For example, some lacked consistent detail around the care of pressure sore, falls and end of life care.

Summary of findings

The provider had maintained improvements around people's activities, and was in the process of making improvements to the premises to accommodate the needs of people with dementia.

Is the service well-led?

Inadequate

The service was not well-led. The arrangements for governance and performance management did not always operate effectively. There had been no review of governance arrangements, plans or the information used to monitor performance. As such, current monitoring systems had failed to identify significant issues that threatened the delivery of safe and effective care.

There was a limited approach to obtaining the views of people who used the service and staff. Feedback was not always reported or acted on in a timely manner. There were low levels of staff satisfaction. Staff told us they did not feel engaged or empowered.

Kent House

Detailed findings

Background to this inspection

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

We undertook an unannounced comprehensive inspection of Kent House on 20, 21 & 24 August 2015. This inspection was carried out to check that improvements we saw in our focussed inspection on 27 February 2015 had been sustained. In addition, we also undertook this inspection to check if the provider had met other breaches we identified in our comprehensive inspection of on 9 & 10 November 2014. We had not looked at these breaches when we inspected the provider in February 2015 because at that inspection we only looked at breaches in relation to the five warning notices. The team inspected the service against all of the five questions we ask about services: is the service safe, effective, caring, responsive and well led.

On the first day of the inspection, the inspection team consisted of two inspectors and a specialist advisor within older people's care. On the second day of the visit the inspection team consisted of two inspectors, the same specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the third day of the inspection, the inspection was carried out by a pharmacist. We reviewed the information we held about the service. We considered information which had been shared with us by the Local Authority and looked at safeguarding issues that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with 11 people who lived at the service, the regional manager, service manager, deputy manager, and seven care staff. Some people had limited verbal communication. We spent considerable time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at areas of the building, including people's bedrooms, bathrooms, the dining rooms and communal lounges. We reviewed records of the service, which included quality assurance audits, staff supervision schedules, staffing rotas, food and fluid recording charts and policies and procedures. We looked at nine care plans and the assessments, along with other relevant documentation to support our findings.

Inadequate

Is the service safe?

Our findings

We asked people and their relatives if the service was safe. Comments we received included, "I am happy with the care my relative is receiving here" and "Staff are kind. I feel safe." The relatives felt their family members were safe. However, these comments were not always reflected in our observations and findings during this inspection.

At our previous inspection on 9 and 10 November 2014 the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 12 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to assess and manage risks to people's health and wellbeing. For example, people at risk of developing pressure ulcers were not repositioned regularly to avoid pressure damage to their skin.

At this inspection we found that some but not all of these areas had been addressed. People were still at risk of developing pressure ulcers. Although risks in relation to pressure ulcers had been assessed, we found that either there was insufficient guidance for staff to reduce these risks, or staff had failed to implement the guidance provided.

For example, we examined skincare care plans of some people at risk of developing pressure ulcers. Their care plans recorded they needed help and support to be positioned regularly. This was necessary so they prevented pressure damage to their skin. However, the records of positional changes indicated that these had taken place infrequently. For example, we saw that on 16, 17, 18 and 19 August 2015 the two hourly repositioning of one person was not always recorded as achieved and there were numerous gaps in the records. The longest time between repositioning occurred on 16 August 2015 when the person was not repositioned for four hours. Having clear and accurate records in place for the prevention and treatment of pressure ulcers helps to ensure that people who use the service receive the care they need in order to promote their health and wellbeing. The deputy manager told us she was not aware the charts were not being completed properly.

In another example, one person had an indwelling catheter which, the deputy manager explained, was left in situ for the duration of time instructed. We reviewed the daily record sheets of the person for July 2015 and there were multiple entries which recorded that the person's catheter was leaking. On 18 July 2015, there was an entry that the catheter bag was 'emptied but urine was smelly'; 24 July 2015, another entry reported a green discharge and on 27 July 2015, an entry indicated the catheter bag was purple. Purple discoloration of a urinary catheter bag is associated with a UTI. The deputy manager confirmed the person was prone to UTIs and on the day of the inspection there was no clear information or risk assessment on how this should be monitored and managed. On 30 July 2015, antibiotic medicine was prescribed for this person. However, this person could have been referred for medical attention earlier given their symptoms and the fact staff were aware they were prone to UTIs

The failure to manage risks to people's health and wellbeing was in breach of Regulation 12(1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the previous comprehensive inspection of 9 & 10 Nov 2014 we had found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 12 (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because medicines were not stored and administered safely.

At this inspection we found that some but not all of these areas had been addressed. People were still at risk because of a lack of robust practices that ensured they received their medicines safely.

For example, although there were improvements in the way medicines were stored, including medicines that required cold storage and some external preparations kept in people's rooms; people remained at risk because safe medicines use was not reflected in people's care plans. The records for people who were prescribed medicines to be taken 'as required' did not contain information to support staff to give these medicines consistently when needed. This included where increased risks should have been highlighted, for example where more than one medicine for the relief of pain had been prescribed and where people had communication difficulties or may not have had the ability to explain their needs to staff. One person was

prescribed a medicine which required a regular blood test and close monitoring to ensure that it was given at a safe dose. Their care plan did not include any details of this medicine or the risks that it posed to the person.

In another example, we were told that one person had their medicines crushed to enable them to take them more easily. When we checked this person's record we saw that it had been audited by the service and they had noted that there was no information from the pharmacist to support the safe administration of these medicines but had not done anything to ensure this person was taking their medicines safely.

We also saw that a staff member had prepared medicines for nebulisation in the staff office. Nebulisation is when a drug delivery device is used to administer medicine in the form of a mist inhaled into the lungs. A mouthpiece or mask is used to avoid the risk of dispersal of the drug into the atmosphere and reduces the risk of skin irritations. In this example, the person had their medicine administered without an attached mask. The staff who administered the medicine explained the person disliked the mask over their face and that the doctor had advised the medicine should be administered in that manner. However, the staff member had not considered or risk assessed, that another person receiving care was sat in close proximity, having already been seated in the small office before the person needing treatment entered the room.

This was a breach of Regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not always managed properly and in a safe way.

At the previous comprehensive inspection of 9 & 10 November 2014 we found the provider was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there were not enough staff with the right experience or training to meet the needs of people living in the home.

At this inspection people remained at risk because the provider did not deploy sufficient numbers of staff to meet their needs. People using the service and staff told us they thought at times there were not enough staff to meet people's needs. One person told us, "The staff are always very busy. They do not have time to sit down and have a chat." Our observations showed a visible lack of staff to respond to people's needs during busy hours such breakfast and lunch time, which was confirmed by staff we spoke with.

The regional manager and the deputy manager told us staffing levels were determined by individual dependency levels. The provider's staffing policy stated that the Isaac Neville Dependency tool must be used for any proposed staffing levels. However, we saw evidence that in some examples this was not used correctly. For example, one person was assigned a score that indicated that the person was '[independently mobile] with or without aids'. However, the moving and handling assessment of this person showed they needed assistance with mobilising. Therefore, the provider could not demonstrate staffing levels reflected the level of care needs and support required to safely meet people's needs.

We observed staff were busy throughout the inspection and care was not delivered in a timely manner. Staff were rushed to provide lunch to people and were not able to spend time to provide people with the care they wanted. The provider's policy on nutrition and hydration stated that mealtimes should not be rushed, but this is not what we observed. We observed lunch from 12:30pm. By 1pm 16 people were seated in the dining room, and two members of staff were serving meals. In the meantime, other staff members were collecting meals for 9 people that had chosen not to come to the dining room or who were being cared for in bed. We saw staff delivered task orientated care as they were continuously rushing from one task to another. Eventually, more staff including an activity co-ordinator came to the dining room to support the two staff who had remained in the dining room supporting 16 people. Some staff told us they needed more support during lunch time.

We saw that there was a note on the outside of a cupboard instructing night staff to wake up people before the morning shift started at 7am. We checked to see if this was the personal choice of the affected people; to be woken up that early. We looked at the care plans of five people and only one had indicated they wished to be woken up as early. A member of staff explained this was done because they did not have enough staff to manage the workload in the morning. We saw from care records that all six people were had a high dependency; they needed to be assisted

Is the service safe?

by two staff and also required hoisting. The regional manager told us she was not aware of this, stating the practice was, "Institutionalised and did not reflect good quality dementia care." However, we saw from staff minutes this was a routine practice because previously night staff were required to wake up 12 people before they completed their shift. At this inspection, this had been reduced to 6 people.

Staff told us they worked beyond their shifts to clear work backlog. We examined the 'daily hours by date' time sheets from May 2015 to August 2015 and we observed staff worked beyond their contracted hours. For example, in May 2015, one staff worked an extra 17 hours; in July 2015, another staff worked 22 hours and in August 2015 another staff worked an extra 37 hours. These extra hours are conservative estimates because some time sheets were not completed and therefore did not record 'actual start time' and 'actual finish time'.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to deploy sufficient numbers of suitably trained staff to meet people's needs.

At the previous inspection of 9 & 10 November 2014 we had found failings in infection prevention and control (IPC). This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that the provider had maintained improvements in managing Infection Prevention and Control (IPC). We saw relevant policies and guidance regarding IPC, including Department of Health's publication: 'The Code of Practice for Health and adult social care on the prevention and control of infections' and related guidance, and a hand washing and hygiene policy. The National Institute of Health and Clinical Excellence (NICE) guidance: Prevention and control of healthcare-associated infections in primary and community care; dated March 2012 was also in place. Relevant infection control audits had been completed since January 2015. We observed infection prevention and control was in line with relevant policies.

There was a safeguarding policy and details of the local authority safeguarding arrangements. Staff could explain how they would recognise and report abuse. They told us they would report concerns to their manager, who they would expect to report to local authority safeguarding team and the Care Quality Commission (CQC). They were aware of the provider's whistleblowing policy and said they would report any concerns or ill treatment of people to external agencies if the provider did not take appropriate action.

We checked staff files to see if the service was following thorough recruitment procedures to ensure that only suitable staff were employed at the home. Recruitment files contained the necessary documentation including references, criminal record checks and information about the experience and skills of the individual.

Inadequate

Is the service effective?

Our findings

At our last inspection in November 2014 we found the provider had not always ensured people ate and drank enough to keep them healthy. The provider had not sought input from healthcare professionals trained in nutritional requirements. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that people's needs in relation to diet and weight loss were still not being met. For example, the nutrition audit that was undertaken in July 2015 recorded nine people had a Body Mass Index (BMI) below 20, and four with a BMI of 20. This meant on BMI alone they had a MUST Score (Malnutrition Universal Screening Tool) of 1 or 2. In line with the MUST guidance, these individuals would have required an improved and increased nutritional intake, regular monitoring, and regular review of their care plan. However, we saw that the provider did not always ensure this guidance was followed. A 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. A MUST of '0' is low risk, '1' is medium risk and '2' and above is high risk'.

We examined the care plan of one person receiving End of Life Care (EOLC). This showed this person weighed 55.30kg in January 2015 and 43.5kg in July 2015, which equated to a weight loss of 11.8kg over the period. Records also showed that this person had a height of 1.63m, which meant with a current weight of 43.6kg, their BMI was 17, and therefore a MUST score of 2. The MUST guidelines state that a person with a MUST score of 2 or high must be referred to a dietitian or nutritional support team and that there should be monthly reviews. We saw from this person's care plan that this guidance was not followed. A referral to a dietician, for nutritional recommendations was not made. We passed this concern to the deputy manager as soon as we realised and on the second day of the inspection we saw this person had been referred to a relevant healthcare professional.

We examined the care plan of another person using the service on the first day of the inspection. The care plan indicated the person was on a pureed diet. The deputy manager could not find detailed information relating to this. However, on the second day, the deputy manager showed us a list stating there was a current referral to a dietician and that the person should be on a soft diet pending evaluation by a dietician. The latest nutritional quality audit dated July 2015 documented the BMI for the person as 14, and therefore at high nutritional risk. The dietary requirement section for soft or pureed diet was blank. The section which asked for specific information relating to GP, dietician or SALT referral had no information relating to any referrals or escalation of concerns.

People receiving care may not always have received essential nutrients because staff were not knowledgeable of their nutritional needs. The chef and care staff told us there were no people on fortified diets. However, the regional manager and the deputy manager had told us some people were on fortified diets and that the chef was aware of this because he was given weekly weights of people requiring fortification. Still, the chef insisted he was not given a list of people with dietary needs. Food fortification or enrichment is the process of adding micronutrients or essential trace elements and vitamins to food. For example, a nutritional review record of one person dated 9 July 2015 documented that this person was on ensure; a nutritional supplement. There was information that kitchen staff had been informed the person was offered full fat milk, honey and yoghurt for fortification. We looked at the food intake charts and noted that on 18 August 2015, there was no record that fortification or high calorie snacks had been offered apart from 40mls of ensure that was recorded as consumed. On 19 July 2015, there was a record that the person had poor food intake but there was no record that any supplements had been offered.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our 9 & 10 November 2014 inspection we found that staff did not receive regular supervision and appraisals. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Inadequate

Is the service effective?

2014. At this inspection we observed staff were still not receiving regular supervision and appraisal. Furthermore, we saw that staff did not have appropriate training to meet the needs of people using the service.

There were no effective arrangements for supporting and managing staff to deliver effective care and treatment. Staff did not receive regular supervision and appraisals to ensure they were adequately supported in their role. The provider's supervision policy stated, 'Supervision meetings will take place every two months and be logged on the home's supervision matrix. An agenda will be agreed in advance and a record of supervision made'. However, staff told us and records confirmed they did not receive regular supervision. We looked at eight staff records and saw that they had not received regular supervision. One staff told us, "I have not had supervision for a while. The last was about seven months ago." Another staff told us, "I have had two supervisions in the last twelve months", and another said "I have had one supervision since January 2015." During this inspection, the regional manager told us they had written letters to staff regarding planned appraisals, however, all the staff we spoke with confirmed they had not received this letter.

We looked at end of life care training (EOLC) and identified that staff had not received training in this area. There were four people receiving EOLC. The provider's policy for 'care for the dying resident' stated, 'Where the resident is diagnosed as having a terminal illness, i.e. where death is imminent, a programme of palliative care will be put into practice. This will be managed by a member of the senior nursing staff trained in the special needs of palliative care, including bereavement counselling'. Staff told us, and their training records confirmed they had not received palliative training or bereavement counselling. Furthermore, the provider did not employ qualified nurses. This may have had a negative impact on the care that people received. For example, we reviewed turning and comfort visit charts of a person receiving EOLC and there was no evidence the person was being repositioned two hourly or visited hourly as instructed in their care plan.

Newly recruited staff were not enrolled on a nationally recognised induction qualification such as the care certificate. We spoke with two newly appointed staff who had been recruited within the last six months and we saw that they did not have a coherent induction programme in place. They could not provide us with an induction package to show what they had covered. This did not ensure staff members had the skills and knowledge to carry out their roles properly and to be able to care for people safely.

This was a breach of Regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about the Mental Capacity Act (MCA) 2005. Most staff understood the importance of ensuring people consented to the support they provided. They told us if they had any concerns about people's ability to consent, this would be discussed with the registered manager or the deputy manager. We examined how the MCA was being implemented. This law sets out the requirements of the assessment and decision making process to protect people who do not have capacity to give their consent. The registered manager had completed this process in some examples. Consent forms had been signed by people or their relatives. In one example, a relative of a person who did not have capacity had signed the care records for this person and there was a copy of a Power of Attorney in place that covered finance and property.

We also looked at the Deprivation of Liberty Safeguards (DoLS) which aims to make sure people are looked after in a way that does not inappropriately restrict their freedom. There were seven DOLS authorisations for people living at the service. We saw the provider had followed the correct process to gain authorisation.

Requires improvement

Is the service caring?

Our findings

At our last comprehensive inspection of 9 & 10 November 2014 we found staff did not make suitable arrangements to ensure people's dignity. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that some but not all of these areas had been addressed. Although there were improvements in ensuring people's dignity, people's expressed preferences and choices for their end of life care were not clearly recorded and acted on.

We looked at arrangements in place for supporting people at the end of life. We saw that the needs of people receiving end of life care were not recorded and kept under review. In some examples, there was no care plan in place for the person's end of life needs and wishes or arrangements to ensure that the person's preferences were kept under review and acted on. We found variation in the standard of records in relation to Do Not Attempt Resuscitation (DNACPR) documentation. We also found that none of the DNACPR forms and patient records we examined had documented that appropriate discussions had taken place with relatives regarding the decision. There was no record if people's wishes regarding this had ever been known or what the different decisions or options had been considered.

Despite these shortfalls, people told us that they were happy living at the home. When asked if they were made comfortable by staff and treated well. They told us, "Yes, very well." Relatives of a person receiving care said of staff, "They're brilliant here," and "Really caring and very helpful." Other relatives of a person receiving care told us, "We are happy and confident that [our relative] is being looked after," and "We're getting what we need for our relative."

People's privacy and dignity were respected. The provider had dignity champions who worked with the registered manager to improve people's experience of care. We found staff were helpful, considerate and kind. Staff were aware of the importance of ensuring that people's privacy was protected. They informed us that they would knock on doors before entering bedrooms and close the curtains if necessary, which we observed during this inspection. People were able to stay in their rooms if they preferred privacy and we observed people were able to go to their rooms at any point during the day.

We saw some caring and sensitive interactions between members of the care team and people with dementia. We saw staff reassuring and re-orientating people in a kind and patient way. We heard a number of staff explaining and providing information to people in an appropriate manner. The people who lived in the home responded well to staff.

However, at times the interaction between staff and people was generally task driven, for example, when assisting them with their lunch and giving them their medicines. Spontaneous engagement was limited, meaningful activities, stimulation and involvement was also very limited.

We recommend that the service seek advice and guidance from a reputable source, around end of life care.

Requires improvement

Is the service responsive?

Our findings

We were told by the provider that there was a new format for care plans and that this was being introduced at the home. The deputy manager showed us this new format. We saw that care plans now included information about people's social interests, hobbies and religious needs. However, we found that some did not always represent people's needs and were not written in a personalised way. We found the information within the care plans patchy and inconsistent and staff could not always find the information we asked for in the files.

We found other areas where care was not person centred and reflected people's preferences. For example, on the first day of the inspection the deputy manager confirmed food of six people receiving care was blended in a liquidiser. We checked the care plans of the respective people, to verify information about their nutritional needs. We found all six people had been advised a soft diet by relevant healthcare professionals. We saw a copy of guidelines which described what a soft diet is. This described a soft diet is, 'a solid food that is soft enough to be broken down with the edge of a fork'. There was no reference in people's care plans for pureed diet, so it was not clear why this was being given. The nutritional guidelines and menu checklist for residential and nursing homes dated 2014, states, 'Pureed diets should only be offered if advised by the speech and language therapist (SALT) or appropriate consultant'. The managers at the service could not explain why people were being offered pureed diets.

A choice of food and drink was available for people. However, the system of offering choices might not have taken into consideration the needs of people with dementia. Twelve out of twenty five people who lived at the home had dementia. Staff told us people chose their lunch for the day in the morning of the previous day and were offered a choice of two meals at lunchtime. However, when we looked at food options on the second day of the inspection there was an option of jacket potato on the food menu even though this had not been prepared. When we asked the chef we were told they had asked people for their preferences before lunch was prepared and no one had selected the jacket potato option. This meant that people with dementia may not have received meals that they were expecting or may have received meals that they had changed their minds about. We also noted that there were no visual aids or prompts to assist people to make choices'.

We found that the staff dependency tool used was not always accurately identifying people's needs for care resulting in a shortfall in staffing numbers. We observed staff not fully offering choice at mealtimes when staff assisted people to eat and we identified that some people's preferences when getting up in the mornings had not been identified and recorded.

The above evidence is a breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that people received personalised care that was responsive to their needs

We asked the deputy manager about the activities available for people who used the service. They told us 'activities coordinators' had the responsibility for ensuring a range of activities were provided. We looked at the timetable on display and saw this included card making, chair exercises, bingo and sing along activities. Trips to local attractions had also been arranged. A relative told us, "Staff engage [my relative] in activities like arts, crafts and pets handling'. We saw that the activities co-ordinators undertook a range of activities with people who lived at the home.

We noted a copy of the complaints procedure was on display in each of the bedrooms. This informed people of the response they should expect if they raised any concerns. All the people we spoke with who used the service told us they had no concerns about making their views known but would mostly do this through the staff. The provider had not received any complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our 9 & 10 November 2014 inspection we found that the systems to monitor the quality of the service were not effective. The auditing practices had failed to see that systems needed to be improved. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that some but not all of these areas had been addressed. The provider had failed to ensure effective systems were in place to assess and monitor the level of service provided. The provider had failed to sustain the improvements we saw at our focussed inspection on 27 February 2015.

Since our focussed inspection there had been some changes in the structure of the management.

Kent House had been without a registered manager since May 2015. We were notified that the deputy manager would be managing the home with support from the regional manager who was going to spend at least two days per week at Kent House and also having daily contact with the service. We found the deputy manager to be knowledgeable about the needs of people and had a supportive attitude. However, the arrangements that were put in place were not sufficient to ensure the provider sustained and continued to make the required improvements.

The provider did not demonstrate good management and leadership. There were low levels of staff satisfaction and reported work overload. Staff told us they did not feel supported and appreciated. One staff member told us, "We are working longer hours than we are contracted to do"; another staff told us, "I do not feel supported. At times we need help on the floor and we do not get it"; and another said, "I do not think we have enough staff." Staff shortage was a recurring theme from staff. In addition, there were no effective arrangements for supporting staff, either through supervision or appraisals.

The provider did not promote a positive culture that was person-centred, open, inclusive and empowering. We read minutes of staff meetings held since January 2015. Although there was evidence that important issues of care were discussed, the minutes lacked the voice of staff. The minutes reflected top down messages from managers to staff. Staff could have used meetings as forums to raise some of their concerns but they did not feel confident to do so. With irregular supervision, staff did not have opportunities of raising concerns.

Staff minutes showed staff had been provided with some guidance regarding what was expected of them. For example, in a meeting that was held in February 2015 staff were reminded to complete relevant charts for fluid and food intake and repositioning of people at risk of developing ulcers. In a meeting that was held in April 2015, staff were again reminded to complete appropriate charts. However, there was a lack of management oversight and monitoring to ensure this was being carried out.

There was a limited approach to obtaining the views of people who used the service. Feedback was not always reported or acted on in a timely way. The most recent analysed survey results were of one that was carried out in May 2014. The provider told us they were still in the process of collating and analysing the results of a survey that was carried out in 2015. In the 2014 survey, people had been asked a variety of questions, to which they required to respond whether they were 'happy, satisfied or unhappy'. From those who responded most people indicated they were either happy or satisfied. For example, whereas five people felt they were involved in writing and reviewing their care plan; three were satisfied and two were unhappy. Although the results had been analysed, this did not lead to an improvement plan, particularly where people had indicated 'unhappiness'. There were no improvements in this area since our inspection in November 2014.

The provider did not have a coherent approach to ensure feedback from people resulted in improvements. For example, although there were 'residents' meetings, the feedback from people did not always translate into a plan of improvement. We read minutes of a 'residents' meeting that was held in February 2015. People gave mixed feedback about various aspects of care. Some people were unhappy with a lasagne dish they had been receiving, because it was served with vegetables and gravy. They preferred to have it with a salad. They also raised issues, with the evening tea trolley and their laundry. We read minutes of another 'residents' meeting that was held May

Inadequate

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2015; four months later, and people had raised the same issues, which meant issues were not been resolved. There was a failure to act on feedback from people to continually evaluate and improve services.

There were a number of audits undertaken since our inspection in 2014. However, we saw that significant issues that threatened the delivery of safe and effective care were not always identified or adequately managed. For example, a nutritional quality audit that was undertaken in July 2015 failed to identify a person with a MUST score of 3, and who therefore needed to be referred to a dietician or a nutritional support team, had been. The audit had also not identified that SALT recommendations were not being followed; people who were on a soft diet recommendation were being served pureed food.

Accidents and incidents were not routinely monitored, reviewed and used to improve the quality of care or safety of the service provided to people. There was a policy for 'Accidents To Residents and Staff.' The policy stated that people should be monitored following a fall. The forms that were used for recording accidents stated that people should be monitored for 72 hours following a fall. We reviewed a file of one person who had a history of falls. There was no risk assessment in place for this person. The deputy manager explained that this had been completed, but they were unable to locate the document. This person had sustained a total of 6 falls before being referred to the falls clinic on 15 July 2015. The mobility care plan noted, 'no changes in my care plan for mobility.' This is despite having the recorded falls.

We found that the provider did not maintain accurate records in respect of care and treatment of people who used the service. There were records of food and fluid intake but these were not effective as they were not always completed fully. We looked at a sample of records and saw gaps in entries that had been made. Therefore it was difficult to know how accurate these records were, and how this information was being used.

This is a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.