HC-One Oval Limited

Ghyll Grove Care Home

Inspection report

Ghyllgrove
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Essex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ghyll Grove Care Home is a residential care home providing personal and nursing care for up to 169 older people. Some people have dementia related needs and some people require palliative and end of life care. The service consists of four houses: Kennett House, Medway House, Chelmer House and Thames House. At the start of our inspection there were 112 people living at the service.

People's experience of using this service and what we found
People's comments about staffing levels were variable. Staff felt regularly stretched, and the focus was on completing tasks rather than providing person-centred care and support. There was a high usage of agency staff and this had a detrimental impact on the quality of care provided. Not all risks to people's safety and wellbeing were assessed or recorded and improvements were still required to ensure people received their medication as they should. Findings from this inspection showed lessons were not learnt and improvements made when things went wrong. People told us they were safe. Suitable arrangements were in place to protect people from abuse and avoidable harm. Staff understood how to raise concerns and knew what to do to safeguard people. Recruitment practices were robust to make sure the right staff were recruited although not all gaps in employment had been explored. People were protected by the prevention and control of infection.

Staff training records showed not all staff employed at the service had received mandatory or refresher training in key topics. Not all agency staff utilised at the service had received or completed an 'orientation' induction when undertaking their first shift at the service. Staff had not received regular supervision. The dining experience for people on Thames and Chelmer house was positive but this contrasted with the experience on Kennett and Medway house. People were not routinely offered the opportunity to sit at the dining table for their meals and some people did not receive their meal in a timely manner. People were supported to access healthcare services and receive ongoing healthcare support. The service worked with other organisations to enable people to receive effective care and support. People were in general supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

People's comments about the quality of care and support they received was variable. People did not always feel they were treated with care and kindness or feel listened too. This was attributed to inadequate staffing levels at the service, high usage of agency staff and staff not having the time to spend with them. Not all people living on Medway and Kennett House were given the opportunity to spend time within the communal lounge and it was stated to us by relatives and staff that people were 'rotated' during the week rather than this being their personal choice.

Improvements were still required to ensure information recorded clearly detailed people's care and support needs. People were not supported to participate in social activities, both 'in house' and within the local community. The service is not fully compliant with the Accessible Information Standard to ensure it meets

people's communication needs. People and those acting on their behalf were confident to raise issues and concerns, however, several people told us they did not know who the manager was and seemed unsure who they should speak to if they had a concern or complaint. Referrals had been made to the end of life register to ensure people's wishes were adhered to.

Improvements were still required to ensure the leadership, management and governance arrangements at the service were effective and outcomes for people assured high quality and person-centred care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The rating at last inspection was requires improvement (published April 2019). There were four breaches of regulation. These related to breaches of Regulation 12 [Safe care and treatment], Regulation 13 [Safeguarding service users from abuse and improper treatment], Regulation 17 [Good governance] and Regulation 18 [Staffing].

At this inspection we found improvements had been made and the provider was no longer in breach of two out of four regulations. The service still remains in breach of Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This service has been rated requires improvement for the last two consecutive inspections.
We have made recommendations relating to risk, medicines management, staff supervision, care planning and record keeping and social activities.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Ghyll Grove Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by four inspectors and two Experts 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.

Service and service type
Ghyll Grove Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced and a comprehensive inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the Local Authority and professionals who work with the service. We used this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 25 people who used the service and 17 relatives about their experience of the care provided. We spoke with 17 members of staff including house managers, qualified nurses and care staff. Additionally,

we spoke with the manager, deputy manager, weekend and night manager and area director.

To help us gain a better understanding of people's experiences we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included people's care records and medication records. We looked at five staff files in relation to recruitment and the service's staff supervision planner. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection to the service in February 2019, suitable arrangements were not in place to ensure enough numbers of staff were deployed to meet people's care and support needs. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and they were still in breach of regulation.

Staffing and recruitment
• No concerns were raised on Thames House about staffing levels. However, less favourable comments were received from people using the service in relation to Chelmer, Medway and Kennett houses. One person told us, "My call alarm is always to hand, but it depends on what time of day it is as to how quickly they [staff] come, after 10.00pm you seem to wait longer. At weekends you wait longer, you can see the difference." A second person told us, "They [staff] don't come very quickly when I call them, could be 15 minutes or more, they [care home] always seem short staffed."
• Suitable arrangements were not in place to ensure there were enough staff to give people the care and support they need. We found people received personal care later than they wished and some people were left in bed for no apparent reason. Comments included, "Last Sunday several people were not gotten up, I presume due to lack of staff" and, "There are insufficient staff, especially at weekends. It means people aren't got out of bed then." This was confirmed by staff as accurate. One staff member told us, "We do not always have enough staff available. If we have the right amount of staff we can get people up, but if not, people are not got up and remain in their room."
• Views were mixed about the use of agency staff and the impact this had on the service. One relative told us, "The regular staff are very pleasant. However, a few weeks ago they [care home] were pushed for staff and there were lots of agency in, they don't know the residents." Another relative told us, "Staff are friendly but regular staff are run ragged, everything takes longer with agency staff."
• Staff told us they regularly felt stretched and under pressure, with the focus on completing tasks rather than providing person-centred care and support.

Effective arrangements remained not in place to ensure there were enough staff available to support people and meet their needs. This demonstrated a continued breach of Regulation 18 of the Health and Social Care (Regulated Activities) Regulations 2014.

At our last inspection to the service in February 2019, suitable arrangements were not in place to protect people from the risk of abuse or to effectively investigate allegations. This was a breach of Regulation 13

[Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found enough improvement had been made and they were no longer in breach of regulation.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe. Comments included, I feel safe here, yes, they [staff] know what to do, nothing fazes them", "Oh yes, I feel safe with them [staff], they're very on the ball" and, "I feel safe, always someone here, got good friends." All relatives spoken with told us they had no concerns about their family member's safety.
• The incidence of safeguarding concerns at Ghyll Grove Care Home had decreased since our last inspection in February 2019.
• Staff had a good understanding of what to do to make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to the management team, the organisation and external agencies, such as the Local Authority or Care Quality Commission.
• Though staff understood their responsibilities to act on and report any concerns, not all staff had attained up to date safeguarding training.

At our last inspection to the service in February 2019, the registered provider had not always provided care and support for people in a safe way. Risks to people were not always recorded and mitigated and medication practices at the service required improvement. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found the service was no longer in breach of this regulation, but improvements were still required.

Assessing risk, safety monitoring and management; Using medicines safely
• Where risk assessments were in place, these identified how risks to people's safety and wellbeing were to be reduced and the actions required to keep people safe. However, not all risks to people's safety and wellbeing were assessed, recorded or followed by staff. For example, information for one person stated they were at high risk of choking. Although there was no evidence to suggest the person received unsafe care and support, no information was recorded detailing how the risk of choking was to be mitigated. The same person had bedrails in place but an assessment to confirm these were appropriate had not been completed. We brought this to the house manager's attention. They told us an assessment would be completed and other people's files checked to ensure these were in place.
• Medication Administration Records [MAR] showed not all people using the service had received their prescribed medication. For example, the MAR form for one person showed they were prescribed eye drops and these were to be administered four times daily. The person's MAR showed between 23 September 2019 and 10 October 2019, this medication was not always administered in line with the prescriber's instructions. The rationale for any omission was not recorded.
• Another person was prescribed a medication which must be taken 30 to 60 minutes before food. The MAR form showed this instruction was not always followed and suggested they received this medication with their breakfast.

We recommend the provider seek independent advice and guidance to assess and record risks to people using the service and to improve the service's medication practices.

• Staff recruitment records for five members of staff were viewed. Most relevant checks were completed before a new member of staff started working at the service. Minor improvements were required as not all gaps in employment had been fully explored.

Preventing and controlling infection

• The service was generally clean and hygienic. However, improvements were required on Kennett House. Sanitary bins were overflowing and when discussed with domestic staff they were unclear of the actions to be taken to address this.
• Personal Protective Equipment [PPE] such as gloves, aprons and liquid soap were available to staff to prevent and control infection.

Learning lessons when things go wrong
• The inspection highlighted some lessons had been learned and improvements made since our last inspection in February 2019. For example, suitable arrangements were now in place to protect people from the risk of abuse. Although improvements are still required in relation to risk management and medication, the service was no longer in breach and a recommendation has been made.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• Staff training records showed not all staff employed at the service had received mandatory or refresher training in line with the organisation's expectations. This referred specifically to safeguarding, safer moving and handling and nutrition awareness.
• Where staff had attained a National Vocational Qualification [NVQ] or qualification under the Qualification and Credit Framework [QCF]; and had limited experience in a care setting, staff had completed the 'Care Certificate'. The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life. Additionally, staff completed an 'in-house' orientation induction when first employed.
• Not all agency staff utilised at the service had received or completed an 'orientation' induction when undertaking their first shift at the service.
• The supervision planner for 2019 showed not all staff had received regular formal supervision. Not all staff were able to confirm when they last received supervision. It was unclear if staff had received an annual appraisal as there were limited records available to evidence this.
• Staff told us they did not always feel supported or valued by the organisation or management team. We were told of a recent incident whereby there were not enough staff on duty within one house because of staff sickness. The manager was told, and staff stated the response received was, "You'll be fine." However, two people did not get washed and dressed until after 2.00pm and an agency member of staff did not arrive until the afternoon. Staff told us they needed the staff in the morning and did not feel the manager was understanding and responsive. One member of staff told us, "We haven't got any support, everyone is fed up and morale is low."
• Mixed feelings were raised about divisions between the qualified nurses and care staff. Comments included, "Some nurses are good and helpful, others are not and talk to us like [swear word]" and, "We do not always get support from the nurses, they say they are too busy and some just sit in the office."

We recommend the provider seeks independent advice and guidance to ensure robust systems are in place for the supervision of staff employed at the service and for agency staff to receive a proper induction.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to their admission to the service. People's protected characteristics under the Equalities Act 2010, such as age, disability, religion and ethnicity were identified as part of their

need's assessment. Staff knew about people's individual characteristics.

Supporting people to eat and drink enough to maintain a balanced diet
• People's comments about the food they received was positive. Comments included, "That [lamb] was very good, I ate the lot", "The food is not bad, the meat and vegetables are nice. When I ask for tea and coffee, I get it" and, "The chef comes and talks to us and says, if you want something let me know, I'm happy to do it for you. He does a good job."
• The dining experience for people on Thames and Chelmer House was positive. People were not rushed to eat their meal and where they required staff assistance this was provided in a dignified and respectful manner. The meals provided were in enough quantities and looked appetising.
• This contrasted with the dining experience on Medway and Kennett houses. People were not routinely offered the opportunity to sit at the dining table for their meals. For example, only two people were seated at the dining table on Medway House. Four people were seated either in a wheelchair or a comfortable chair within the communal lounge but were not asked if they wished to sit at the table to have their meal.
• Observations showed that without significant input from people's relatives at mealtimes on Kennett House, staff would struggle to assist people to eat and to receive their meal in a timely manner. The manager was observed to visit Kennett House at lunchtime on the first day of inspection. One relative told us, "I have never seen the manager at lunchtime, this is a pantomime, it has happened because you [Care Quality Commission] have come in. There are more agency staff than regular staff today, I have never seen the agency staff assisting before, but they are today, like a bolt out of the blue."
• Although the lunchtime meal on Medway House commenced at 12.45pm, the last person received support and assistance from staff to eat their meal at 1.50pm, over an hour later. This was because of the large numbers of people living on Medway House who required staff support and there were not enough staff available to complete this in a timely manner. The manager had visited Medway House at lunchtime and although they put on an apron, did not enquire from staff if they could help and provided no assistance to people using the service.
• Where people were at risk of poor nutrition, their weight was monitored at regular intervals and appropriate healthcare professionals, such as dietician and Speech and Language Therapy Team [SALT] were consulted for support and advice. Nevertheless, improvements were required to ensure information provided by healthcare professionals were updated to the person's care plan.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service worked with other organisations to ensure they delivered joined-up care and support and people had access to healthcare services when they needed it and confirmed their healthcare needs were met. One person told us, "If I'm not well, they [staff] call the senior staff to check up on me, they've sent me to hospital a couple of times, but they talk it over with me first."
• The service was part of the 'Red Bag Care Home Scheme'. This is a new national initiative. The aim is to promote and improve communication and relationships between the care service, ambulance crews and NHS Hospital; enabling relevant healthcare information about a person to be shared.

Adapting service, design, decoration to meet people's needs
• Ghyll Grove Care Home is a purpose-built care home consisting of four individual houses. People had access to a small garden adjacent to each house.
• There were enough dining and communal lounge areas for people to use and choose from within the service, but these were not regularly used.
• People had personalised rooms which supported their individual needs and preferences.

Ensuring consent to care and treatment in line with law and guidance

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Staffs understanding of MCA and DoLS and how this impacted on people using the service was variable.
• Staff asked for people's consent before providing care and support.
• People's capacity to make decisions had been assessed and these were individual to the person. However, best interest decisions were not routinely recorded where people had bedrails in place or a sensor alarm to alert staff if they got out of bed and mobilised within their room.
• Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• People's comments about the quality of care and support they received was variable. Positive comments included, "They're [staff] very good actually, they look after you well. They are caring and kind, not grumpy and miserable", "Most of them are quite smiley and bright, they chat to you and try to make you feel good" and, "The staff are kind."
• Where less favourable comments were made, these included, "The staff are quite good, but some of them get impatient with me, I'm just not very fast these days", "Some staff are better than others. Some of them rush me but others will sit and have a nice chat with me" and, "Some of them [staff] don't really seem to care a lot, some of them take longer with me than others."
• People did not always feel they were treated with care and kindness or feel listened too. This was attributed to inadequate staffing levels at the service, high usage of agency staff and staff not having the time to spend with them.
• People and those acting on their behalf told us they did not always receive regular baths, showers or assistance with their oral hygiene. Information available suggested people's comments were accurate. One person told us, "I would like one [bath or shower], they [staff] give me a wash in bed if you can call it that. I often feel like they're [staff] rushing me. They don't brush my teeth." Another person told us, "I could ask for a bath or a shower if I wanted one, but they don't tend to offer it." When asked about their oral hygiene they told us, "They [staff] brush my teeth, if they feel like it but some just want to get finished quickly." One relative told us, "They don't brush [relative's] teeth and I know because they've had the same tube of toothpaste, it's not going down." This was also attributed to inadequate staffing levels at the service, high usage of agency staff and staff not having the time to spend with them.
• Not all people living on Medway and Kennett House were given the opportunity to spend time within the communal lounge and it was stated to us by relatives and staff that people were 'rotated' during the week rather than this being their personal choice. Relatives comments included, "There's normally only two of them [people who use the service] up in the mornings, maybe three in the afternoon, there's more up today because you're [Care Quality Commission] here" and, "I have a feeling that staff alternate who gets up on which days, they [staff] can't get them all up because they haven't got time."
• The quality of conversations and social interaction was much better for those people who did not have dementia or complex care needs.

Supporting people to express their views and be involved in making decisions about their care
• Staff did not always support people properly to have choice or give information in a way they understood

such as visual prompts to actively involve people to make choices. This referred specifically at mealtimes.
• People and those acting on their behalf had been given the opportunity to provide feedback about the service through the completion of questionnaires.

Respecting and promoting people's privacy, dignity and independence
• People were not always treated respectfully. As already cited within this report, not all people were given the choice or option to spend time within the communal lounge.
• People's privacy was respected. People received support with their personal care in private. Staff were discreet when asking people if they required support to have their comfort needs met.
•People were supported to maintain their personal appearance to ensure their self-esteem and sense of self-worth. People's clothing was coordinated, and people were supported to wear items of jewellery.
• People were supported to maintain and develop relationships with those close to them. Relatives confirmed there were no restrictions when they visited, except at mealtimes, and they were always made to feel welcome. A comment recorded on a well-known care review website stated, "We are always made to feel welcome when we visit, and the staff are friendly and approachable."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People's care and support plans did not show how the service responded to their differing needs in terms of interests, social activity and stimulation. People's personal history was sparse and therefore staff were not provided with a good understanding of the person's past life to help understand them and initiate conversation.
• People living on Chelmer, Medway and Kennett houses were not actively encouraged and supported to take part in leisure and social activities. Comments from people using the service included, "Some days there's nothing to do, it gets boring", "Staff don't have the time to come in and chat with me, the days are very long" and, "There has been enough to do in the past. There was an activity person who went above and beyond but since they left, things have gone pear shaped. I don't see a lot going on." Staff confirmed this as accurate. Comments included, "We [staff] don't do any [activities]. I would do them, but I don't have the time. Sometimes we have entertainment come in, but there should be something every day" and, "We [staff] acknowledge it's a big problem within the home, there's no excuse, I know."
• The above contrasted with Thames House. Staff were observed chatting with people and supporting them with social activities. These included, board games, jigsaws, people looking at newspapers and magazines of their choice and some people having a manicure.

We recommend the provider consults with and uses a reputable source to support them in identifying activities which people are interested and able to participate in. For example, Alzheimer's Society, the Social Care Institute for Excellence and the National Institute for Health and Clinical Excellence.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
• People with more complex needs did not always receive personalised care which was responsive to their needs.
• Care plans were not as up to date and reflective of people's current care needs. The lack of up to date and accurate information placed people at potential risk of receiving inappropriate care.
• Where people could be anxious and distressed and exhibit inappropriate behaviours towards others, information relating to known triggers and specific guidance for staff on how best to support individual's, required improvement. Where information was recorded relating to specific incidents, evidence of staff interventions to demonstrate the support provided and outcomes was not always recorded.
• The care file for one person recorded them as having a religious faith which could impact on their health

and wellbeing should they require significant medical attention. Information relating to the person's or their family member's wishes were not recorded and there was no guidance for staff about what to do should the person's healthcare needs deteriorate.
• Record keeping relating to the delivery of care provided, required improvement as it was difficult to determine if people's needs were being met. Though there was no impact on people using the service, improvements were needed to ensure monitoring records, for example, information relating to food and fluid charts were consistently completed by staff.
• We found no evidence to suggest that people who required end of life care support received poor care. However, care plans relating to people's end of life care were not sufficiently detailed to include people's preferences relating to their protected characteristics, culture and spiritual needs and required improvement.

We recommend the provider seeks independent advice and guidance to ensure robust arrangements are in place to record people's care and support needs.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• We did not see enough evidence of how AIS had been applied. The activity programme and menu were not in an easy read or large print format to enable people with a disability, living with dementia or sensory loss to understand the information.

Improving care quality in response to complaints or concerns
• Several people told us they did not know who the manager was and seemed unsure who they should speak to if they had a concern or complaint.
• Where people had raised concerns, these had been responded to in an open and transparent way.
• Compliments were readily available to capture the service's achievements.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection to the service in February 2019, effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and they were still in breach of regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The leadership and overall management of the service did not ensure it was consistently well-managed and led.
- Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. Specific information relating to this is cited within this report and demonstrated the provider's arrangements for identifying and managing shortfalls and areas for development were not robust and required significant improvement. There was a lack of understanding of the risks and issues and the potential impact this had on people using the service.
- People's comments about the management of the service were variable and suggested not all people using the service received positive outcomes. People and those acting on their behalf told us staff shortages, high agency use, and lack of social activities had a detrimental impact on the service and the quality of care people received.
- Staff comments included, "I don't feel valued by the organisation, I don't know why, but I don't. Nobody says anything to you" and, "There is no support really."
- Lessons were not learned as failings identified had not been addressed by the provider to make the required improvements.
- Audits completed did not always have an action plan in place, identifying the areas for improvement and the actions to be taken to make the required improvements. Where action plans were in place it was not always possible to determine if required actions had been addressed as no information was recorded.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Since our last inspection to the service in February 2019, a new manager and deputy manager had been

appointed. The manager was not registered with the Care Quality Commission.
• Not all people spoken with knew who the manager was. One relative told us, "I don't know what positions people have, it would help if I did know who was in charge. I'm not sure if I've seen them or not." Staff confirmed they rarely saw the manager visit the individual houses. Comments included, "When you're the manager you've got to make yourself known." Staff told us communication with the manager was poor. One staff member told us, "[Manager] doesn't say anything to you, it's like you're invisible. [Name of manager] doesn't communicate unless they need something."
• Roles, responsibilities and accountability arrangements, although in place within each house, were not effective on Chelmer, Medway and Kennett House. Staff did not feel all qualified nurses or house managers were effective role models.

Effective arrangements were not in place to ensure good governance and oversight of the service. This demonstrated a continued breach of Regulation 17 of the Health and Social Care (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Meetings were also held for people using the service and for those acting on their behalf, to enable them to have a 'voice'.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. However, although staff told us meetings were regularly held and they had a 'voice', little change or improvements made were noted.

Working in partnership with others
• Information available showed the service worked in partnership with key organisations to support care provision and joined-up care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the quality of the service and to ensure compliance with regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective arrangements were not in place to ensure there were sufficient staff available to meet people's care and support needs and there was an over reliance on agency staff.