The Abbeyfield Kent Society

Abbeyfield Edward Moore House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
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?	**Requires improvement**

Overall summary

The inspection was carried out on 19 and 23 November 2015. Our inspection was unannounced.

Abbeyfield Edward Moore House is a care home providing accommodation and personal care for up to 39 older people. At the time of our inspection 27 older people were living at the home, many of whom were living with dementia. Some people had sensory impairments and some people had limited mobility.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

There were not enough staff deployed to ensure that people received care and support in an effective and timely manner.

People were not protected from abuse or the risk of abuse. The manager and staff were aware of their roles and responsibilities in relation to safeguarding people; however, safeguarding incidents had not always been appropriately reported to the local authority and CQC.

Risks to people's safety and welfare were not always managed to make sure they were protected from harm. Accident and incidents were not always thoroughly monitored, investigated and reported appropriately. Risk assessments lacked detail and did not give staff guidance about any action staff needed to take to make sure people were protected from harm.

Medicines were not always appropriately managed. The temperature of the medicines storage area exceeded safe levels. People's prescribed creams and lotions had not always been stored securely.

Some areas of the home were not clean. Some areas of the home had a strong odour of urine, slings that were used to hoist people smelt of stale urine.

Systems to monitor the quality of the service were not effective. Audits identified areas where action was required. However, action taken to remedy quality concerns was not timely. Policies and procedures were out of date, which meant staff didn't have access to up to date information and guidance.

Staff had not all received training relevant to their roles. Staff had received supervision and good support from the management team.

People had choices of food at each meal time which met their likes, needs and expectations. However, guidance from professionals had not been followed to assist a person with swallowing their food.

People did not always have activities planned to meet their individual needs, there were limited activities on offer. People had expressed they wanted activities and trips outside of the home.

Effective recruitment procedures were in place to ensure that potential staff employed were of good character and had the skills and experience needed to carry out their roles.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority, these had been authorised. Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff supported people to do as much for themselves as possible to help them maintain their independence. People were treated with dignity and cared for in the privacy of their own rooms.

Visitors were welcomed at the home at any reasonable time and people were able to spend time with family or friends in their own rooms or in the communal areas of the home. People's information was treated confidentially and personal records were stored securely

Staff understood their roles and responsibilities. The staffing and management structure ensured that staff knew who they were accountable to.

People were supported and helped to maintain their health and to access health services when they needed them.

People and their relatives knew who to talk to if they were unhappy about the service. People's view and experiences were sought during meetings and surveys. Relatives were also encouraged to feedback about the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

People were not protected from abuse or the risk of abuse. The manager and staff were aware of their roles and responsibilities in relation to safeguarding people. However, safeguarding incidents had not always been appropriately reported to the local authority.

Risks to people's safety and welfare were not always managed to make sure they were protected from harm.

There was not enough staff deployed in the home to meet people's needs. Effective recruitment procedures were in place.

People's medicines were not always well managed.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff did not have all the essential and specific training and updates they needed. Staff did receive supervision and said they were supported in their role.

People were offered a choice of drinks and food. However, dietary advice given by healthcare professionals was not always followed.

Staff were aware of the Mental Capacity Act 2005. Where people's freedom was restricted Deprivation of Liberties Safeguards were in place.

People received medical assistance from healthcare professionals when they needed it.

Is the service caring?

Requires improvement

The service was not consistently caring.

Care provided was task orientated

People were treated with dignity and respect. People's confidential information was respected and locked away to prevent unauthorised access.

People were involved with their care. Peoples care and treatment was person centred.

Relatives were able to visit their family members at any reasonable time.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were not always provided with personalised care and did not have access to activities to meet their needs.

Summary of findings

People's and relatives views were gathered but feedback had not always been acted on.

The home had a complaints policy, this was on display in the home. The provider had responded to complaints in an appropriate manner.

Is the service well-led?

Requires improvement

The service was not consistently well led

Systems to monitor the quality of the service were not effective. Action taken to remedy quality concerns was not timely. Policies and procedures were out of date.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately.

The provider was not always aware of their responsibilities. They had notified CQC about important events such as injuries resulting from accidents and Deprivation of Liberty Safeguards (DoLS) applications but safeguarding concerns had not been reported appropriately to the local authority or CQC.

Abbeyfield Edward Moore House

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 23 November 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

Before the inspection, we reviewed previous inspection reports and notifications before the inspection. A notification is information about important events which the home is required to send us by law.

We spent time speaking with 15 people, eight relatives and two visitors. We spoke with 12 staff including care staff, senior care staff, the cook, the handyperson, the head of quality assurance and head of compliance and assurance from the provider's head office. Some people were not able to verbally express their experiences of living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions with people and observed care and support in communal areas.

We contacted health and social care professionals to obtain feedback about their experience of the service.

We looked at records held by the provider and care records held in the home. These included five people's care records, risk assessments, staff rotas, five staff recruitment records, meeting minutes, policies and procedures.

We asked the care coordinator to send additional information after the inspection visit including feedback from surveys and training records. The information we requested was sent to us in a timely manner.

We last inspected the service on the 12 August 2014 and there were no concerns.

Inadequate

Is the service safe?

Our findings

Most people told us they felt safe at the home. Comments included, "Oh yes, it is all safe"; "I'm not frightened of anybody"; "Yes, I feel safe here" and "I would think that I'm safe, but you never can tell, can you" One person said they felt safe, "Apart from when (another person) is about at this end" of the building. Two people talked about raised anxiety levels caused by one person who could be aggressive and violent towards people and staff. We observed that some people were afraid of one person who could become confused and anxious, this person was observed approaching other people, shouting and waving their walking stick.

Relatives felt that their family members were safe at the home. Comments included, "Yes, she is safe. We looked at an awful lot of Homes with this in mind"; "A lot safer than she was at home"; "She is very safe here" and "I can walk out of here and feel that she is okay. Well looked after and safe". However one relative was less sure that their family member was safe, they explained that, "He is left alone a lot. No one talks to him". They went on to explain that the staff did not seem to know their family member well and needed prompting to check the records relating to health concerns.

Relatives remarked that the home was clean and tidy. One relative said, "All is spotless. It is cleaned every day and the bed is stripped on Fridays". Another relative told us, "It is all clean all of the time. I see the cleaners each morning".

There did not appear to be sufficient staff on duty throughout the first day of our inspection. The home had one member of care staff allocated to each of the four units in the home. Two staff were allocated to work between two areas as floating staff. Staff allocated to work within the units had to wait for the floating staff to assist them with care and support for people that needed assistance. We observed that this resulted in delays for people receiving care and support, food at mealtimes and periods of heightened anxiety which people may find challenging. One person continually asked for a period of one hour to go to bed, staff members tried to encourage the person to stay up longer to have food and drink. The staff recognised that the person was becoming distressed and offered reassurance that they would support them to go to bed. They explained to the person that they would have to wait until a staff member became free to help them.

During the morning we heard an agency staff member asking another staff member for help as they were concerned that it was 11:50 in the morning, they had not supported one person to get up out of bed as they needed another person to help them. There were a number of staffing vacancies which were covered by agency staff. We spoke with the care coordinator about our concerns and they agreed that the level of staffing was not meeting people's needs. The staffing had increased on the morning of day two of our inspection as a result of the feedback we had given. However the senior staff had not been able to find additional agency staff to provide higher staff levels to meet people's needs for the afternoon shift. This meant that people were again subjected to delays in receiving their care and support. One person said "I can get anxious" and talked about having to wait to be transferred on to the toilet in the mornings, because the stand aid was in use downstairs and the staff had to wait for it to be free, to assist the person. The person added "They need another one up here".

Comments from people, relatives and visitors were made about the staffing levels. People told us how it affected them. One person told us, "They've never time to sit and talk". A relative said, "There were moves to take them into the garden more, but there are not enough staff. They do all they can, but there are not enough". Another relative said, "They work so hard, but there are not enough of them to do everything" and another relative said, "There are not enough staff, there was a shortage". One relative was very concerned about the use of agency staff. They said, "I have complained about the agency staff to the manager. The floater is not always here and there have been so many agency lately. There are always excuses: holidays, people off sick. It is always the same".

The number of staff employed was not based on an analysis of how much time was needed to provide appropriate levels of care and activities for people.

The example above was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had completed safeguarding adults training. 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 had access to the providers safeguarding policy which detailed that staff should follow

the local authorities 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. The manager detailed to us during the inspection incidents that had happened that had not been reported to the local authority or the Care Quality Commission. Records of incidents in the home that we looked at confirmed this. The provider had not appropriately reported alleged safeguarding concerns, incidents, had not followed the local authorities' policy. They had not put in place systems to protect people when incidents had occurred. This meant that effective procedures were not in place to keep people safe from abuse and mistreatment.

The example above was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a trained staff member administering people's medicines during the home's lunchtime medicines round. The staff member checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. The medicines trolley was locked when the senior staff left it to administer medicine to someone. People were asked if they were in pain and whether they required PRN (as and when required) medicines. The staff member giving out medicines told someone that they could not have their Co-Codamol yet as they had had their morning dose late. The person agreed and said, "When can I have it". The staff member replied, "When I know it's been four hours, I'll come and find you". This evidenced that the staff member was following the maximum dosage instructions and guidance relating to pain relief to ensure the person was not overdosed. Medicines were mostly given safely. Staff discreetly observed people taking their medicines to ensure that they had taken them. However, staff did not check that people were ready to have their medicines before they dispensed them from the original packaging or the pharmacy filled aid. This meant that medicines were then put back on the trolley in a medicines pot with a note. This increased the likelihood of medicines errors. Medicines errors and incidents had been appropriately reported and guidance sought from medical professionals.

The temperature for the medicines fridge was not always checked daily and it had been colder than two degrees and warmer than eight degrees on several occasions. This was also picked up in the audit carried out by the pharmacy in June 2015. No action had been recorded to demonstrate what had been done to prevent this from happening. Medicines stored over a certain temperature for a long period of time may lose its efficacy and cause people harm.

Prescribed creams, lotions and ointments were not always locked away to prevent misuse. Each person had a small cabinet located in their bedroom to store creams to ensure they were accessible to care staff who were responsible for administering these. We found some of these creams on display in people's rooms. The medicines policy detailed that people would have 'As and when required' (PRN) protocols in place to describe their needs. People did not have individual PRN protocols in place, which were prescribed medicines as required. Staff trained to administer medicines said that they asked people if they wanted them and if they said yes, then they gave them. This meant that people unable to effectively communicate their needs may not receive PRN medicines when they needed them.

This failure to manage medicines effectively was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was mostly clean, tidy and free from offensive odours. However, some commodes located in people's room were not clean, they were stained and dirty. One hoist store room upstairs had a very strong odour of stale urine. We found several slings hanging up in the corner of this store room which smelled strongly of stale urine. These slings had not been washed after they had become soiled which increased the risk of infection to people and staff. There was a strong unpleasant odour of stale urine in one area of the home. The flooring within the bedroom was not suitable to meet the person's continence needs as it could not be easily cleaned.

This failure to protect people from the risk of infection or to maintain a clean environment was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adequate procedures were not in place to ensure that staff could evacuate people in the event of a fire. People living in the home were not able to use the stairs and relied on the

Inadequate

Is the service safe?

lift. The lift could not be used in the event of a fire. Evacuation chairs were not in place in the stairwells to aid evacuation of people living on the top floor of the home in the event of a fire. The Regulatory Reform (Fire Safety) Order 2005 states that 'In the event of danger, it must be possible for persons to evacuate the premises as quickly and as safely as possible'. The provider had not considered how the people living on the top floor of the home could safely be evacuated.

This was a breach of Regulation 12 (1) (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been undertaken to ensure that people received safe and appropriate care. Risk assessments included a list of assessed risks relating to day to day support and activities. For example, risk assessments were in place to provide staff guidance with pressure area care, moving and handling, self-neglect, nutrition and hydration and choking. Risk assessments gave clear guidance to staff about safe working practices. Some risk assessments were reviewed regularly, however some had not been updated to reflect on incidents and accidents that had happened. For example, one person had frequently become physically and verbally aggressive with other people. The person's risk assessment detailed that they may start to shout or raise their walking stick. It did not detail that the person had physically pushed people over. The person's care plan and risk assessments also detailed that they benefitted from a non-English speaking staff member. Rotas showed that this was not always available and staff confirmed this. Staff were not always able to provide care which was safe which met each person's needs.

We observed that one shower room in one area of the home had a steep slope leading to the shower, there was no barrier to prevent people falling off the side of this slope. The handy person explained that this shower room was due to be replaced and a flush floor shower fitted which would reduce the risk to people using the shower room. Appropriate measures had not been put in place to minimise the risks of people using the shower room until the new shower was installed.

The failure to do all that is reasonably practical to mitigate risks to people was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff followed control of substances hazardous to health (COSHH) guidance to ensure that cleaning products were safely stored and used.There was a sluice room in every unit in the home, however not all had pedal operated bins in place. The handyperson showed us that pedal bins had been sourced from another home. These were being stored outside and were waiting to be cleaned before putting these in place. Staff had access to personal protective equipment (PPE) and were seen wearing this when they carried out tasks that required this to be used.

Recruitment practices were safe. All staff were vetted before they started work at the service through the Disclosure and Barring Service (DBS) 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. Staff employment files showed that references had been checked. Application forms showed a full employment history.

The home had been suitably maintained. The handyperson explained they were in the process of decorating areas of the home, which included empty bedrooms and corridors. People and their relatives gave positive comments about the maintenance. They told us, "When the boiler broke, they issued the plug in heaters straight away". People gave examples of the handyperson being responsive to fixing things when they broke. Such as replacing a bedroom door handle when it broke. The fire alarm system had been checked regularly to ensure it was working correctly. This was tested weekly.

Requires improvement

Is the service effective?

Our findings

People told us that their health needs were well met. People told us, "When I first came here, I put on weight. I had a dietician come to see me and I changed things"; "A doctor comes in. He is due in to see me today"; "If I want a doctor, they call one for me" and "They always put the cream on my skin". People also told us that the food was good and they could always ask for more food if they wanted it. Comments included, "It is very good food here"; "It is all right. They give you what you want"; "I can have a cooked breakfast"; "The cooked breakfast is the best meal and then it's the meal of the day"; "The food is good. There is plenty. A choice at lunchtime and you can have what you want for breakfast" and "It is all right really, and you can always ask for more of it". One person told us "The food is horrible".

Relatives were mostly positive about the healthcare their family members received. Relatives told us, "They call a doctor straight away and then call us as well, if she is ill". A relative explained that their family member's health was, "Deteriorating now, they always get the doctor. They absolutely understand her condition here. I don't have to worry and rush in here". Some relatives gave us negative feedback about the healthcare; they explained that action to address health issues had not been timely. They said that staff had not fed back to them changes in their family member's health such as refusing medicines, not being able to swallow tablets and concerns around mouth care. Relatives gave positive feedback about the food. Comments included, "The food looks excellent, I think. She eats it"; "More of a choice now" and "Well, it looks okay and it is nice and hot when it comes". One relative said, "Lunch is too early as breakfast can be late, but there is plenty of food, too much, sometimes".

Most staff had received training and guidance relevant to their roles. Training records evidenced that 41 out of 50 staff had attended health and safety training. Moving and handling training had been attended by 37 out of 50 staff, two staff were new so had not completed this yet. Forty six staff out of 50 had attended dementia awareness training. There was a rolling programme of training planned throughout the year, which included four dates for dementia training later in November 2015. Staff had not attended epilepsy training, despite providing care for people who were diagnosed with epilepsy. We spoke with staff about their understanding of epilepsy and types of seizures. They did not have suitable understanding and awareness, they did not recognise that seizures take a number of different forms or how to respond. This put people at risk because staff did not recognise when people were having seizures.

Failure to provide suitable training to meet people's needs is a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff were working through the care certificate as part of their induction. They were completing their induction with the support of the senior carers and care co-ordinator. Weekly meetings were held to go through each module of the care certificate to check progress. Staff told us that they had opportunities to complete qualifications. A number of staff were in progress with their qualification. Staff received regular supervision from their line manager and annual appraisals, during which they and their manager discussed their performance in the role, training completed and future development needs. Staff felt they received good support from the management team in order to carry out their roles.

People had choices of food at each meal time and chose to have their meal in the dining room or their bedroom. People were offered more food if they wanted it and people that did not want to eat what had been cooked were offered alternatives. For example, one person had a cheese sandwich for lunch instead of turkey, potato and vegetables. People were offered a range of drinks with their food. At lunchtime, the previous day's menu had been displayed in some areas of the home; staff explained that this was because someone had written on the white board with a permanent pen. The previous day's food had been a meat or fish dish. On the day, the choice was a turkey dish or a 'sausage plait'. This had been rectified by the second day of inspection.

A senior staff member told us that the home had been trialling earlier meal times for people who required assistance with eating which enabled staff to provide dedicated time to assist them. Some people had to wait for their meals. We observed one person waiting for support. There was one staff member allocated to this area of the home. The staff member helped the person once the other people were eating. The staff member could not watch everyone at the same time and therefore hadn't noticed

one person eating from a knife. We observed that people who required assistance with their meals got their meals at the same time or after others. One person's care plan detailed that they should have soft mashed food, following advice gained from the speech and language therapist (SALT). They were given the same food as everyone else. The same person had eaten their breakfast at 12.15. They were given lunch at 13:00. Staff had not recognised that they had just eaten breakfast and did not suggest encouraging the person to have their meal later on.

This was a breach of Regulation 14 (4) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Snack boxes were available to people throughout the home, containing a variety of snacks including chocolate bars, biscuits and fruit. A relative commented positively on the new snack boxes, "Even grapes were included" and there was "Always tea, juice and milk shakes". When people required their food and fluid intake to be monitored this was being done regularly and consistently by the staff. People had been weighed monthly to monitor if they gained or lost weight and action was taken as a result of these checks.

The staff we spoke with had a clear understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for two DoLS and these had been processed and approved by the local authority. DoLS applications had been made in relation to people who lacked the capacity to make decisions about their care and residence and, under the responsibility of the state, were subject to continuous supervision and control and lacked the option to leave the home. Care files showed that mental capacity assessments had been carried out.

The community nurse felt that their role in delivering healthcare to people was facilitated by the attitudes of the staff at the home. The nurse felt that staff were, "Lovely to me and helpful" and they "Try their best, they take residents to their rooms for me, they work hard". People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Staff spent time with people to identify what the problem was and sought medical advice from the GP when required. People confirmed that they were seen by the GP when they needed it. Records evidenced that staff had contacted the GP, district nurses, social services, community psychiatric nurse and relatives when necessary. Staff had called 111 for advice and guidance when people were unwell or when they had fallen. Ambulances had been called when people needed medical attention.

Adaptations to the premises had been made to meet the needs of people with dementia. There was clear signage to help people identify what certain rooms such as toilets and bathrooms were for. Toilet doors had all been painted a certain colour to help people locate them.

Requires improvement

Is the service caring?

Our findings

People told us that Abbeyfield Edward Moore House staff were kind and caring towards them. Comments included, "They are not rude at all"; "There is nowhere nicer. They are very kind to me"; "They put my pictures up, my favourite football bits. They are good people here"; "The staff are brilliant. They look after me"; "They are very nice to me. The night staff are nice, too. They look in"; "The staff are mostly okay, the agency staff are terrible. I have never known staff so bad" and "Everybody knocks here. And they call me by my first name, which I like".

Relatives told us they felt welcome in the home. Comments included, "You can come in right up until late in the evening if you want to. You are always welcome"; "Sometimes I've had to wait for them to open that door for up to 20 minutes. But that's all. Otherwise we are all welcome" and "I can come in late. It never feels awkward at all. We are all very welcome at any time". The home had signs welcoming visitors and encouraging them to make hot drinks. Relatives also told us that staff were kind and caring towards their family member. Relatives said, "The carers are really all good. They are so kind to her. They have a knack with her. She has a great big smile for the carers and she is always clean and tidy and well turned out whenever I come in. It is such a lovely, friendly home"; "We are very happy with the care. They are great, friendly staff, totally approachable"; "They treat them so well on their birthdays, with banners, cake and everything" and "I am very happy with it all here. They are really good to her here. They are all polite and so patient with her. They all do their best for her". One relative who had a few concerns said, "She gets quite good care here, but I feel I have to visit frequently".

We observed that staff interacted with people throughout the day. However this interaction was sometimes focused on care tasks rather than general discussion. For example, one staff member turned a person's chair around, speaking only briefly to them. Another person became distressed, and said that they wanted to go home, but did not know how to. The staff member in the room at the time did not stop their writing to offer reassurance to the person. We observed that staff provided reassurance to people when there had been altercations between people, this was reactive to the situation and often difficult to manage when the person required a staff member who spoke their preferred language.

People were supported to make decisions and choices and these were respected. Where people were able to, they had signed their care plans and completed their own information so that staff knew about their history and people important to them and their lives. This showed they were actively involved in their care and support.

People were supported to be involved in their community, community groups visited the home, such as singing groups, the brownies and the Red Cross. People spoke highly of the hair dresser that provided a service from the salon on the upper floor of the home. The hairdresser visited the home on a weekly basis. Some people continued to use the hairdressers they had used previously. One relative told us "There's a good hairdresser coming in". One person showed us their manicured nails which their relative said had been done at the home. The home catered for people's spiritual needs. Religious services were displayed on the noticeboard. There was a Christian ethos to the home, with prayers and a cross displayed in the reception area. Posters displayed on the walls advertised a Christmas service and Christmas community events. We met a nun who explained they visited the home on a weekly basis to meet the needs of people. This was promoted on a notice. Staff explained that one person was supported by family members to worship at the Guru Nanak Darbar Gudwara temple which was situated opposite the home.

People's bedrooms were decorated with their own furnishings. The doors to people's rooms had their names on to remind people whose room it was. Some thought had been given to individual bedroom settings where possible. One person had asked to be moved to the ground floor because they found it difficult to live with one person on the upper floor. People were able to bring in personal items to help make the bedrooms more personal and all were able to watch TV in their bedroom if they wished or in the lounge if they chose. Some bedrooms had ensuite shower rooms and toilets which meant that people's personal care was carried out in the bedrooms. Those rooms without an ensuite had communal bathrooms close to their rooms. All bedrooms had wash basins for the sole use of the person.

People's privacy was respected. We observed staff knocking on peoples doors before entering, even when the door was open. Staff gave detailed description of when they provided care and support they ensured that they talked to the

Requires improvement

Is the service caring?

person to find out what their choices were and ensured that people were covered up to protect their dignity. One staff member said they "Close curtains, close doors and cover with towel" when providing personal care to people.

We observed that people who required assistance to move from chairs to wheelchairs in communal areas were supported by staff who were mindful of protecting people's privacy and dignity. Screens were put up to prevent other people watching. Relatives who had seen their family members transferred by staff using a hoist commented that they were happy with the way in which this was carried out.

One relative said, "They always have two people. They try hard and they tell her about it, but she still doesn't like it". Another relative told us, "I've seen it, they use two to do it and they tell her what is happening".

People's information was treated confidentially and their personal records were stored securely. People's individual care records were stored in locked cupboards in each dining area of the home to make sure they were accessible to staff. People's main files were stored in the office area. Staff files and other records not required on a day to day basis were securely locked in cabinets within the offices to ensure that they were only accessible to those authorised to view them.

Requires improvement

Is the service responsive?

Our findings

People told us that staff were responsive to their care needs. Comments included, "The nurse comes to help me. There's not long to wait"; "Sometimes we might have a bath, but otherwise it is a wash down. There are other people, you see"; "They [staff] are always around"; "They help me in the bath, no problem, when I like" and "I have showers I like that much better. They say when it is time to go to bed. We wait till then".

Relatives told us they had been invited to care plan reviews. One relative said, "We have to go through her care plan soon. I want to go through it and look at her risk assessment. I am sure they will let me look when I want to". Relatives knew who to talk to if they were concerned about care. A relative who had raised a complaint said the complaint had been handled really well, "I always say if I have concerns". Two relatives had made complaints relating to care provided by agency staff. Some relatives had concerns about the responsiveness of the service, they gave us examples of when they had not been notified of significant events such as their family members falling out of bed and out of character behaviour. One relative said, "They catch me when I come in, but they don't phone much. It is not as good as it used to be".

We gained feedback from people about their activities. One person told us, "It gets boring here, and there is nothing to do" and "I haven't been anywhere since I came in". Other comments included, "There's not really much to do. I might do some reading". Relatives said, "There are not enough carers for outings"; "There are not enough activities at all"; "A carer provided the parachute [a game] herself. They liked that"; "There is not enough stuff to do. She gets bored" and "They do try to do things but she doesn't want to do much". One relative said they would like to see more entertainers coming in to the home.

People didn't always have enough to keep them occupied. The activities plan for the month was displayed on notice boards. The activities planned for the day was a quiz. The activities schedule showed that there was one planned activity each day of the week. Some of these activities listed people's birthdays as an event. Activities included easy listening music, keep fit with balloons, nail care and one to one chats, movie day, cards and dominoes and bingo. Very few activities were observed during the inspection. The activities co-ordinator helped a person with a jigsaw, and also ran a group activity quiz which involved people thinking of names. Some people had newspapers delivered daily. One staff member told us, "Last year we had lots of visits from PAT (pets as therapy) dogs, but this year none".

We spoke with the activities co-ordinator and senior care staff and examined the activities calendar to see how people were supported to engage in social, educational or occupational activities. The home had introduced a system called 'Wish Tree'. People had expressed wishes which the staff were going to work to achieve. The wish tree was displayed on a wall, it showed that many people wanted to go out. The activities co-ordinator explained that they had organised for lots of new activities which involved community groups coming in to the home, such as schools, dance groups and singers. Trips had been displayed on the notice board, advertising a lantern parade at a local religious site. One staff member said they were "Trying to organise a bus so people could see the Christmas lights". The activities co-ordinator explained how they were booked to attend a course to help them identify and explore more activities for people.

The examples above showed that the provider was not providing care or activities for people in a responsive or person centred way. This was a breach of Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

'Residents' meetings were held. We looked at the last meeting records which had taken place on 4 November 2015. People were able to contribute to the meeting and to make suggestions concerning their welfare and future service provision. The meeting minutes showed that special birthdays were discussed as was a planned trip to see the Christmas lights in the community and new menu boards. People were asked if they were happy living in the home, all those present said they were and had no complaints. People had been asked for feedback during meetings and had been given satisfaction surveys to complete. People had been asked about the general cleanliness of their rooms and other facilities, choice of leisure facilities available and how well their privacy was met. The feedback gained was positive. Everyone who lived upstairs said it was excellent. People living downstairs had also said it was excellent but added that the decoration was poor, due to bad furnishings.

Requires improvement

Is the service responsive?

Relatives meetings were also held giving relatives opportunity to feedback about the service. We looked at the last meeting minutes which detailed that relatives had felt confident to address concerns. Minutes of the last meeting had been reviewed to ensure that action points had been addressed.

People's needs were fully assessed with them before they moved to the home to make sure that the home could meet their needs. People's care records contained care plans, risk assessments, and care reviews that had been signed by the person whose care was being reviewed. The care plans included information on; personal care needs, medicines, leisure activities, nutritional needs, as well as people's preferences in regards to their care. Staff had up to date, relevant information to enable them to provide care and support. Each person's care plan detailed their life history, their care and support needs and what they could do for themselves.

The provider had a complaints policy and procedures which included clear guidelines on how and by when issues should be resolved. It contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. The complaints procedure was displayed in communal areas, which meant that people and their relatives knew how to formally complain.

The provider had dealt with complaints appropriately; the registered manager was dealing with one which had yet to be resolved. Complaints had been resolved in a timely and satisfactory manner. Staff we spoke with were clear about their responsibilities in the management of concerns and complaints.

Compliments had been received from relatives and visitors. One received from a visiting paramedic stated the 'Home was pleasant clean and tidy'. Another compliment read, 'A huge thank you to all the staff at Edward Moore Gravesend for the fantastic party they held for my mum to celebrate her 100th birthday'.

Requires improvement

Is the service well-led?

Our findings

People told us the home was well run and the management team were approachable. Comments included, "I've told the manager about (person's name) causing trouble at this end"; "I like him, but it is a shame when you like someone and they go"; "He is a really nice chap. Doing his best"; "He is very friendly and approachable" and "His office door is always open".

Relatives told us that the registered manager had made a difference to the home. Comments included, "Totally approachable"; "On top of the staffing problems"; "He is lovely. He knows all their names. He has really got things moving here. He has had all the lounges redecorated and rearranged furniture to make it more cosy". One relative explained that there had been three managers within 11 months.

A healthcare professional told us, "The manager is excellent, he both listens and attends" and "Sometimes he has to assist on the floor which is not really good. The higher management need to look at staff numbers here".

The majority of policies and procedures were out of date. The policies and procedures had not been reviewed and updated regularly and therefore had not kept up with changes in legislation. Policies relating to the recruitment and selection of staff detail that employment histories will be collected to evidence the last 10 years of employment. This does not reflect the regulations which states that a full employment history must be obtained. There was not a Mental Capacity Act (2005) policy in place. The head of quality assurance told us they were in the process of developing new policies and procedures, these were going to be launched in 2016. This meant that staff did not have up to date guidance and support to follow while delivering care.

Relatives had been sent satisfaction questionnaires in 2014 by the provider. Surveys had not been sent out in 2015. Relatives had logged within these surveys that a number of improvements were needed in regards to activities, staff shortages, food and laundry services. The provider had collated responses to each of the concerns raised. However, some of the concerns that the provider had stated they had addressed were still evident during the inspection, such as lack of staff and activities. This meant that the provider had not dealt with concerns in a timely or effective manner to improve the quality of care.

There were quality assurance systems in place. The management team carried out audits of infection control, health and safety and medicines on a monthly basis. The audit completed by the provider in July 2015 identified a number of areas for improvement. Recommendations had been made within the report and the head of compliance and assurance had developed an action plan. The audit had highlighted some of the areas of concern we found during our inspection. The head of compliance and assurance had revisited the home in November 2015 to check that actions had been completed, they explained that they carried out two follow up visits. The action plan was amended to show that most items had been addressed. However, a number of actions had not been addressed such as; adequate staffing levels, policies and procedures in place for staff, maintenance of the garden area, lack of training regarding end of life care. The updated action plan had recorded that not all people had a 'this is me' person centred plan in their care file.

The examples above evidence a breach of Regulation 17 (1) (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations, deaths and serious injuries. The provider had not always notified CQC or the local authority about safeguarding events that had occurred.

This failure to notify CQC was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Records relating to people's care and the management of the home were stored securely. Records were securely kept. People's care files and personal information had been stored on shelving in the office, which had a key coded lock.

Staff told us they felt free to raise any concerns and make suggestions at any time to the registered manager and knew they would be listened to. Staff told us that they were

Requires improvement

Is the service well-led?

aware of the home's whistleblowing policy and that they could contact other organisations such as the Care Quality Commission (CQC) and the local authority if they needed to blow the whistle about concerns. Posters advising staff how to whistle blow were displayed around the home. Staff meeting records evidenced that staff discussed a range of subjects and felt confident to ask questions and make requests.

The staff were confident about the support they get from the registered manager and senior staff. The registered manager received support from the provider through regular managers meetings, and monthly supervision. The senior staff meeting records showed that care plans were discussed and the need for seniors to complete a daily 'walkabout'. The meeting records also evidenced that the home was using 'Too much agency staffs. This does not provide continuity of care'. We asked to view the daily walkabout records. The care co-ordinator found that these had not been completed for a week. Seniors meeting records evidenced that issues identified in medicines audits had been discussed to ensure that issues had been addressed and to enable staff to make appropriate changes.

The values of the home were to treat people with compassion, dignity and respect, act with integrity, be people focussed and be open and adaptable. We observed that the staff had embedded these values in to their work.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not ensured that people received appropriate care and activities that met their needs and reflected their preferences.** Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had not established systems and processes to effectively prevent abuse.** Regulation 13 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider had failed to follow guidance prescribed by a healthcare professional.** Regulation 14 (4) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had not ensured that leadership and quality assurance systems were effective to make sure people were safe and they received a good service.** Regulation 17 (1)(2)(a)(b)(e)(f)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not notified CQC of events and incidents without delay. Regulation 18 (1)(2)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks of unsafe care and treatment Regulation 12 (1)(2)(a)(b)(e)(f)(g)(h)

The enforcement action we took:
We served the provider and registered manager a warning notice and asked them to meet the regulation by the 10 February 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured there were suitable numbers of staff deployed. The provider had not ensured that staff were suitably trained and competent to provide safe and appropriate care. Regulation 18(1)(2)(a)

The enforcement action we took:
We served the provider and registered manager a warning notice and asked them to meet the regulation by the 10 February 2016.