Krystlegate Limited

Whitebirch Lodge

Inspection report

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Kent
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Tel: 01227374633

Date of inspection visit:
14 March 2018

Date of publication:
18 April 2018

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?	**Inadequate**

Summary of findings

Overall summary

This inspection was completed on 14 March 2018 and was unannounced.

Whitebirch Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Whitebirch Lodge provides accommodation for up to 19 older people who need support with their personal care. Accommodation is arranged over two floors and a stair lift is fitted to assist people to get to the first floor. There were 16 people living at the service at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider and registered manager lacked oversight of the service. There was no formal system of checks or audits to ensure compliance with the fundamental standards and regulations. At the start of our inspection the registered manager told us they were aware, 'some of their paperwork was lacking' and 'some of their care plans required updating.' Although they had contacted a specialist nurse from the local clinical commissioning group for advice and had updated three people's care plans we found concerns regarding risk and medicine management, staff training and restrictions to people's freedoms had not been appropriately authorised.

Some people had no care plan in place to give staff guidance about what support they needed and risks relating to their care and support had not been assessed. One of these people had developed a pressure sore, and there was no plan in place to help keep their skin healthy. Staff did not monitor the fluid input and urine output of a person's catheter and this had recently become blocked, placing them at risk of an infection. Guidance for staff regarding how people wanted their care to be delivered was also lacking. This limited people's involvement in planning their care and support. No consideration had been made regarding how people wanted to be supported at the end of their lives. Analysis was not completed when accidents or incidents occurred at the service, limiting the opportunities for learning from them and reducing the risk of them happening again.

The lack of guidance and inconsistent approach to the assessment of people's needs meant staff relied on their own knowledge of people to support them. Although most staff had worked at the service for some time, and knew people well, they had not received training in topics specific to people's needs such as pressure care management. Staff had received some training in catheter care and dementia, but most of this was many years ago.

There was no formal system in place regarding the assessment of staff competency. Staff were administering people's medicines without being assessed as safe to do so. This had been identified as a concern in an external audit of a pharmacist in November 2016 and again in February 2018, but no action had been taken to rectify this concern.

Although people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service did not support this practice. The registered manager lacked understanding regarding Deprivation of Liberty Safeguards (DoLS). One person had been assessed as lacking capacity to consent to their care at the service and was unable to leave. This restriction had not been applied for, and appropriately assessed and authorised.

People, their relatives, staff and other stakeholders had been asked their views on the service, but these responses had not been analysed, and areas for improvement recommended had not been actioned.

The electrical system at the service was not safe. A qualified electrician had assessed the safety in September 2017 and identified areas requiring immediate action and these actions had not occurred. Staff had not always been recruited safely. Although there was enough staff on each shift, there were no systems in place to assess how many staff were required if people's needs changed.

People and their relatives were complimentary about the care provided, and said that staff were kind and caring. Staff treated people with dignity and respect and encouraged them to be as independent as possible. Throughout the inspection people were engaged in a range of activities, including a discussion on current affairs and a visit from an entertainer. There had been no recorded complaints since our last inspection, and people told us the registered manager and a representative of the provider were regularly at the service, and were approachable. Staff told us they felt well supported by the provider and met regularly with their line manager.

People were supported to eat and drink enough, and food looked and smelt appetising. People were offered a range of drinks and snacks throughout the day. Healthcare professionals visiting the service told us they worked well with staff, and people were supported to see a doctor if they became unwell. People were supported to lead healthier lives and took part in regular exercise classes.

Staff told us they knew how to recognise and respond to abuse and were confident the registered manager or the provider would take action if they had any concerns. When safeguarding issues had arisen the registered manager had worked with the local safeguarding team.

The provider told us they wanted the service to have a 'family feel' and staff and people shared this vision. Everyone described the premises as 'homely' and people were able to bring pictures and objects in from home to decorate their bedrooms. Small adaptions, such as a stair lift were in place to make the service more accessible. The service was clean and free from odours.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications in an appropriate and timely manner and in line with guidance. The registered manager had displayed the rating from our last inspection in the entrance hall of the service.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Risks relating to people's care and support had not always been assessed and mitigated. The electrical system in the service was not safe.

No analysis was completed of accidents, and no other incidents were recorded, meaning learning opportunities when things went wrong were limited.

Medicines were not always managed safely.

There were enough staff to keep people safe, but there was no system in place to assess how much staff were needed. Staff were not recruited safely.

Staff knew how to recognise and respond to abuse.

The service was clean and people were protected from the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received training in topics related to people's needs. There was an inconsistent approach to assessment, and some people's care and support had not been planned effectively.

Restrictions on people's freedoms had not been appropriately authorised.

People received assistance from a range of healthcare professionals. People were supported to lead healthier lives and took part in regular exercise classes.

People had enough to eat and drink.

Small adaptions, such as a stair lift were in place to make the service more accessible.

Is the service caring?

Requires Improvement

The service was caring.

Staff were kind and treated people with compassion.

People were encouraged to be as independent as possible.

People were treated with respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a lack of guidance for staff regarding how people wanted their care to be delivered. People's wishes for the end of their lives were not routinely discussed or documented.

There had been no complaints since our last inspection.

People took part in a range of activities within the service and relatives told us their loved ones were 'kept busy.'

Is the service well-led?

Inadequate

The service was not consistently well-led.

The provider and registered manager did not complete any formal checks or audits on the service. They had failed to identify the concerns we found.

The provider and registered manager had failed to adhere to their regulatory responsibilities and ensure compliance with the fundamental standards and regulations.

People, their relatives, staff and other stakeholders had been asked their views on the service, but no analysis had been completed of their responses.

The registered manager had contacted professionals from other organisations and requested assistance with improving the service before our inspection.

The registered manager told us they wanted the service to have a family feel, which staff and people felt was provided.

Whitebirch Lodge

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 14 March 2018 and was unannounced. Two inspectors and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider was not given the opportunity to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the registered manager, one of the owners of the service, three care staff and two senior carers. We spoke with four relatives and a visiting healthcare professional. We looked at six people's support plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys.

During our inspection we spent time with the people using the service. We spoke with eight people. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experiences of care. 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.

After the inspection we spoke with an additional healthcare professional and the local safeguarding team.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "I feel safe in every way; I wear a buzzer and if I press it they come in like a shot." Another person said, "I like it here, I like the feel of the place." A third told us, "I feel safe when I am being hoisted." Although feedback was positive, we found concerns regarding risk management, which left people at risk of harm.

Some people had no care plan or risk assessments in place to guide staff on how to support them. One of these people had developed a pressure sore. No one at the service was able to tell us what grade the pressure sore was, as this had not been documented anywhere. Staff contacted the district nursing team who told them the pressure sore was 'grade two.' A grade two pressure sore is 'an open wound or blister.' There was no plan in place or guidance for staff regarding what support the person needed to manage their pressure area, or how to prevent it from getting worse. We asked staff what support the person needed and were told conflicting information. A senior member of staff told us the person should not be wearing 'plastic over knickers' as this made them sweat, exacerbating the pressure area. Other members of staff told us the person was still wearing these knickers. The person was at risk of their pressure area getting worse, leaving them at risk of avoidable harm.

Another person had a catheter in place. A catheter is used to empty the bladder and collect urine in a drainage bag. A basic care plan had been completed regarding their catheter care, which stated, 'full assistance needed.' There was no risk assessment and no guidance for staff regarding what kind of assistance the person needed. The care plan stated, 'to encourage the resident to have a fluid intake of 1500-2000mls.' Staff did not record how much the person drank or their urine output so were unable to tell us if they had been drinking the recommended amount. On the morning of the inspection staff had contacted the district nurse as the person's catheter was blocked. As there was no monitoring of the person's input and output they were unable to tell us how long they believed the catheter had been blocked for. A blocked catheter can pose a risk to a person of infection and other problems.

Some people were supported to use paraffin based creams to help keep their skin moisturised. Paraffin based creams can lead to an increased risk of fire, as they are highly flammable. There were no risk assessments in place regarding the use of these creams and no monitoring to check if the creams had soaked into people's bedding or clothes, further increasing the inflammation risk.

The registered manager lacked oversight regarding risks and did not complete any analysis when accidents occurred. Staff documented when people fell, and we were told there were no other accidents or incidents at the service, however we saw instances in people's daily notes when they had become distressed 'and been a risk to themselves and others.' Staff had contacted medical professionals, but no incident form had been completed regarding this incident so no analysis had been completed. A 'falls diary' was completed and located in people's files, which listed the falls which people had experienced, but no analysis was completed regarding these falls, to look for trends or patterns or ways of reducing the risk of the person falling in the future.

The electrics of the service were not safe. An inspection of the electrical installation had been completed on 27 September 2017 and been assessed as 'unsatisfactory.' There were 28 separate areas that required remedial works. Including one listed as, 'C1 (danger present – immediate action required)' and 27 listed as 'C2 (potentially dangerous – urgent action required).' This work had not been completed, over five and half month after the inspection had been completed, leaving people at risk if the electrics did not work or caused a fire. We discussed this with the registered manager and they contacted an electrician during the inspection. They emailed us after the inspection to confirm the works had been completed.

There was a fire risk assessment in place and people took part in regular fire drills. There was clear guidance for staff and each person had an up to date PEEP in place. A PEEP is a personal emergency evacuation plan, which outlines people's individual needs and how they should be supported to leave the service in an emergency.

Staff had completed training in 'medication awareness,' however, there was no system in place to assess their competency and ensure they were safe to administer people's medicines. We discussed this with a representative of the provider, and they told us they were 'regularly present' at the service and would be 'aware of any issues,' but confirmed there was no formal system in place to observe staff. This had been identified in audits from an external pharmacist in November 2016 and again in February 2018, but no action had been taken to rectify this issue and ensure staff had the skills and knowledge in place to administer people's medicines safely.

Staff did not record the temperature where medicines were stored. If medicines are stored in a room where the temperature is too hot or too cold this can impact on their effectiveness. Without monitoring of the room temperature it was impossible to assess if medicines were stored safely. Staff told us they recorded the temperature of a fridge used to store medicines, however this only occurred intermittently. Between 1 and 14 March there were seven days when no temperature had been recorded.

The registered manager and the provider had failed to identify, assess and mitigate risks relating to people's care and support. Medicines were not managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us they received their medicines as and when they needed them. One person said, "My medicines arrive bang on time every day." Medication administration records (MARs) were fully completed and there were no gaps, indicating people received their medicines regularly. Handwritten MARs had been double signed to show they had been checked by a second member of staff and were correct. When people were prescribed medicines on an as and when basis, for example, for pain relief there was clear guidance in place for staff regarding when and how much of their medicine should be administered.

Staff were not recruited safely. We reviewed three staff files and full recruitment checks had not been completed. The registered manager and provider had failed to gain a reference from one staff member's last place of employment. There were no interview notes on file to confirm they had been assessed as having the skills necessary to start employment. Two staff members employment history was not date specific and contained only years and not months, and no one had verified if their employment had been continuous.

The provider and registered manager had failed to ensure staff were recruited safely. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Our observations showed that there were enough staff on duty to meet people's needs, and staff did not appear rushed. A relative told us, "Staff always come quickly when [my loved one] needs them." Although

there seemed to be enough staff there was no formal method of assessing how many staff were needed for each shift. There were three members of care staff on shift between 7:30am and 8:30pm each day. Outside of these hours there were two staff members of available. Feedback from healthcare professionals told us that people's needs were increasing as they became older, and more frail. The registered manager told us they adjusted the number of staff, depending on anecdotal feedback. However, without a system in place to assess the number of staff required, particularly if people required more assistance as their mobility decreased or if they were unwell, for example, there was a risk the number of staff may not be sufficient.

We recommend that the provider and registered manager seeks advice from a reputable source regarding assessing the level of staff required in relation to people's needs.

Staff knew how to recognise and respond to abuse. One member of staff told us, "I would take action if I noticed any signs of unusual bruising, for example. I would report it to the manager. If necessary I could whistleblow, I could also report directly to social services if needed." When potential safeguarding incidents had occurred the registered manager and senior staff had worked with the local authority safeguarding team. People were treated equally and staff worked to prevent discrimination.

The service was clean and free from odours. One person told us, "It is clean, very tidy and we have good meals here. The girls are good. There is nothing I don't like about this place." A relative said, "The thing that is obvious is how clean it is. It is absolutely spotless." Staff had received training in infection prevention and control and wore personal protective equipment when necessary.

Requires Improvement

Is the service effective?

Our findings

There was an inconsistent approach to assessment of people's needs.. One person had moved into the service the night before our inspection. The registered manager had completed an assessment with the person, recording their basic care and support needs and this had been shared with staff. We met and spoke with this person, and they told us they were comfortable and that staff had been kind and caring since their arrival.

However, when other people had moved in, no assessment had been completed, as there was no care plan or risk assessment in place. Letters from healthcare professionals were stored together, but there was no guidance for staff regarding how to support some people effectively or manage the risks related to their care. Staff had used some tools such as Waterlow assessments (to assess the risk of people developing pressure areas) and a malnutrition universal screening tool (MUST) when assessing some people's needs and not others, again, their use was inconsistent. Due to the lack of consistent assessment and guidance for staff, up to date training had an increased importance, as staff would need to act using the knowledge gained in their training to ensure people received effective care.

Most staff had received training in essential topics such as safeguarding, moving and handling, first aid and mental capacity. People and their relatives told us they thought staff were knowledgeable and one relative commented, "You can see it in the way they help people in the hoist. They all seem very well trained."

However, apart from this essential training there was a lack of oversight and consistency regarding training that staff received. There were some people living at the service who were living with dementia, and who could become confused. Eight of 16 members of care staff had received training in dementia awareness, but most of this training was some years ago. Only one member of staff had received training on dementia in the past two years and one member of staff had completed their training in 2000, nearly 18 years ago. We observed staff treating people with compassion, and easing their anxieties, however research into dementia has changed during this time.

One person required staff assistance to manage their catheter care. Although most staff had received training on catheter care at some point, there were only four members of staff who had completed this training in the past two years. Staff had not recognised the importance of recording when a person's catheter bag had been changed or monitoring their input and output to ensure the catheter was working correctly.

There had been no training in pressure care or skin integrity and some people had pressure areas. No one at the service had recognised the importance of knowing what grade of pressure sore people had developed so they could monitor any changes. Similarly, people had displayed behaviour that challenged, becoming anxious and aggressive and staff had received no training in how to manage this

Staff knew people well and most staff members had worked at the service for some time and this did

mitigate some of the risks related to the lack of training. However, as people's needs changed, and they became more dependent the provider had not recognised the need for up to date or increased training to ensure people could be cared for effectively.

When new staff started working at the service they completed an in house induction and were given an opportunity to get to know people. However, this was not linked to the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected in health and social care workers. Staff competency was not assessed in any way, so there was no way of ensuring that staff had met these fundamental standards.

The provider and registered manager had failed to ensure that there enough trained and competent staff on shift. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff met with their line manager to reflect on events that had happened in the service. Each member of staff had an annual appraisal to discuss their training and development needs. Most members of staff had worked for the provider for a considerable period of time and told us they felt well supported.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff and the registered manager lacked understanding regarding DoLS. The registered manager was in the process of completing capacity assessments for people. One person had been assessed as not having capacity to consent to living at the service. They were under continual supervision, and were unable to leave. The registered manager had not applied for a DoLS for this person, meaning this restriction had not been appropriately authorised as lawful.

The provider and registered manager had failed to ensure that restrictions on people's liberty were appropriately authorised. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff offered people choices throughout the inspection, and understood the principles of the MCA, which were displayed on a poster in the dining room. Staff told us they always assumed people had the capacity to make decisions, and when they required assistance showed them different options, such as clothing and food, to help them decide.

Healthcare professionals that worked with the service told us that they were prompt to seek advice and listened to their recommendations. One healthcare professional told us, "They are pretty good here" and, "They always seem genuinely concerned for people." The registered manager had been in contact with a specialist nurse from the clinical commissioning group to seek advice and guidance with regards to updating people's care plans.

People received the support they needed to manage their healthcare conditions and to live healthier lives. Although care plans and risk assessments were lacking in some cases, people's medical notes and records

were all stored together. People were encouraged to be as active possible, and took part in regular exercise classes. When people became unwell staff contacted people's doctors or the relevant health care professionals. During the inspection an audiologist visited the service and carried out checks on people's hearing.

People told us that they enjoyed the food at the service and had plenty to eat and drink. People said, "The food is very nice." "The food is good, I enjoy it." And, "They brought me a cup of tea in at 6:30. My breakfast was very, very, satisfactory, I had a choice of cereal, and there was fruit and toast"

The atmosphere at lunch time was calm and relaxed, and staff were on hand to assist people throughout the meal. One person did not appear to be eating, and staff asked her if they wanted some more gravy. Once the person had been given more gravy, staff sat with them, encouraging them to eat. The person finished their meal and smiled broadly, seemingly having enjoyed the food. Throughout the day people were offered a choice of hot and cold drinks and a variety of snacks.

The registered manager told us they wanted the service to have a 'homely' feel. There was a large lounge and dining room and people had their own individual bedrooms. Corridors were wide enough for people to move freely through in a wheelchair, or portable hoists if needed. There was a stair lift available to allow people to access the first floor of the service. People had bought in photos, pictures and ornaments from home to decorate their bedrooms.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring. One person said, "The staff seem very nice and friendly." Another person said, "The staff are friendly and give me no cause for complaint." A third person told us, "I have been in another home for respite. This place is much better and it is smaller. The staff are very good."

Although we observed that staff were kind and caring the provider and registered manager had failed to ensure the systems and processes within the service supported staff to provide personalised care. Staff had not received training related to people's specific needs including dementia awareness. When staff had received training, this had not always been updated to ensure they were aware of best practice.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Some people had a visual impairment and other people were living with dementia. Staff spent time one on one with people offering them reassurance and ensuring they understood information that was presented to them. Information was not provided in a larger font or easy read format. This was an area for improvement.

Throughout the inspection staff treated people with compassion and were attentive to their needs. We observed many warm, natural interactions where staff spent time listening and talking to people. Staff knelt on the floor when people were sitting down, ensuring they were able to give people eye contact, and one member of staff placed their hand on a person's arm in a reassuring manner. One person told us, "The staff are lovely. They are fantastic, I cannot praise them enough. They treat people so kindly."

One person had recently moved into the service. Throughout the day staff spent time with this person, speaking to them and checking that they were comfortable and happy with the move. The registered manager and a representative of the provider both spent time chatting with this person, offering reassurance and welcoming them to the service.

People were encouraged to be as independent as possible. During the inspection we observed staff encouraging people to do things for themselves. One person was encouraged to eat their dinner without support, although staff ensured they were near the person at all times if they were struggling. Other people told us how staff supported them to wash their backs, and hard to reach places, but they were always encouraged to do as much as they could for themselves.

Staff respected people's privacy. During the inspection we observed staff knocking on people's doors, and waiting to be invited in before entering. People confirmed that this was how staff always behaved. One person said, "Staff always knock before they enter my room."

People's relatives and loved ones were always welcome at the service and were encouraged to visit regularly. Relatives told us they were always made to feel welcome, One relative told us, "You get a cup of

tea as you walk in the door and you don't even have to ask. All the staff know our names." Another said, "You do not feel like you are getting in the way."

Most people living at the service were able to make their needs known to staff. When people required support their families and loved ones offered them assistance. One person told us, "[My relative] looks after me. We asked to be moved to a room downstairs; it was provided when one became available." People were aware they could be supported by an advocate if needed. An advocate is someone who supports a person to make sure their views are heard and their rights upheld.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that the service was responsive and thought that people received person-centred care. One relative said, "My loved one has looked so much better since they have been here." Another relative told us, "It is nice when we go, because they look after [my loved one] just like we would." Although feedback was positive, we found that further work was required to ensure people received person-centred care.

At the start of the inspection the registered manager told us that they were aware some people's care plans required updating. Care plans should be personalised and contain a step by step guide to staff regarding how to support people, including their preferences, what they could do for themselves and what support they required from staff. Three care plans had been reviewed and updated and contained information regarding how to support people in line with their wishes and preferences. The information regarding the remaining 13 people at the service differed greatly.

Two people had no care plan or risk assessments in place at all. They had both been living at the service for the past few months. There was no information regarding how they liked to be supported or how staff should assist them with their care. One person's daily notes showed that they became distressed and anxious and there was no guidance for staff regarding how to respond if this occurred. Staff had not received training in supporting behaviour that challenged, which further increased this risk of inconsistent care.

Another person had received support in the community from the domiciliary care agency run by the provider. They had been in hospital and then moved into the service. Staff had been provided with the care plan from when the person had lived at home. However, there was no information regarding how they should be supported now that they had moved. The situation had changed for the person including the fact they now had 24 hour care rather than individual, short calls to their home each day. There was no up to date information about these changes.

The registered manager told us that staff knew people well, and that most people could tell staff how they wanted to be supported. However, some people living at the service could be confused or were living with dementia. This impacted on their ability to make their needs known. Without accurate guidance there was a risk people would receive inconsistent care from staff.

There were no plans in place regarding how people wanted to be supported at the end of their lives. The registered manager told us that they did not routinely have these conversations with people or their families. Although the service was not currently supporting people at the end of their lives, they had done so in the past, and there had been no systems in place then, to ensure their wishes were recorded either.

The provider and registered manager had failed to ensure that people's care was delivered in line with their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection people were engaged in a range of activities. People told us they enjoyed the range of activities on offer. One person said, "I like doing my knitting and we have exercise class and also entertainment." A relative commented, "It always seems busy and that has impressed me."

During the morning of the inspection people took part in an exercise class. This was a regular activity, and people were involved in counting how long each exercise should take, and showing others how to move correctly. Staff facilitated a group discussion over coffee, talking about current affairs with people. A theatre entertainer visited the service and carried out a performance. People were engaged throughout, and given the opportunity to try on costumes, and sing along.

There had been no complaints since our last inspection. People and their relatives told us they would happy to speak with the registered manager or representatives of the provider if they had any concerns. A relative told us, "I have got the registered manager's number, but I have never had to use it. They are definitely 'on it.''

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they thought the service was well-led. One person said, "I think we are well led, including the way we are assisted. I consider this is one of the best homes in Herne Bay; I am a retired health worker and have spoken to lots of people about homes." A relative told us, "I am happy that [my loved one] is happy here. They are much safer here. We picked this place because one of our relatives works in the care industry and is in the know." Although feedback regarding people's care and the management was positive, we found multiple concerns during our inspection and the provider and registered manager lacked oversight of the service.

We asked the registered manager how they developed the service and improved the quality of care provided. They told us there was nothing that they could provide to show us this. There were no formal systems of checks or audits in place and no processes to measure and review the delivery of care, treatment and support against current guidance. The registered manager and a representative of the provider worked daily at the service, and were clearly well known by people and staff. They told us they 'popped in' and 'observed staff's practice' but nothing was formally recorded.

The provider and registered manager were aware that there were some shortfalls in their paperwork and documentation, and told us this at the start of the inspection. They had contacted a specialist nurse from the local clinical commissioning group who was due to visit the service in April and offer some advice and guidance. They had started to update three people's care plans and these contained more information for staff. However, we identified that some people had no care plans or risk assessments in place at all. Documentation regarding people's care and support was not regularly checked, and there was no systematic plan in place to show how improvements were going to be made. Staff had not received training in topics specific to people's needs, such as skin integrity or pressure care. Other training, such as dementia awareness was out of date.

When essential work had been recommended as being completed by an electrician, to ensure electrical systems were safe, these had not been completed.

An external pharmacist had completed an audit of the service in October 2016 and February 2018, both visits had been since our last inspection. They had identified ongoing concerns regarding the management of paraffin based creams and a lack of assessment of staff competency that had not been rectified in this two year period. Although since the February 2018 audit the registered manager had ordered a thermometer to check the temperature of the room where medicines were stored, there was no plan in place to ensure that all areas of improvement identified in the audit had been completed, and to ensure essential requirements, such as assessing the competency of staff were actioned.

The provider and registered manager lacked oversight when incidents occurred, and steps were not taken to prevent situations from happening again. Staff documented when people fell, but apart from this, no accidents or incidents were recorded at the service. No analysis was completed of these falls, to look for trends or patterns and to see if the risk could be prevented in the future. One person's daily notes showed

they became distressed and had been 'a risk to themselves.' Although staff had contacted health care professionals and sought support for the person, no analysis had been completed of this event, and no guidance was put in place for staff on how to respond if this incident occurred again.

The registered manager had asked for feedback from people, their relatives, staff and other stakeholders involved in the service. Although most feedback was positive, comments had been received regarding wear and tear in the building and the benefit of more activities being arranged. No analysis of this feedback had been completed, and there was no plan in place to implement the recommendations or areas of improvement that had been identified.

Although senior staff met regularly to discuss people and their changing needs, the staff team as a whole did not meet regularly to discuss issues that arose in the service. One member of staff said, "No, we don't have regular staff meetings, I think we should." We were shown minutes from a meeting held in April 2017. Staff had suggested small lockers could be made available, to leave their valuables in when on shift. We spoke with staff, who told us these had not been provided.

Records relating to people's care and support were not always stored securely. Medicines administration records (MARs) were kept on top of the locked medicines cabinets in the dining room, and were freely accessible to people and their visitors. Care plans and people's personal confidential information were stored in a cupboard in the dining room, but this cupboard had no lock on. There was the potential of a data security breach, and people's confidential information being read by others without their permission.

The provider and registered manager told us they were members of the Kent Integrated Care Alliance (KICA) and regularly attended their meetings to discuss running care services. They also told us they read updates provided by the Care Quality Commission and other organisations. Although they were making attempts to keep their knowledge up to date, they had not ensured compliance with the regulations and fundamental standards. The provider and registered manager had worked with other organisations, such as the local safeguarding team when incidents had occurred.

The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the service. They had failed to hold an accurate and contemporaneous record regarding each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager, and a representative of the provider told us their vision for the service was, "To make sure everyone is looked after well. We want a 'family feel' and to make sure it is a nice, friendly environment to live and work." Staff echoed this 'family ethos' saying, "I think we make sure everyone is looked after well. I want to make sure this is a nice, friendly environment to live in and work." A family feel can be achieved however checks on people's health and well-being are still required to ensure everyone's safety.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

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

on a notice board in the entrance hall.

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 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had failed to ensure that people's care was delivered in line with their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to identify, assess and mitigate risks relating to people's care and support. Medicines were not managed safely.

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 and registered manager had failed to ensure that restrictions on people's liberty were appropriately authorised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the service. They had failed to hold an accurate and contemporaneous record regarding each person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager had failed to ensure staff were recruited safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had failed to ensure that there enough trained and competent staff on shift.