The Abbeyfield Kent Society

Barnes Lodge

Inspection report

Tudeley Lane
Tonbridge
Kent
TN11 0QJ

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Barnes Lodge is a purpose built residential care home offering personal care and accommodation to older people and people who are living with dementia. The service replaced another care home that was previously located on the same site and owned by Abbeyfield. Staff and people from the previous home had moved to Barnes Lodge. The service is registered to accommodate a maximum of 101 people and can provide respite care for short periods of time. It does not provide nursing care. The service opened in September 2016 and had two floors of the three floor building open at the time of our inspection. There were 36 people living at Barnes Lodge.

This inspection was carried out on 3 and 7 March 2017 and was unannounced. The inspection team included two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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. A new manager had appointed and had begun working in the service.

At this inspection we found that some regulations were being breached. Risks to individual's safety and welfare had not always been managed effectively. This was in relation to the risk of choking, food allergies, developing pressure wounds, falls, moving people safely, aggressive incidents and dehydration.

Staff had not received essential training to enable them to carry out their roles effectively. This had impacted on staff's ability to effectively plan people's care and meet their needs.

The principles of the Mental Capacity Act 2005 (MCA) had not been followed when obtaining consent from people to care and treatment. This meant that people's right to make their own decisions had not been promoted and care had been provided without people's consent.

People's needs had been assessed before they first moved to the service, but they did not have a care plan that addressed all their assessed needs. People's care plans lacked the detail necessary to ensure staff

could provide personalised care. Care had not always been delivered in line with people's care plans. People's care records were not completed with sufficient detail to show that they had received the care they needed and to allow the registered manager to review that care.

The service was not always well led. Systems for monitoring the quality and safety of the service were not always effective in ensuring that necessary improvements were made. Where shortfalls in the service had been identified action had not been taken to resolve the problem.

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

The risk of infection spreading in the service had been minimised and the premises were kept clean, but we found there was an odour of urine on the ground floor of the premises. We have made a recommendation for improvement.

People had enough to eat to meet their needs. However, it was not clear that people's hydration needs were adequately monitored.

People's care plans did not demonstrate that they were encouraged to retain or develop their independence. We have made a recommendation for improvement.

It was not always clear that people had been involved in reviewing their care plan. We have made a recommendation for improvement.

People were safeguarded from the risk of abuse. Staff knew how to recognise the signs of abuse and how to report concerns. There was a sufficient number of staff to meet people's needs in a safe way and the registered provider had ensured robust checks had been made about the suitability of new staff.

People's medicines were managed safely and they received them at the correct time.

The accommodation was suitable for people's needs and was comfortable and homely. Consideration had been given to the needs of people living with dementia to help them find their way around their home.

People, and their relatives, told us they felt the staff were caring and treated them kindly. People felt that their privacy was respected and they were treated with respect. Staff knew people well and understood their personalities. Staff provided reassurance and comfort to people when needed.

People told us that they enjoyed the group activities programme.

People and their relatives were aware of how to make a complaint and they felt their views were listened to.

The registered manager understood the requirements of their role and they were open and transparent. Staff felt that the registered manager provided a good level of support and had made positive changes to the culture of the service.

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 were not always managed effectively to ensure people's safety and welfare.

Staff knew how to recognise the signs of abuse and report any concerns. The registered provider had effective policies for preventing and responding to abuse.

There was a sufficient number of staff to ensure that people's needs were consistently met to keep them safe. Safe recruitment procedures were followed.

Medicines were administered safely. People received the medicines they needed at the right time.

The risk of the spread of infection in the service was appropriately assessed and reduced.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received essential training to enable them to carry out their roles effectively. This had impacted on staff's ability to effectively plan people's care and meet their needs.

Not all staff understood the principles of the Mental Capacity Act 2005 (MCA) and they had not acted in accordance with the legal requirements. Some people had been provided with care when they had not consented to this. The correct process had not been followed to make decisions in people's best interests where they did not have the capacity to make the decision themselves.

People were supported to be able to eat sufficient amounts to meet their needs and were provided with a choice of suitable food and drink. however, people's hydration needs were not always adequately monitored.

People were referred to healthcare professionals promptly when

needed.

The premises met the needs of the people living at the service and was comfortable and well maintained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The service had not developed effective care plans that enabled people to retain or develop their independence.

It was not evident that people had been involved in making decisions about their care or reviewing their care plan.

Staff knew people well, communicated effectively with them and treated them with kindness and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's individual needs.

People views on their needs were sought and an assessment carried out of their needs, but care plans did not address all these needs. Care had not always been delivered in line with people's care plans.

People's care plans lacked the detail necessary to ensure staff could provide personalised care.

People enjoyed a range of group social activities, but their care plans did not identify how they would be supported to continue to follow their individual hobbies or interests.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems for monitoring the quality and safety of the service were not always effective in ensuring that necessary improvements were made. However, the registered provider had developed an improvement plan to address this.

Accurate records were not maintained to allow the manager to

monitor care delivery.

Staff felt supported by the registered manager and felt positive about the culture of the service. The registered manager understood the requirements of their role and they were open and transparent.

Barnes 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 carried out 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 was carried out on 3 and 7 March 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. As part of our planning for this inspection we looked at records that were sent to us by the registered provider and the local authority to inform us of significant changes and events. We spoke with the local safeguarding team and commissioning team to obtain their feedback about the service.

We looked at seven people's care plans, risk assessments and associated records. We reviewed documentation that related to staff management and recruitment. We looked at records of the systems used to monitor the safety and quality of the service, menu records and the activities programme. We also sampled the services' policies and procedures.

We spoke with six people who lived in the service and five peoples' relative to gather their feedback. We spoke with the manager, deputy manager, activity staff and four care staff as part of our inspection. 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.

This was the first inspection of the service since registering with the Commission.

Requires Improvement

Our findings

People and their relatives told us they felt safe living in the service. One person said, "Yes I feel safe here" and another said "Yes….I do like it here." A person's relative told us, "I'm quite happy that mum is safe here." People told us they felt there were enough staff working in the service to meet their needs. A person's relative told us, "I feel happy now that the staff numbers are picking up."

Risks to individual's safety and welfare had not always been managed effectively. We saw that a care plan and risk assessment had not been updated for a person who had been requiring regular support to change their position to reduce the risk of developing pressure wounds. Their health had improved and they were mobilising, but the care plan had not been reviewed to reflect this. Staff were unclear if they should be continuing with the repositioning or not; some staff had recorded that they had done so and others had not. There was an inconsistent approach to the management of risk for this person.

Three people's risk assessments identified they were at high risk of falls, but there were no action plans in place that specified what action should be taken to reduce the risk. We saw that three people had had frequent falls in January and February 2017 and the analysis of the accidents and incidents forms by the registered manager had identified that they required a review of their falls risk assessment. We checked whether these reviews had taken place and found that only one person's risk assessment had been reviewed and updated. This meant that the risk of falls had not been reviewed to learn from previous incidents and reduce the risk of reoccurrence.

We saw a person being moved in a wheelchair without foot plates. This meant that their feet were catching on the ground as they were being moved, which placed them at risk of injury. The registered manager told us the person was unable to use a regular footplate due to a leg injury, but that staff had been instructed to use a cushion to support the knee. This was not being used and there was no reference to the use of the wheelchair or cushion in the person's care plan or risk assessments. The deputy manager told us they had made a referral to an Occupational Therapist for advice about a suitable wheelchair, but this had not been recorded in the care plan. There was no information in the care plan to inform staff how to support the person to move safely until they could be seen by the Occupational Therapist.

A person moved to the service on the day of our inspection. An assessment identified the person had an allergy to shellfish. A care plan had not been written and chef had not been informed of the allergy when we checked at 10.45am, despite the person being due to arrive for lunch at 12pm. We raised this with the deputy manager who informed the chef. Another person had moved to the service the previous day and had

an assessment that identified they required their food to be pureed and they were allergic to eggs and cheese. An incident report showed that the person had been given a jacket potato with cheese for their first meal at the service, the previous evening. The care plan contained information that conflicted with the assessment as it stated the person required a soft diet, which is a different texture to a pureed diet. The lack of clarity in the plan and the staff failure to note the information in the assessment placed the person at risk of choking or an allergic reaction. On the second day of our inspection the registered manager told us that they contacted the person's GP about the allergies, but there was no information about this on their medical records. The registered manager was continuing to make enquiries about this. The same person had arrived at the service with a fluid thickener. There was no information in the care plan about the amount that should be used. On the second day of our inspection the deputy manager told us they had requested guidance from the person's GP about this, but was awaiting a new prescription. The lack of care planning in this area meant that staff did not have accurate information about how the person's needs should be met.

We found that one person's care notes showed that there had been 13 incidents of aggression towards staff during personal care that had not been reported to the registered manager. This meant that there had been no analysis of the behaviour to attempt to find a cause. The person's care plan had not been updated to include information about this risk nor a risk assessment completed. This left staff without guidance about how to support the person with this behaviour. The Head of Care Operations for the provider showed us a form that had been introduced for monitoring complex behaviours. This included a checklist for assessment and areas to consider for action. However, this had not yet been implemented at the service.

The premises were generally safe for people to use and had been well maintained. However, we found that a service lift was unlocked when not in use, which may present a risk of injury.

Risks to people's safety and welfare had not been appropriately managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an appropriate business contingency plan for possible emergencies. First aid kits were available in prominent locations. There was a procedure in place for evacuating people from the building in the event of an emergency, such as a fire. People had individual evacuation plans to ensure staff knew how to help them evacuate the building safely. Staff had access to an emergency 'grab file' containing important details about people and their needs. The maintenance staff member carried out regular checks of the premises and equipment for fire safety.

People were safeguarded from the risk of abuse. Staff we spoke with had a good understanding of safeguarding procedures and they were able to describe steps they would take to report concerns, if they felt they needed to do so. There was a safeguarding policy in place for the service. Staff were aware that they would need to escalate concerns to their manager or the relevant agency if required. There was a whistleblowing policy in place and this included guidance about how staff should raise concerns about practice. Staff we spoke with were confident that the culture within the home supported open reporting of concerns. A staff member told us "Safeguarding is protecting people against any form of abuse. This can include neglect, physical and mental. I report all concerns to the head office. I know I can report higher if I want to or to the CQC." Another staff member said, "If I was to witness abuse I would report it to the manager and we can go to head office."

People's medicines were managed so that they received them safely. We saw staff administering medicines and accurately recording when people had taken these. All senior staff had completed medicines training. One senior staff member told us, "I have completed a two module medication administration course; it was very thorough and made me feel more confident in giving medicines." Senior staff made checks of the

medicines records at the handover to each shift to ensure there had been no errors. The deputy manager carried out monthly checks to ensure the practice was safe. We found that there was no written guidance in place to inform staff of the circumstances in which they should administer medicines prescribed to be given 'as required'. For example a person was prescribed a medicine to be given as required for agitation. There was no written guidance to describe to staff how the person presented when they were agitated and at what point during their agitation the medicine should be given. This left it open to individuals staff members interpretation of what was meant by agitation and placed the person at risk of inconsistent use of this medicine. We recommend that the registered provider ensure there is guidance for staff on the use of 'as required' medicines.

There was a sufficient number of staff on duty at all times to meet people's needs in a safe way. People and staff told us there were enough staff to meet their needs. The staffing rotas showed that sufficient numbers of care staff were deployed during the day, at night time and at weekends. A senior carer provided leadership to staff on each shift in each wing of the service. The registered manager told us that they were recruiting a team leader for each floor. They were also recruiting more care staff in preparation for increasing the occupancy at the home. The registered manager submitted a staffing return to the registered provider each month to allow the staffing numbers to be reviewed in line with individuals' dependency assessments. Shortfalls in staffing due to sickness or leave were covered by staff taking additional shifts and, where this not possible, agency staff would be deployed to ensure that appropriate staffing levels were maintained. Auxiliary staff, such as housekeepers, catering staff, laundry assistants and an activity coordinator were employed which allowed staff with responsibility for providing care to be able to focus on supporting people.

The registered provider had ensured robust procedures for the recruitment of new staff. Staff had provided two references prior to taking up employment and a full employment history. They had filled in questionnaires to show that they were fit and able to undertake the work they had been employed to do. Gaps in employment history were explained. Staff had provided proof of their right to work in the United Kingdom. Staff completed Disclosure and Baring Service (DBS) checks to ensure that they were suitable to work at the home. All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. New staff were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

The risk of infection spreading in the service had been minimised and the premises were kept clean, but we found there was an odour of urine on the ground floor of the premises. The registered manager described action that had been taken to address this, but the problem had not been fully resolved. The registered manager showed us evidence of a plan to replace the carpet in a bedroom where the problem was occurring. There was a schedule of cleaning for the service and housekeeping staff worked in the service seven days a week. There was an appropriate supply of personal protective equipment throughout the service and we saw that staff used this as needed. Suitable hand washing facilities were available and reminders about safe hand washing were displayed. There was alcohol gel in dispensers throughout the home and staff were observed regularly using this. There was a large and well organised laundry that enables staff to keep clean and dirty linen separately to reduce infection risks. The service held a policy on infection control and practice that followed Department of Health guidelines and helped minimise risk from infection. Staff understood and followed safe procedures for managing soiled laundry and clinical waste.

Inadequate

Our findings

People told us that they felt the service was effective in meeting their needs. They told us staff had the necessary skills to provide the care they needed and that they supported them to access health services as needed. One person said, "I find the staff very well trained." Another person told us, "I don't need any help, but they help others. I go out to the opticians and my family organise it and take me." People's relatives told us that they were satisfied with how their relative's needs were met. One person's relative told us, "Yes… physically they have gone all out to do what they can for her…the hospice, doctors, nurses and here….I'm very impressed by them. They have surpassed any expectations that I had." Another person's relative said, "Yes they care for her needs very well." However, our inspection found that the service was not always effective.

Staff had not received essential training to enable them to carry out their roles effectively. There was an ongoing programme of training for staff to complete that included safeguarding, first aid, infection control, safe moving and handling, equality and diversity, person centred care, dignity and privacy and the Mental Capacity Act 2005. The training records showed that not all staff had completed the training the registered provider had identified as essential for their role. For example, of the 43 staff employed, 13 staff had not yet completed training in safeguarding people from abuse. Thirteen staff had not completed infection control training, eight staff had not completed safe moving and handling and ten staff had not completed first aid training. This meant that people could not always be assured that they were being cared for by staff with the necessary knowledge and skills to ensure their safety. Only three of the five senior care staff had completed training in care planning. We found that care plans were not always completed and reviewed effectively to meet people's needs. 16 staff had not received training in managing behaviours that challenge the service. We found examples where incidents of aggression had not been reported and there was a lack of care planning to inform staff how to effectively support people when they became frustrated or aggressive. Only five staff had completed training in record keeping. During our inspection we found that a number of care records, including food and fluid charts, were not being completed consistently.

Staff had not received training in all the areas they required to carry out their roles effectively. This had impacted on staff's ability to effectively plan people's care and meet their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff had recently completed training in equality and diversity and most staff had completed dementia awareness training. The registered manager described further dementia training that was planned including a virtual dementia tour and training delivered by a person experiencing dementia. New staff were required

to complete the Care Certificate. The 'Care Certificate' was introduced in April 2015. It is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. We saw that seven staff were working on their Care Certificate at the time of the inspection. Staff told us that they were supported to undertake qualifications relevant to their roles. One staff member said, "I have recently completed my NVQ level three and we are now looking at the level four."

Staff were supervised and supported in their roles. The registered manager carried out individual supervision meetings with staff every two months. Staff confirmed that supervision meetings took place and they told us this was an opportunity to discuss their work and any issues they had or training they needed. Staff had an annual appraisal of their performance. Staff told us that they felt supported and could request any additional training they felt they required.

The principles of the Mental Capacity Act 2005 (MCA) had not been followed when obtaining consent from people to care and treatment. The 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.

Over half of the staff team had not been trained in the Mental Capacity Act. This meant that they may not have the knowledge and skills required to ensure the requirements of the legislation are met when seeking consent from people. Staff we spoke with were not able to accurately describe the principles of the legislation. When asked about the MCA one staff said' "I do not understand." The deputy manager was unclear when they had last received training in the Mental Capacity Act and was not clear about the requirement that assessments of people's capacity must be decision specific.

During the inspection we heard a person shouting "No, stop it" in a bathroom. We asked the Head of Care Operations, who was at the service at the time, to investigate what was happening. They said that the person was receiving care from a chiropodist, but that they did not like having the treatment and therefore it was provided in their best interests due to their diagnosis of dementia. A member of care staff was supporting the person with the appointment. However, upon checking the person's care records we found that a MCA assessment had not been carried out to identify if the person could consent to the treatment before a best interest's decision was made. There was also no record of the best interest decision or the process that had been followed. The Head of Care Operations stopped the treatment until an assessment of their capacity to consent could be completed. The staff member supporting the person had not taken action to stop the treatment when the person was communicating that they did not consent. No other staff in the vicinity had intervened.

We found that three people's care records we viewed contained Mental Capacity Act assessments stating they did not have the capacity to make a decision, but they did not specify what the decision was that was to be made. These assessments had been completed by the deputy manager and a senior member of care staff. One person had a Mental Capacity Act assessment that detailed the decision to be made as 'to identify short term memory loss'. This shows that the staff completing the form lacked understanding that the assessment process is used to determine if a person can make a particular decision for themselves. As part of the assessment the person was asked to recall the ingredients used to make a cake to determine if they were able to retain the information. This is not in line with the requirements of the Mental Capacity Act 2005. The relative of another person had signed a form giving consent to care and treatment of their relative, but a MCA assessment had not been carried out to establish if the person could make this decision themselves. It was not recorded that the relative had Power of Attorney.

An MCA assessment had been completed correctly for a person in relation to a decision about using a crash mat in case of falls from their bed. It had been identified that the person did not have the capacity to make the decision and a decision to use the crash mat was made in their best interests. However, the process followed for making the decision and who was involved had not been recorded.

The principles of the Mental Capacity Act were not followed when seeking consent from people for care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Three people using the service had a DoLS authorisation in place and other applications had been made. People told us they could go out with staff when they wanted to. Staff told us that although some people had a DoLS authorisation they were still enabled to go out when they wished, but may require staff to support them to do so.

People told us that they were generally satisfied with the meals provided, however it was not always evident that people had enough to drink. One person told us, "The food alright…yes there's a choice and we choose every day." Another person said, "The food is of a good quality and there's always more if we want it." The menu provided two choices of meal per day and people told us that if they did not want either meal the chef would prepare an alternative. Staff offered choices concerning what people would like to have to eat and drink and where they preferred to have their meals. People were given the assistance they needed to eat their meals. A senior care staff told us that a person was at risk of not eating enough and had their food intake monitored. We found that there was no monitoring of their food intake and the senior staff were unable to clarify why this had not happened. Where people required their fluid intake to be monitored to reduce the risk of dehydration this had not been carried out consistently. Care staff told us that sometimes staff forgot to fill in the charts to show what people had drunk. During the lunch period we saw that some people waited a long time to receive a drink from staff. There were water machines around the service, but these were not all supplied with cups.

Staff did not always adequately monitor and respond to people's hydration needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had care plans in place to meet their health needs. People's care records showed many health and social care professionals were involved with people's care, such as district nurses, GPs, chiropodists and dentists. People were weighed monthly and staff reported concerns about people's health to their GP as needed. A handover system was used to ensure that staff were aware of people's health each day when they arrived for work. This ensured that staff responded effectively when people's health needs changed. Staff told us that they reported concerns about people's health to the manager who took action. One staff member said, "The registered manager is good, if you have any concerns they seem to get sorted. I had a concern about a resident's legs starting to swell and now it is sorted."

The accommodation was provided in a new building that had been purposely designed for the care of people living with dementia. The environment was homely and comfortable. Each floor had been divided into two units and given a street name so that people have an address for their bedroom. Each person had a different coloured bedroom door to help them identify their own room. There were clear signs around the home to help people find their way. Contrasting colours had been used to make it easier for people with

visual impairments to identify doorway, handrails and switches.

There were several lounges with kitchenettes and dining room on each floor and areas of seating around the home where people could sit quietly. The registered manager told us about plans to make seating areas in the hallways interesting themed spaces for people to use, for example an indoor garden area. One lobby area had been designed to represent a street with a shop. The registered manager told us they planned to develop and operate a shop. Sufficient numbers of bathrooms were available to meet people's needs and all bedrooms had ensuite shower facilities. There was a bathroom with a therapy bath with music, lights and bubbles on each floor. There was a library and a café, although we only saw the café being used by staff during the inspection. The service provided a hairdressing salon with a waiting area and nail bar. People had access to a large well maintained courtyard garden with areas of seating and tables. The garden contained a red post box where people could deliver their mail.

Requires Improvement

Our findings

People, and their relatives, told us they felt the staff were caring and treated them kindly. One person told us, "Staff are very obliging and kind here." Another person said, "They are very kind and patient." People felt that their privacy was respected and they were treated with respect. People's relatives told us they found the staff to be caring. One person's relative said, "I find the staff to be very approachable, friendly and very discreet." However, two people's relatives told us that they did not feel the service supported people to rehabilitate in order to safely return home, despite admissions being made on this basis. One person's relative told us, "There is no emphasis on re-enablement. Some of the simple tasks could have been supported such as making a hot drink and snacks to help them prepare to go home." Another person's relative told us, "Changes were not made to their care plan [their relative's] to reflect their progress and set new targets to enable them to continue progressing with a view to going home."

People's care plans did not demonstrate that they were encouraged to retain or develop their independence. The service had been designed with facilities to encourage people to be independent, including a café for people to help themselves to drinks and snacks. However, this was not stocked with easily accessible drinks and snacks to encourage people to use it. We did not see anyone using this facilities or staff enabling people to do so. There was some equipment for people to use to promote independent mobility, such as walking frames, but people's care plans did not specify what action could be taken to increase their independence. The care plans had not been written in a way that identified areas for potential development of independence skills. We recommend that the registered manager review individuals care plans to identify and plan for areas where they could increase their independence.

People benefitted from staff that knew them well and understood their personalities. We heard staff enquiring about people's well-being and asking after their relatives. One staff member told us, "I have been working for the company for 18 years and I love working with the residents here. This is what makes me stay." Staff were able to tell us about people's interests and things that were of particular importance to them. We saw positive interactions between staff and people throughout the inspection. For example, two people were enjoying a game of scrabble together. The staff member facilitated the game, but gave them the space and privacy to play together. When people asked for tea or coffee staff knew how they liked it. One staff commented "You like it with milk and one sugar don't you?" There were soft toys and dolls around to provide comfort to people and to allow people living with dementia to care for the dolls as babies. People had a 'This is me' document that gave information about their background and the things that were important to them. We saw staff providing reassurance and comfort when people were anxious or distressed. They gave them a hug and were warm and caring in their manner, holding people's hand and

comforting them. People's birthdays were celebrated with a banner on the door, a birthday cake, and a party for afternoon tea.

People's right to privacy and dignity was respected. Staff spoke with people in a respectful way and addressed them by the name they preferred. People were assisted discreetly with their personal care needs in a way that respected their dignity. Staff had supported people to wear their glasses, dentures and hearing aids if they needed these. They were enabled to express themselves through their preferred dress. We saw that staff were respectful in their interactions with people and we noted that they knocked on doors before entering rooms. People's records were kept securely to maintain confidentiality. Staff held handover meetings in the staff room and were careful not to discuss people's needs in front of others.

Clear information about the service was provided to people and their relatives when they moved to the service. A brochure about the facilities and services was provided. There was a clear complaints procedure which was made available to people. It was evident that people and their families had been involved in making decisions about how their care was delivered when they moved to the service. It was not always clear that people had been involved in reviewing their care plan as their needs changed. We recommend that the registered provider review how people are involved in reviewing their care plans to ensure they are supported to make ongoing decisions about their care.

Requires Improvement

Our findings

People and their relatives told us that the staff were responsive to their needs and requests, but some commented that the care could be more person centred. One person said, "Yes they meet my needs very well." Another person said, "They do provide the care I need up to a point yes, but the care could be more person-centred." A person's relative told us, "The care could be more person-centred, for example mum loves the piano and is quite a good pianist. A member of staff found a book of sheet music which she gave to mum. Unfortunately there was no `next step'… they have a piano and with very little encouragement mum would have played it….but no-one thought to encourage her." Another person's relative told us that the service had been responsive to a change in their relatives need. They told us, "They've been fantastic. When mum came back from hospital they had already arranged for an air mattress and mum is turned every hour."

People's needs had been assessed before they first moved to the service. The assessment process included seeking the views of the person about their own care needs. It covered all areas of people's needs including their physical health, personal care needs and emotional needs. People had a care plan written which included some, but not all of their identified needs. Most people using the service were living with dementia, but the care plans contained very little information about what type of dementia they had, what the symptoms of this were and what staff needed to do to support them to live well with their dementia. One person's care plan contained information about vascular dementia, but the care plan contained reference to Alzheimer's. The care staff we spoke with told us they thought the person had vascular dementia and that there was incorrect guidance information in the plan. These are two different types of dementia that will present different symptoms and the person will require different support.

Some people's care plans noted that they could become upset or anxious. In some instances this was related to their memory loss. There was no guidance for staff to tell them how to respond to each individual person in these circumstances, although staff acknowledged that everyone if different and will require a different response. One person's care plan stated that the person could become anxious if they felt they could not find their children, but there was no plan in place for supporting the person when this happened. This meant that the person may have their emotional needs unmet.

People's care plans lacked the detail necessary to ensure staff could provide personalised care. One person's care plan stated that staff should respect the person's religious beliefs, but there was no information about what these were or what support the person wanted or needed to practice their faith. The assessment for a person living with dementia showed that they disliked onions, but this had not been added

to their care plan and staff were unaware of this dislike. Another person's care plan, written in February 2017 stated that the person was incontinent and a continence assessment was required. There was no information about whether a referral for the assessment had been made, if it had taken place or what the outcome was. There was no information about any continence aids that were to be used in the meantime and there was no detail in the plan about how to support the person to manage their continence. Another person's care plan did not include information about the continence aids that staff told us they used.

Care had not always been delivered in line with people's care plans. We saw that three people's care plans stated that they needed to be checked every 30 minutes throughout the night to ensure their safety and comfort. Their care records, where staff recorded the care given, showed that these checks were only being made every two hours. A person's care plan stated that they preferred to receive personal care from a male care staff, but would accept a female care staff. The person's care records showed that they had refused personal care on occasions and this had been when it had been offered by female staff. There was no evidence that a male care staff had been provided to offer the care instead.

There was a lack of personalised information in people's care plans about how to support them to continue to enjoy hobbies they had before moving to the service. Information had been gathered, through the assessment process, about people's hobbies and interests, but this information had not been used to develop care plans to ensure they were able to continue with their hobbies.

People did not have personalised care plans in place that were effective in meeting their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People told us that they enjoyed the group activities that were provided. One person said, "Yes…I have enough to occupy my time." Another person said, "Yes there's lots of things games, quizzes, art, music and I really enjoy the armchair exercise." The service employed an activities coordinator who arranged group activities for people. The activities programme included movies, manicures, reading newspapers, games, quizzes, walks, parties, church services and music and exercise sessions. During the inspection we saw that a reminiscence tea was held. This was very popular with people at the service and some people's relatives were also involved. People were enjoying singing songs from earlier years. The activities coordinator told us "We have a reminiscence box sent to us from the library that is changed every four weeks. We are given enough material to cover those four weeks."

The activities coordinator described how they planned the activity programme for the service. They said, "I ask residents what they would like to do and this is how the activity schedule has developed. We started with two activities a day, but this has increased to four. A lot of people like music, quizzes and films and we have a pet therapy dog visit every two weeks." There was a knitting basket in the lounge and colouring pads and pencils were located throughout the home. We saw one person using the materials provided. Outdoor activities had been arranged for the summer including BBQs and gardening. The registered manager had purchased some raised planters and quotes had been obtained for solar lights, bird feeders and wind chimes. People had opportunities to go out on outings. Visits included Knole Park and garden centres. Some people had also been supported to go out individually for shopping and coffee.

Staff were responsive to people's needs and requests throughout the inspection. People did not have to wait long for staff to attend when they asked for assistance or used their call bell.

People we spoke with, and their relatives, were aware of how to make a complaint and they felt their views were listened to. One person told us, "I would speak to one of the carers; I think that they would listen to

me." Another person said, "I would speak with the manager or the deputy if I had a complaint." A person's relative told us that when they had needed to make a complaint it had been handled effectively. They said, "We were listened to. Some items had gone missing. They were very quick to respond and they searched for the items and offered to replace them."

Detailed information about how to complain was provided for people in the brochure and in the reception of the home. The manager had taken appropriate action to investigate complaints and provide feedback to the complainant within an appropriate timeframe. People were invited to give feedback about the quality of the service through residents and relatives meetings and an annual satisfaction survey.

Requires Improvement

Our findings

People and their relatives told us they felt the service was well led. One person told us, "I can approach the manager if I need to. I do talk to the manager." Another person told us, "I am happy with the care here, they meet my needs very well." However, our inspection found that the service was not always well led.

Systems for monitoring the quality and safety of the service were not always effective in ensuring that necessary improvements were made. A compliance audit completed by a quality manager for the registered provider identified in January 2017 that there was a person with epilepsy using the service, but that staff had not received training to meet this need. This was identified again in the February audit. At the time of the inspection in March 2017 training had been scheduled, but had not yet taken place. The same audits identified shortfalls in care planning and record keeping, care plans not being updated to reflect changes in needs and diet notifications for the kitchen not reflecting what the care plan said. These were all areas that we found remained an issue during our inspection and had not been appropriately addressed. However, the registered provider had recently developed an improvement plan with the registered manager to address the shortfalls, which they shared with us.

People's care records were not completed with sufficient detail to demonstrate that they were receiving the care they needed. For example, one person's care plan said they needed to be checked during the night every two hours. There was no report in the daily care notes to show this had happened. Two people's care plans stated that they required regular assistance to access toilet facilities to maintain their continence. This care was not recorded as being delivered in the daily care notes. A speech and language therapist had issued a report with guidance for a person to manage choking risks. The information had not been written accurately in the care plan and the instruction that staff must supervise the person when eating had been missed off. The majority of care plans we viewed were not up to date or had information that was missing, for example a person's assessment document was missing. The registered manager had previously identified where care plans required updating and told us that all care plans had been updated by the deputy manager. However paperwork had gone missing and this was under investigation. We saw evidence of the investigation reports. The deputy manager took action to begin updating the care plans during the inspection. Failure to accurately complete care records meant that the registered manager was not provided with the information needed to monitor that people's needs were being met.

The policies and procedures were appropriate for the service, but we found that the whistleblowing policy had not been updated since March 2013. However staff understood the process for reporting concerns outside the organisation if they needed to. Staff were able to describe the key points of significant policies

such as the safeguarding, infection control and complaints policies. They were aware of where to access the policies when they needed them.

The registered provider had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The registered manager had met with staff, people using the service and their relatives to keep them up to date with plans to further develop the service. Staff felt that the registered manager provided a good level of support and had made positive changes to the culture of the service since moving from the previous care home. One staff member said, "The managers' approach is good. Positive changes have been made and staff are now working properly. As a result some have left but we know more staff are coming in." Another staff member said, "I love it here. Some staff from the previous service do not accept that we are changing for the better. Within six months this will be a great service." The registered manager had regular supervision with the Head of Care Operations and had a development plan in place which included completion of the Skills for Care registered manager's induction programme. The registered manager had identified areas of the service that could be further developed to become more person centred. This includes the development of the environment to provide a stimulating space for people who were living with dementia. The activities programme was under review to provide people with opportunities to retain links with their local community through social events and activities.

The registered manager understood the requirements of their role and they were open and transparent. They had notified the Care Quality Commission of any significant events that affected people or the service. Where things had gone wrong in the service the registered provider had fulfilled the requirements for duty of candour by being open and honest with people and their families and had assured them about the action taken to put things right. The registered manager took responsibility for keeping up to date with changes in legislation and guidance. They attended local registered manager network meetings and meetings with managers of other services operated by the registered provider. The service had signed up to the Hospice in the Weald federation scheme and had begun accessing training through them in end of life care.

The registered manager submitted to the registered provider a monthly return about the service including accidents and incidents, infection rates, staff vacancies and training. This was used as a basis for discussion in the registered manager's supervision. The registered manager carried out a monthly safety check of the premises and a monthly kitchen audit. We found that these audits had ensured quality and safety standards were maintained.

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 registered provider had not ensured that people had personalised care plans that were effective in meeting their individual needs. 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured the principles of the Mental Capacity Act were followed when seeking consent from people for care and treatment. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that risks to people's safety and welfare were appropriately managed. 12 (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

	The registered provider had not ensured that people's hydration needs were met. 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service. 17(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured that staff received training in all the areas they required to carry out their roles effectively. This had impacted on staff's ability to effectively plan people's care and meet their needs. 18 (2)(a)