Uniquehelp Limited

# Whitstable Nursing Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The inspection took place on 11 and 12 April 2016 and was unannounced. The previous inspection was carried out on 3 December 2014 and rated as 'requires improvement'. There were breaches relating to staffing levels and the potential risks associated with insufficient staff being available to meet people's needs and people did not always have their dignity protected. The service provided us with an action plan telling us how they would resolve these issues.

Whitstable Nursing Home provides nursing care and accommodation for up to 34 older people, some of whom may also be living with dementia. The service is an adapted detached building situated near to the seafront of Whitstable. The accommodation is provided on two floors, with most bedrooms on the ground floor, the upper floor is accessed by three staircases and one passenger lift. There are 20 single and seven shared rooms, three with en-suite facilities. There are two separate lounges and an open dining area available for people to use. On the day of the inspection, there were 25 people living in the service.

The service is run by a registered manager. 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.

At the previous inspection the provider could not demonstrate that there were always sufficient numbers of suitably, qualified, skilled and experienced staff employed to meet people's assessed needs. Although staffing levels had increased since that time people's needs continued not to be met by sufficient numbers of suitably, qualified, skilled and experienced staff during this inspection.

There were insufficient staff on duty to demonstrate compassionate person centred care practices.
In between meals people were left for long periods without activity or conversation. Although people's personal care needs were met staff carried out their duties in a methodical task-led approach spending no time conversing with people except when assisting with personal care.

People were not fully protected by robust recruitment processes. The employment history of new staff was not explored thoroughly. Processes in place to protect people from abuse were not robust, because staff had not received up to date training, which helped them understand abuse and how to keep people safe. Staff did not receive the necessary training, supervision and support in order to provide the knowledge and skills to care for people.

Choices of food were supplied, but people were not supported to eat and drink in a way that supported their independence. Staff were not effectively monitoring people under observation for dehydration.

People's care, treatment and support needs were assessed before they moved to the service and a plan of care developed to guide staff on how to effectively support people's individual needs.

Plans of care were not personalised to ensure that people received the most appropriate and safest care and treatment, which took into account their needs, preferences and choices.
Information in the care plans were not kept up to date. Reviews of people's care did not contain evidence of the involvement of people in their care and treatment.

There were limited opportunities for people and others involved in the service to provide feedback, and the provider had not acted on feedback received to improve services. Quality assurance systems were either out of date, absent or had not been used as indicators of where the service needed to improve.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Some people had been assessed as lacking mental capacity to make complex decisions about their care and welfare. The registered manager had consulted the local authority with regards to making DoLS applications, so people were not deprived of their liberty unnecessarily.

Medicines were stored and administered safely to people by registered nurses in accordance with current legislation.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not always safe.

There were insufficient numbers of staff available to meet people's needs.

Risks to people were not managed to ensure their safety.

Thorough checks to ensure only suitable staff were employed were not carried out on staff before they started to work.

People were at risk of infection as not all areas of the service were clean. Medicines were stored and administered safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not receive an induction or supervision. Significant gaps were identified in training staff received. There was no system in place to support staff and identify their training and development needs.

People at risk of dehydration did not have their fluid intake needs assessed or monitored consistently.

Deprivation of Liberty Safeguards (DoLS) applications had been made in accordance with the Mental Capacity to ensure that people's best interests were always promoted.

People's health care needs were monitored and reviewed and they had access to healthcare professionals when needed.

### Is the service caring?

**Inadequate**

The service was not caring.

People were not treated with respect and their dignity was not always upheld.

Staff support was task-led and staff had no time to engage with people unless working directly with them.

People were not involved in decisions about their care.

## Is the service responsive?

**Inadequate**

The service was not responsive.

Care plans did not always contain sufficient and up to date information about people's needs to allow staff to deliver care in a responsive and personalised way.

There was a lack of activity provision to meet people's individual needs.
People who remained in their rooms received very little mental stimulation or interaction.

People and relatives gave feedback that was not responded to by the provider. Complaints were not always recorded or responded to.

## Is the service well-led?

**Inadequate**

The service was not well led.

Action had not been taken to address previous breaches of regulations we had identified.

A range of audits were in place, but these had not been followed. There was no system in place to assess and monitor the quality of care people received.

Opportunities to improve following comments and feedback from people and their relatives had not been taken.

# Whitstable Nursing Home

**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.

The inspection took place on 11 and 12 April 2016 and was unannounced.

Three inspectors and an expert by experience undertook 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 expert by experience at this inspection had mental health knowledge and dementia experience.

Prior to the inspection we looked at previous inspection reports and notifications. A notification is information about important events, which the provider is required to tell us about by law. We did not ask the provider to complete 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.

During the inspection we looked at documentation about care including six people's care plans, seven people's activity files, and a selection of medicines records. We read the 'At a Glance' files of four people, which told us about their life background and summarised their preferences and interests. We examined health and safety records, such as accident and incident forms, checks of equipment and utilities and personal emergency evacuation plans. We also checked staff recruitment files, staffing rotas and appraisal, supervision and training records.

We spoke with five people who lived at the service and four visiting relatives. We spent time in the lounge, and moved around the service to observe how staff interacted with people. We spoke with the management team, five care staff, and two ancillary staff. 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.

Following the inspection we asked for further information on the registered manager, and this was provided

promptly.

Inadequate

# Is the service safe?

## Our findings

People told us they felt safe living in the service. One person told us, "There is no reason not to feel safe". Relatives told us they had no concerns about the care delivered in the service. People told us, "Sometimes you hardly see a soul and at others it's busy with them" and "When people are ill they could do with more people around". A visiting relative said, "I think it's a happy place. I've never heard them raise their voice".

At the previous inspection the provider could not demonstrate that there were sufficient numbers of suitably, qualified, skilled and experienced staff employed to meet people's assessed needs. Staff told us the staffing levels had increased since that time, but people's needs were still not being met by sufficient numbers of staff during this inspection. People's needs were assessed by using a dependency tool, but there was no evidence that the results of this assessment were analysed to determine the staffing levels required to meet people needs.

There was a lack of staff presence in the lounges where people were spending their day and people spent long periods of time not engaging with anyone or asleep in their chairs. On the first day of the inspection one person unsteadily stood up twice in the lounge asking for attention and an inspector had to intervene to ensure the person was safe and use the call bell to summon staff.

People were still being brought down to the lounge at 12:15pm, following their morning personal care routine, and lunch was at 12.30pm. Two people were taken into the dining room for their lunch at 12.55pm, but did not receive their lunch until 1.30pm; other people in the lounge also did not receive their lunch until 1.30pm. Staff were only in the lounge or dining room if they were involved in a task, such as bringing someone into the lounge to assist them into a chair. The afternoon entertainer was ready to start at 2.00pm and people were still eating lunch in the same room, which impacted on people trying to eat and on the space available for the activities going on.

On both days of the inspection one nurse and five care staff were rostered on duty from 8am to 8pm to care for and support 25 people. One of these care staff was also rostered to cover kitchen assistant duties from 2pm to 7pm (so they would leave their care duties during this time).

Staff told us they worked a 12 hour shift and they scheduled breaks within it. The breaks were for 10 minutes in the morning, 30 minutes for lunch and 10 minutes in the afternoon/evening. This meant the staff reduced to five in total (carers/nurse) for nine hours and 10 minutes of the 12 hour shift each day during the inspection. Care staff were also being used in place of ancillary staff at times further reducing the number of staff available to care directly for people in the service.

Records also showed that since 14 March 2016 only four care staff had been on duty for the day shift, or part of it, for 10 of those days. For two of these days this had reduced to three staff from 2pm to 7pm when care staff had to cover kitchen duties. If two staff then had to support a person with mobility needs, only one staff member would remain available to support all other people.

The provider had failed to ensure there were sufficient staff deployed to meet the needs of people. This is a continuing breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was recruiting at the time of the inspection and a new kitchen assistant and activities coordinator started during the inspection.

The systems in place to protect people from abuse were not robust. Records showed that 12 of the 27 care/nursing staff did not have up to date training in safeguarding adults. Staff were able to describe different types of abuse and knew to report any suspicions or allegations to the registered manager or senior management. The registered manager had a copy of the local Kent and Medway safeguarding protocols. However the safeguarding policy that was available to staff did not reflect the protocols and the correct reporting of safeguarding concerns to outside agencies, to ensure people were safe.

The provider had failed to have systems and processes established and operated effectively to investigate and report any allegations of abuse. This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not fully protected against the risk of fire. An annual fire safety assessment had been undertaken by a contractor in which several recommendations for improvement were made, to ensure fire safety compliance, such as removing a photocopier from under the stairs. These recommendations had not all yet been addressed, so people remained at risk of fire when action by the provider could reduce this risk. Personal emergency evacuation plans (PEEPs) had been put in place, but these did not detail the specific support people needed to be evacuated in the event of a fire.

Risk assessments contained insufficient guidance to make sure people were safe. There were risk assessments in each person's care plan to identify risks to peoples' safety, such as falling, malnutrition, dehydration, and developing pressure ulcers, but these were not all personalised to reflect peoples' specific needs. For example, a person who required assistance with their transition between bed and chair had no personalised detail on the method of how this should be done safely, or what hoist and equipment staff should use.

Although incident and accidents were monitored, audits of these were inconsistent as not all had been completed recently, and no records were made to identify any trends or actions that could be taken to prevent further occurrence and minimise the risks to people.

People were living in an environment where there were risks to their health and safety. There was an area where a hand gel dispenser in a corridor leaked onto the carpet creating a blackened, mouldy area. Most peoples' bed bumpers, used to protect them from injury while in bed were cracked and flaky, posing an infection control hazard. Once this had been pointed out by the inspection team, staff told us they would replace these.

Records showed that a coded access system had been installed recently on a stair gate at the top of the stairs. Staff told us this was to prevent a person falling down stairs. However the person had been moved to a bedroom on the ground floor. The stair gate remained locked at the time of the inspection, but without a risk assessment in place to establish this was the least restrictive option to keep people safe. This had resulted in people being restricted who could access the stairs safely.

Large items of equipment were stored in one person's bedroom and two wheelchairs were in one person's

single bedroom posing additional safety hazards to people. Once highlighted to staff, they did take action to resolve this.

The provider had failed to ensure that risks to people were managed safely and had not done all that was reasonably practicable to mitigate any such risks to people's health and safety. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not fully protected by robust recruitment processes. The recruitment files of three staff contained evidence of a Disclosure and Barring Service (DBS) check having been undertaken (these checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people), proof of the person's identity and a recent photograph. However a full employment history was absent from the files examined, so the provider could not be certain of the suitability of the recruited staff to work with people safely.

The provider had failed to ensure that all the required information in respect of a person employed was in place. This is a breach of Regulation 19 and Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were suitable supplies of personal protective equipment available and staff used this protective clothing appropriately throughout the day of the inspection. In the laundry room dirty and clean clothing was kept separately, to minimise the risk of any infection spreading.

People's medicines were managed safely. Medicine Administration Records (MAR) were completed after people had been given their medicines. These were supported by an individual photograph of each person, and details about their allergies and the medicines they received. This ensured the right medicine was given to the right person. Staff supported people with their medicines in a safe and unhurried manner. People were given the chance to accept or decline their medicines.

Medicines were stored securely and temperatures in the storage area were checked to ensure these did not exceed recommended levels and medicines remained in good quality. The medicine trolley was kept secure when not in use. Records of controlled drugs were up to date and supplies consistent with these. The homely remedies policy had been agreed by the GP and anyone requiring homely remedies on a regular basis was referred to the doctor for a prescription. Homely remedies are a stock of medicines kept by the service that they purchased from the chemist and used in an emergency, such as paracetamol for pain relief.

Requires Improvement

# Is the service effective?

## Our findings

People told us that they were well treated. One person said, "I feel as though I'm treated alright" and another spoke about staff saying "Not easy for people to do these jobs and they have to learn somewhere. A lot of them are jolly good". We also heard, "Food is quite good". "Food is great".

Staff told us that newly employed staff undertook an induction training programme, which included shadowing experienced staff and familiarizing themselves with the building, procedures and people's routines. However there was no evidence that new staff had undertaken any sort of orientation induction since August 2015. Senior management told us that the new Care Certificate should have been implemented in the service. The new Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. However there was no evidence of this during the inspection.

Records confirmed at the time of inspection between seven and 12 staff needed to undertake training to update their knowledge and skills in order to provide safe and effective care and support to people. There were also considerable shortfalls in other training, which the provider classed as mandatory and additional training, such as dementia, falls, palliative care, equality and diversity, dignity and respect, hand hygiene, syringe driver, pressure care, percutaneous endoscopic gastrostomy tubes and catheterisation. The registered nurse on duty described online training they did with the Nursing and Midwifery Council, and they told us plans were being made to update their practical skills in taking blood samples.

Staff did not receive appropriate support, supervision and appraisals, in order that they could provide effective care to people. Senior management told us staff should receive supervision at least four times a year, although the supervision policy stated every two months. Records showed that seven staff members had not received any supervision in 2016. Another four staff had received supervision, but records confirmed this was not an opportunity for staff to discuss their learning and development and any concerns they may have, it was a reflective session focused on an area of their practice, such as communication or infection control. This meant staff and management did not have proper opportunities to review their overall practice or behaviour together to ensure they worked effectively.

The last staff meeting in January 2016 had identified that some care staff were not performing, in that they were working very slowly, 'do not get on' and it was effecting team morale; staff told us during the inspection this continued to be the case and we could find no evidence of these shortfalls being addressed with staff to ensure people received effective care and support. The previous staff meeting to this had been in May 2014 and records and discussions confirmed no staff had received an appraisal since 2014.

A hand over was given between each day and night shift so staff going off duty could report on peoples' activities and well-being to the staff coming on duty and staff would be given their duties by the registered nurse who was team leader. However, staff were not completely clear about their roles and responsibilities. A group of staff were observed at 9.15am discussing amongst themselves, which people they should be supporting when the allocation of this had been completed at handover at 8am. Staff could not explain why

their method of working had not been decided on earlier and adhered to.

The provider had failed to ensure staff received appropriate support, training and supervision and had failed to ensure that staff were suitably skilled and competent to undertake their roles and responsibilities This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at risk of dehydration were not monitored properly to ensure they had sufficient fluids. People being nursed in bed had fluid charts on which the drinks offered to them and the amounts they drank were recorded. Staff told us that night staff totalled the amounts of fluid taken by people over a 24 hour period. Records had not all been tallied up. Peoples' daily notes stated 'fluid intake maintained', but this statement did not explain whether the person was getting the right amount of fluids for their needs. Peoples' care plans did not explain how much fluid was required to maintain good health, so that staff could recognise if insufficient fluids were being taken and seek medical advice.

The provider had failed to ensure people received safe care and treatment in respect of their hydration needs. This was a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had adequate food. People were provided with a rolling menu, which provided a varied and nutritious choice of food daily. For people who wanted additional choices there were alternatives such as salad, baked potato and omelette. However the notice board, which showed the menus for people to see, was located in a quiet corner of the dining room where most people would not see it and therefore would have to ask staff if they wanted to know what was on the menu.

Food supplements and fluid thickeners were available for use as prescribed by the dietician. The cook knew people and their dietary needs well and had guidance information concerning people under assessment for weight loss, and people requiring soft diets and those with diabetes had the appropriate nutritional support. Artificial sweeteners were used instead of sugar and full fat dairy products were used, due to their nutritional value. People requiring soft diets had foods pureed separately to maintain colour and texture to entice the appetite. Additional foods, such as sandwiches were available for people who were hungry outside meal times. Cakes could be bought in for celebrating birthdays and relatives made welcome for these events.

The majority of people had food in their rooms and were served there, before those people sitting downstairs were served. This meant people were left waiting for long periods to have their meals. China cups and plates were not in use and staff told us that this was due to the lack ability of people to hold them, but people were not given a chance to try to use these. People's independence in performing simple day to day tasks was not supported and the overall experience of dining was not made a sociable time for people to enjoy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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. Capacity assessments had been undertaken for people living with dementia, but there was inconsistent evidence of monthly reviews being carried out. As a result some people's capacity to make

decisions of their own would not be known. This is an area that requires improvement.

A person in the service was subject to a DoLS authorisation from the local authority. The application for this DoLS had been made in the person's best interests with the involvement of people who knew the person best and by an independent mental capacity assessor. As required by law the registered manager had applied for authorisation to the local safeguarding authority because the person's freedom of movement had been restricted.

The building had not been adapted in ways to make living with dementia easier. There was little pictorial signage to indicate direction for people to go within the network of narrow corridors. This meant that people living with dementia who were independently mobile would have difficulty orientating themselves within the building. A clock on the wall was not working, so it would not help orientate people to time. The orientation board, displayed in one lounge to help people with dementia know what the date and day was, was showing Friday 8 April until lunchtime on the first day of the inspection. There were some picture signs to depict toilets or dining area, but people's bedroom doors lacked any form of identification that would assist with people's sense of belonging or orientation. This is an area for improvement.

People's healthcare needs were met. People's care plans gave staff written guidance about people's health needs and medical history and included information about people's medical conditions and what support they required from staff and other professionals to maintain their well-being. People's health care needs were regularly reviewed and nurses undertook regular checks on people to monitor their health, making referrals to other health professionals as appropriate, such as the diabetes nurse, doctor, psychiatrist and chiropodist. This helped to ensure that people received the healthcare support they required.

Inadequate

# Is the service caring?

## Our findings

Feedback from people and their relatives received during the inspection told us, "They (staff) care as much as they have time for" and "Sometimes I think some things are not necessary like bedtimes, especially if I'm watching my soap. It doesn't feel like home".

People were not always respected or their dignity upheld. In the activity records a member of staff had written about a person, 'is still very vocal and can be quietened by chocolate'. Staff meeting minutes showed a staff member had recorded that 'some people were touching everything with poo hands'. The use of language like this in care documentation showed lack of respect for people.

The care and support staff gave to people in communal areas was for the majority of the time task orientated. One person was assisted to eat lunch by a staff member. There was no conversation to make this a pleasant experience only a question "want any more?" and then told "that's it" when the plate was empty.

People were transferred using a hoist in the lounge and again the only communication was some instructions to people, such as "put your hands on the bar". On some occasions people's feet were lifted or the hoist started to move or a sling was place around a person without any explanation or warning to the person. One person was told to "have some patience" when they became anxious and this was despite their care plan stating 'can be anxious doing interventions and needs plenty of reassurance'.

Following a previous inspection when people were seen being weighed in the lounge, a screen was put into place before a person was transferred using a hoist in the lounge. Staff told us this was to uphold people's dignity during the transfer. This gave privacy from other people sitting in the lounge, but not from anyone walking past in the corridor. The screen compromised other people's dignity by being placed in front of the television that they were watching without being asked if this was alright. Other people had to move their feet so the screen would fit in.

Staff went round to people at lunchtime with cutlery wrapped in a plastic apron. They put the aprons on people sitting in the lounge and dining room without asking or explaining what they were doing. They laid the cutlery down ready for people to use, but instead of doing this using the handles of the cutlery they handled the ends where food would be. Everyone in the communal areas had a plastic apron on and there was no information within their care plan as to whether this was their choice. Drinks arrived straight from the kitchen or from staff with jugs and were placed in front of people. When we asked why staff said that it was because this was the person's choice. People did not however, have a chance to choose an alternative drink at the time. Staff were seen walking to the drinks table to get people drinks in the lounge, which was placed in front of the television, which people were watching although there was no acknowledgement of this or the impact on people watching.

The provider had failed to ensure that people were treated with dignity and respect at all times. This is a breach of Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence to show that people were involved in decision making about their care, treatment and support. Care plans contained records to complete when people had been involved in reviews of their care, and for consent from people, such as agreeing to bedrails, but in the care plans we looked at these were unsigned. Observations showed that during meal time's decisions about what drinks to have and for cream or custard to be put on their meals were made by staff. We asked staff why people could not help themselves we were informed that it was "due to people's lack of ability".

People were not receiving care that was appropriate, met their needs and reflected their personal preferences. This is a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014

Relatives told us that they could visit their family member when they wanted and they felt welcome at the service at any time. For one relative this included bringing a dog; a popular visitor whom other people also enjoyed.

Inadequate

# Is the service responsive?

## Our findings

People were asked who they would talk to if they wanted to complain. One person responded, "You can talk to the manager" and another person said, "I would tell one of the care takers". Relatives who visited regularly told us that if they had a concern they would approach the registered manager or deputy manager with them.

Peoples' care and treatment was not person-centred. Peoples' care plans contained assessments of people's care and treatment, but lacked detailed information about people's preferences and wishes in relation to how they wanted to receive their care and support, to ensure their support was delivered consistently and in a way they wanted. For example, in one person's care plan staff had stated the person was 'unable to discuss' plans for their end of life care, but did not indicate what attempts had been made to find out what the person's preferences might be, by talking to relatives or carers. Another person's care plan stated 'nursed in bed', but no detail was provided, which showed how this could be done to support the person while they were in bed. This meant staff may deliver care and support in an inconsistent way and not in line with people's wishes and preferences. Peoples' daily progress notes stated that a person may have 'eaten and drunk well', but did not detail how much, or whether what they had eaten was enough in terms of the person's health needs and choices. Monthly reviews of the care plans stated that the current care was 'to continue', but without demonstrating any involvement or discussion with the person concerned.

The provider had failed to ensure that care plans reflected people's assessed needs, preferences and remained up to date and they were developed collaboratively with people. This was a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's complaints were not managed consistently. There was a clear complaints procedure displayed within the service. The complaints log showed there had been one complaint since the last inspection. However the registered manager had determined that it did not fall under the scope of the complaints procedure for the service. Quality assurance records showed that one person had commented that they "did not know of it" (the complaints procedure). Within in a quality assurance survey one person had raised a concern about the conduct of a member of staff in the comments section, and they stated they had already spoken to senior staff about it. However this was not recorded as a complaint when it was raised with senior staff or following the comment on the survey. The member of staff did receive supervision, although it was not clear if they were aware that an actual complaint had been raised against them or that the person who had complained had received feedback about what action had been taken.

The provider had failed to ensure complaints were effectively managed and responded to. This is a breach of Regulation 16 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported to follow their interests and take part in activities. People were observed to be alone for long periods either in bed or in the lounges without conversation or activities. A new activities person started work on the day of inspection. Staff told us they were supposed to do activities with people, but said it was impossible as they did not have the time with their other duties. Records showed that no

activities had been provided for people since at least 8 March 2016. On the two days of inspection entertainers were providing musical entertainment in one of the lounges. This had been arranged at short notice on the days of our inspection.

The provider had failed to ensure people's social preferences and needs were met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had not provided continuing opportunities for people and others involved in the service to provide feedback and act on that feedback to improve services. The provider's policy stated they should have undertaken a quality assurance survey every six months, but this had not happened. In August 2015 a survey had been undertaken and the results analysed. Results showed that 13 surveys had been completed and between 50 per cent and 93 per cent of people that responded indicated that areas of the service they were asked about were good and above. However there was no action plan to improve the areas that could be improved. People had made comments and there were no records that any action had been taken to address these comments or whether people had received any feedback. Staff and professionals were not canvassed for their views. Senior management told us there were residents meetings held. However the last minutes that could be found were for a meeting held in August 2015. During this meeting people had requested specific trips out and we asked staff if these had taken place and they told us they had not.

The provider had not sought or acted on feedback about the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

There was an established registered manager at Whitstable Nursing Home, although they were on leave at the time of the inspection. Rosters examined showed the registered manager worked 9am to 5pm Monday to Friday with the occasional nursing shift 8am to 8pm.

All care providers must notify us about certain events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes when a person is subject to a Deprivation of Liberty Safeguards (DOLs). Records showed that people had DOLs authorisations in place and a statutory notification informing us about this had not been made.

The registered person had not notified the Commission of events which they had a statutory obligation to do so. This is a breach of Regulation18 of the Care Quality Commission (Registration) Regulations 2009.

There were no effective systems to assess, monitor and mitigate the risks relating to people's health, safety and welfare or to assess, monitor and improve the quality and safety of the service provided. The audits folder showed most audits that had previously been undertaken by staff within the service, such as infection control, had stopped in March 2015 and staff and senior management told us they did not know why. A medicines audit that should have been undertaken monthly had been completed once since August 2015. Some health and safety checks were done, but no analysis of audits were present to indicate what actions were required to attain compliance with legislation or to minimise risks to people.

The culture of the service was not inclusive nor empowering of staff, nor person centred in the approach to the care and treatment of people. Staff did not have access to robust policies and procedures to ensure they worked effectively. During the inspection staff and senior management found it difficult to find policies and procedures that were asked for. Senior management told us that a new set of policies and procedures had been introduced, but these files were empty so staff would have been unable to refer to them should they have had a concern. Policies examined required review or updating. For example, one policy referred to previous legislation and another gave incorrect information about reporting abuse. The training and supervision matrix showed that there were shortfalls in staff receiving up to date training and supervision, but there was no evidence of management action to address these shortfalls. Discussions with staff and senior management during the inspection confirmed that they were not aware of how many vacancies the service had or how many staff were required to be recruited in order that minimum staffing levels could be maintained.

Records showed that improvements took a long time to implement. The Environmental Health Officer (EHO) had visited in January 2016 and the service had reduced from five stars to four stars. There were two shortfalls recorded on the report. One was in relation to out of date food and staff told us this had been addressed by changing the system for dating food. The other required staff involved in food handling to be trained in food hygiene. Records showed this member of staff still required training even though the EHO was due back in April 2016.

Senior management undertook visits to the service to assess and monitor the service. Records showed there had been three provider visits in the last 12 months September and November 2015 and February 2016. In September 2015 the senior manager stated that the registered manager was holding a dignity meeting in October 2015 where staff would receive dignity training and appoint dignity champions who would register. One of the staff identified for a dignity champion told us during the inspection they were still waiting for their training. At this visit implementing the Care Certificate was discussed with staff, but this has not yet happened. The report of the visit also stated that the call bell system needed updating and this had not happened at the time of the inspection. Shortfalls identified during the inspection had not been identified by senior management, such as the lack of staff appraisals since 2014, the lack of staff induction records and the infrequent staff and resident meetings.

The provider did not have adequate systems and processes in place and operated effectively to ensure compliance. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The registered person had not notified the Commission of events which they had a statutory obligation to do so.<br>Regulation 18(4) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider did not carry out, collaboratively with the relevant person, an assessment of the person's needs and preferences.<br>Regulation 9(3)(a) |

| 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<br><br>People were at risk of harm because the provider lacked systems and processes to prevent the abuse of service users<br>Regulation 13(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider did not operate an effective system for identifying and responding to complaints so people's complaints had not been responded to. |

Regulation 16(1)

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Records did not show a full employment history in any of the recruitment files examined, which the regulations required and to protect people from the risk of harm and abuse.<br>Regulation 19(2) and Schedule 3 |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not treated with dignity and respect at all times during care and treatment.<br>Regulation 10(1) |

**The enforcement action we took:**

A warning notice was issued to the provider that they take action to ensure people are treated with dignity and respect at all times.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider was not doing everything reasonably practicable to mitigate the risk of harm to people<br><br>People's hydration needs were not regularly reviewed and hydration assessments did not identify requirements to support the agreed care and treatment of people.<br><br>Regulation 12(1)(2)(b) |

**The enforcement action we took:**

A warning notice was issued to the provider that they take action to ensure that people received care and treatment in a

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have adequate systems and processes in place and operated effectively to ensure compliance.<br><br>The provider had not sought or acted on feedback about the service.<br>Regulation17(1)(2)(a)(b)(e)(f) |

**The enforcement action we took:**

A warning notice was issued to the provider requiring them to have systems and processes established and operated to

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The numbers of qualified, competent, skilled and experienced staff to meet people's care and treatment needs were insufficient.<br><br>The provider had failed to ensure staff received appropriate support, training and supervision.<br><br>Regulation 18(1)(2)(a) |

**The enforcement action we took:**

A warning notice was issued to the provider requiring them to take action to ensure that people had their needs met by