Abbey Healthcare (Westmoreland) Limited

Kendal Care Home

Inspection report

Burton Road
Kendal
Cumbria
LA9 7JA

Tel: 01539790300
Website: www.abbeyhealthcare.org.uk

Date of inspection visit:
03 May 2016

Date of publication:
21 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection of Kendal Care Home took place on 3 May 2016.

We last carried out a full comprehensive of this service on 30 September and 06 October 2015. The registered provider did not meet the requirements of the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014 and was rated as 'Inadequate'. The service was placed in 'special measures' by the Care Quality Commission (CQC). The special measures framework is used to help make sure that registered providers found to be providing inadequate care significantly improve. It requires there is a timely and coordinated response from a provider where CQC has judged the standard of care to be inadequate. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kendal Care Home on our website at www.cqc.org.uk.

We further carried out four other visits to the service between 20 December 2015 to 01 February 2016 to follow up on two warning notices issued.

During this inspection in May 2016, we found the provider had made improvements and was meeting the fundamental standards inspected with the exception of Regulation 12 (Safe care and Treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

As a result of the improvements made, the service has been taken out of special measures. The service will be expected to sustain the improvements and this will be considered in future inspections.

Kendal Care Home provides nursing and residential care for up to 120 older people, some of whom are living with dementia. The home is over three floors and has a passenger lift for access to these. There are three units in the home and all the bedrooms are single occupancy with ensuite facilities. Each of the three units have communal dining and lounge areas. There is a cinema room for people to use. The home is set back from the main road, with level access grounds. There is ample car parking for visitors. At the time of the inspection there were 58 people living there.

The service did not have a registered manager in post at the time of this inspection . A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered provider had recruited a suitable person for this post and they were working in the home when we inspected. They were in the process of applying to register with CQC as the registered manager.

We found that the registered provider had been making improvements as outlined in their action plans . We

found that medicines were now being handled safely and the management of training had improved with a programme of planned training in progress. The service was also using a dependency tool assessment to help ascertain the numbers of staff they needed based upon people's dependency and individual needs.

At this inspection we saw that improvements had been made in applying the principles of MCA and training was being given to help staff deal with situations where restraint might be needed. At this inspection the monitoring of nutrition and hydration had significantly improved and was being addressed through monitoring by management. At this inspection we found that improvements had been made in reviewing and monitoring all care plans and assessments.

The two new breaches of regulations were in relation to making sure there were appropriate governance structures in place for all aspects of care being provided and to continuously improve the welfare of people. The registered provider had not demonstrated to us they had done everything possible to ensure the care and interventions provided were in line with nationally recognised guidance for the use of low level restraint. This lacked clear monitoring and analysis to make sure people received appropriate intervention a to prevent avoidable risks.

People we spoke with who were living in the home were positive about their care and the changes that had taken place within the home. They told us, "I feel safer living here" and that "The staff are lovely" and "Nothing is too much trouble". We spent time with people on all the units during the day. We saw that the day staff offered people assistance and took up the opportunities they had to interact with them and offered reassurance if needed. Care staff knew how to protect people's privacy and we observed this in practice.

People living at Kendal Care Home were able to see their friends and families as they wanted and go out when they wanted with them. There were no restrictions on when people could visit them. We could see that people who were able to made day to day choices about their lives in the home and were able to follow their own faiths.

We found that the registered provider was keeping the numbers of staff up to acceptable levels in line with the dependency tool the service used and were using some agency staff to meet this. We found that a system of management staff cover and on call systems was in place and this was well advertised throughout the home. This meant that a member of management staff should be easily contactable outside normal working hours. People living in the home told us they felt the staff "worked hard" to look after them.

During observations at lunch time we saw that people who required support with eating received this in a respectful way with staff prompting people with their meals and asking them what they wanted to eat and drink. We saw some good interactions between staff and people living there including encouraging people to help themselves to what they wanted.

Sometimes on the unit where people were living with dementia staff from other units supervised for short periods on night duty. This was when all three staff on the unit were giving personal care to a person needing three to assist them. This was not ideal to take staff from their work duties on other units and we recommended that the registered provider take advice on risk assessing this practice.

We saw that recruitment was continuing in the home and new staff had been employed in activity provision, nursing, care assistants and a new manager. There were safe systems of recruitment being used and the staff recruitment files showed that a Disclosure and Barring Service (DBS) check had been completed before they had started working in the home. The registered provider had systems in place to train staff in recognising possible abuse and how to respond if they suspected it

Medicines were now being safely administered and we saw that accurate records were kept of medicines received and disposed of so they could be accounted for. The time between morning and lunchtime doses of the some medicines were not always recorded and we recommend that the service seek advice and guidance from a reputable source on how to manage this risk. For medicines requiring refrigeration we recommended that the registered provider consider current best practice guidance on this.

Some audit findings on care plans that required updating had not been followed up to ensure they had been addressed. We recommended that the service seek support and training on managing the follow up on audit results to make sure all care plans were updated promptly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Significant improvements had been made to medication administration and on providing staffing based upon the dependency needs of people.

The improvements made to systems in place the home to help ensure safe care were still being embedded.

Staff we spoke with in the home knew how to recognise possible abusive situations and how it should be reported.

Is the service effective?

Requires Improvement

The service was not always effective.

Training, learning and development for staff was being assessed and planned for and in progress. When this was complete all staff should have the knowledge and competence to effectively and safely fulfil the requirements of their roles.

Systems were in place to make sure people were protected from improper treatment, as set out in the Mental Capacity Act 2005 but recognised guidance was not being used to oversee any incidents of low level restraint authorised under DoLs.

There were systems in place to make sure the nutritional and hydration needs of people were being assessed and provided for.

Is the service caring?

Good

The service was caring.

Staff demonstrated knowledge about the people they were supporting, for example information on their likes and dislikes and daily routines.

People's privacy was being promoted and we saw that where staff engaged with people it was friendly and polite.

There were information leaflets and booklets available for

people in the home to look at and inform and their choices. This included information about support agencies such as advocacy services that people could use.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The improvements being made to systems for reviewing care plans in the home to help ensure plans were person centred and up to date were still being embedded.

Support was provided to follow their own interests and faiths and to maintain relationships with friends and relatives and local community contact.

There was a system in place to receive and handle complaints.

Is the service well-led?

Requires Improvement

The service was not well- led.

There was no evidence that restraint, when it was needed, had not been subject to rigorous monitoring to make sure the people were protected from any inappropriate care or treatment.

A new manager had been recruited but there was no registered manager in post at the time of the inspection.

There were systems being used to assess the quality of the service provided. Restraint monitoring had not been implemented as part of the improvements being made.

Kendal Care 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.

We visited the home on 3 May 2016. The inspection was unannounced and the inspection team consisted of four Adult Social Care (ASC) Inspectors and a pharmacist inspector.

During our inspection we spoke with 12 people who lived in the home, six relatives/visitors, four nurses, eight care staff, ancillary staff, including domestic, catering and activities staff. We also spoke with a visiting religious minister who provided multidenominational services. We spoke with the new manager, the regional manager, the unit managers and the newly appointed activities supervisor. We observed the care and support staff provided to people in the communal areas of the home and at meal times. We spoke with people in communal areas and in private in their bedrooms. We looked in detail at the care plans and records for nine people and tracked their care. We looked at records that related to how the home was being managed. We looked at the recruitment records for eight new staff working in the home and the profiles of agency staff being used on shifts.

We spent time speaking with and observing people and staff in various areas of the home including the dining rooms and lounge areas on both sites. We were able to see some people's bedrooms and bathrooms and the communal bathrooms and laundry and kitchen areas.

We looked at records, medicines and care plans relating to the use of medicines in detail for people living on all three units. We observed medicines being handled and discussed medicines handling with staff. We checked the medicines and records for 10 people and spoke members of nursing and care staff with responsibility for medicines.

Some people living at the home could not easily give us their views and opinions about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us better understand the experiences of people who could not easily talk with us. It is a useful tool to help us

assess the quality of interactions between people who use a service and the staff who support them.

Before our inspection we reviewed the information we held about the service, including information we had asked the registered provider to send to us on staffing levels. We also contacted local commissioners of the services provided by Kendal Care Home to obtain their views of the home. We spoke with community and specialist nurses and health care professionals involved in providing care and support to the people living there to get their views on service provision and performance.

We looked at the information we held about notifications sent to us about incidents and accidents affecting the service and people living there. We looked at the information we held on safeguarding referrals and applications made under deprivation of liberty safeguards.

Before this inspection, the provider completed and returned to us a current 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 any improvements they planned to make.

Requires Improvement

Is the service safe?

Our findings

All of the people who were able to speak to us who lived in the home were positive about the support they had received and about the staff. One person told us "I feel safe, I feel like I am at home" and another said "They [staff] answer my bell, I feel much safer being in the home". We were told that "The staff are lovely, nothing too much trouble. They used to be really run off their feet but it seems better now". We were also told "The staff are kept busy all the time but they come in and check up on me". One person said "I have to be hoisted now and there's always two to do it" and also "I have no regrets about moving in, I need nursing care".

At the last comprehensive inspection in September and October 2015 we found the management of medicines in the home did not follow the services policies and procedures and current best practice. Also while there were adequate numbers of staff being made available to support people the staffing levels could fluctuate and lacked continuity.

Relatives we spoke with also had positive things to say about the service. One commented, "I am very, very happy with the staff, there are always two to hoist [relative]". Another told us "There seems to be enough staff about, they always answer [relatives] bell". One family member commented "It's friendly, I know most of the staff on here now, I feel [relative] is very safe". A relative who was visiting told us "There seem to be a few more staff about, some new ones and there are two nurses always on now".

Some staff were positive about the direction of the service and told us "There have been lots of improvements in the last few months" and that "Things seem better organised now, much smoother". "We were told that the service was "moving forward at last" and also "I think there is now usually enough staff". However other people working there had different experiences and told us they did not think there was not always enough staff.

We found at this inspection that the registered provider was working to maintain staffing to acceptable levels and planning rotas based upon a dependency tool to try to make sure all units had sufficient suitable staff. We saw that this system was in its early stages of implementation and needed to embed and be used consistently to demonstrate its long term effectiveness as a staff planning tool.

Agency staff were still required on day shifts to cover sickness and were used predominantly on night shift. Recruitment was continuing to try to achieve a full permanent staff establishment on both day and night shift and dependency tools were being gradually embedded to help staff levels remain more stable. We found that management checked the numbers of staff on all the shifts throughout the day and responded to any unexpected absences, moving staff if needed to provide sufficient cover.

We looked at the staff rotas for the previous six weeks and those planned for the next four weeks. We saw that these were affected by unexpected staff absences and were altered as a result to try to maintain cover. The management currently had adequate staffing levels in excess of their assessed dependency levels. We discussed with the management team that this would require very close monitoring should the service start

to take new admissions.

When we inspected on 3 May 2016 there were two care staff rostered to support the 10 people who lived on the residential unit, one a senior carer. Dependency levels were low on the unit but we could see when occupancy was higher there had been three staff on day duty. The night rota had planned for two staff. Due to sickness there were gaps on the night rota yet to be filled for four days of the week. We were told this would be covered either internally or using agency staff.

Care staff on the unit told us "I have time to give people, with 10 people we have not needed to ask for any more staff". They told us they "enjoyed" spending time with the people on the unit. No one on the residential unit had any complaints about the staff or their availability. One person on the unit told us the staff were "All lovely lasses, do anything for you, very kind".

There were 24 people living on the nursing unit and there were two registered nurses on duty all day when we visited and one rostered for night duty There were seven care staff available to assist people during the day and two at night.

On the unit where 24 people were living with dementia there were two registered nurses on duty all day and one at night. The unit appeared to be well organised in terms of division of work on the day shift. Dependency levels were high on the unit. Thirteen people required regular repositioning, four people were subject to a deprivation of liberty order (DoLs), one person required up to three staff for personal care and moving and handling and there were two people who tended to stay awake at night and move around the unit. Therefore there may be times when all three staff could be fully occupied assisting one person and there would be no staff presence to monitor the unit, answer call bells and supervise those still awake and mobile. We discussed this with the management team. They told us that a staff member from another unit could supervise short periods when all three staff were engaged in giving care to be available should anyone need assistance.

We recommended that the registered provider take advice on risk assessing this practice.

We found that a system of management staff cover and on call systems were in place and this was well advertised throughout the home. This meant that it should be easy to contact a member of management outside normal working hours.

We looked at the medicine charts belonging to ten people on each of the three floors of the home. There were no 'gaps' in the records of administration. The amount of medicine in stock on the day the chart started was recorded so medicines could be accounted for. We checked the stock of some people's medicine against the chart records and found no discrepancies. This indicated that the records were accurate and people were given their medicines in the right way. We also saw extra information (protocols) guiding staff how to administer medicines prescribed only when required.

Care staff on the residential unit confirmed that they had been given training on medication and been assessed for competency. We watched people who lived on the middle and ground floors of the home being given their medicines. Apart from one occasion where an open medicine trolley was temporarily left unattended staff administered medicines safely. Staff respected people's preferences about how they took their medicines and gave medicines at the right times.

During our visit a safe length of time was left between morning and lunchtime doses of the same medicine. However, staff did not record the exact time tablets were given so there was a risk of a person receiving

doses too close together. We recommended that the service seek advice and guidance from a reputable source on how this can be managed and recorded.

People were able to self administer their medicines if they wished and could do so safely. We saw appropriate agreements and assessments relating to self-medication in people's records. The agreement asked people to store medicines securely but we found that one person left some tablets unlocked while away from their room. This could put other people living in the home at risk if they went into the room and took the tablets. We discussed this with the management team who were going to consult with the person about locking their bedroom door when they were out.

Medicines that are controlled drugs were stored and recorded in the way required by law. The home continued to audit the use of medicines, though audits were done were less frequently on the middle nursing floor.

Medicines were being stored securely and at the right temperatures. However, medicine refrigerators were not monitored properly as maximum and minimum fridge temperatures were not recorded. We had previously found at the last comprehensive inspection that refrigerator temperatures for the safe storage of some medicines were not being recorded every day.

We recommended that the registered provider consider current best practice guidance on the storage of medicines requiring refrigeration.

The registered provider had systems in place to train staff about recognising possible abuse and how to respond if they encountered this. Staff working on the unit told us they had received training in safeguarding adults. We saw information on all the three units on what to do if anyone, staff, person living there or visitor, suspected someone was being abused in some way or at risk of abuse or harm. This meant staff and people using or visiting the service had information on what to do so they could act themselves.

Risks to people were being identified and assessed. Each care record had information about the risks associated with people's care and how staff should support the person to minimise the risks. Care records included risk assessments of people's mobility and moving and handlings needs, the use of bedrails, the potential risk of falls and of pressure ulcers developing.

The staff recruitment files showed that security checks were being done on new staff. We looked at the records for the four new nurses employed, the new activities supervisor and care staff. Disclosure and Barring Service (DBS) checks had been completed before people had started working in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. Confidential checks on health for prospective employees were carried out in respect of requiring any reasonable adjustments. This had been recommended at the last comprehensive inspection. Profiles of qualifications and registration confirmation for all agency nurses working there were being held with their induction information.

Significant improvements had been made to medication practices and planning staffing against assessed dependency. The steps taken need to embed into the service provision and continue to be maintained and monitored to promote continued improvement. This will promote sustained good and safe practice.

Requires Improvement

Is the service effective?

Our findings

People who lived in the home gave us their views on the food provided. One person told us they were 'resident of the day' that day so they could choose whatever they wanted for their lunch. They said usually staff came round to ask them what they wanted from the menu. One person said "The food is very good some days, others not so good". Some people had pictorial menu formats to help them choose. A relative we spoke with about care in the home told us "The staff seem to know what they are doing".

At our previous inspection 30 September and 6 October 2015 the registered provider had not provided the support and systems for permanent and agency care and nursing staff to ensure they had the training needed to make sure they could effectively fulfil all the requirements of their roles. At this inspection we found this had improved. Also the registered provider had not ensured the systems in place were effective to make sure people were always protected and that staff always worked within the requirements of the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards

There was a training matrix in place recording the training staff had done and what they needed and this indicated systematic approach was being taken to identifying training needs. Training needs were being identified and training was being organised and records were being kept of the training done. However some training ,although the dates were planned, still had to be completed to make sure all nursing and care staff could respond correctly to all people's needs. The training matrix showed fire training was up to date and mandatory training was being attended to but the progress to achieving all the required training was slow with many gaps on e-learning being done by staff. There were profiles for agency staff to show their qualifications, security checks and induction to the home. The service still had work to do to make sure their planned training was completed in full by everyone who needed it.

Staff we spoke with told us that they were getting more regular supervision and that they were doing the planned training. Staff we asked confirmed they had completed the mandatory training first, including updating moving and handling training, infection control, safeguarding and first aid. We were told that they had talked about the training they needed to do at their supervisions. Staff we spoke with were keen to undertake training to support their roles especially in dementia care.

We were told by staff on the unit where people were living with dementia that training had been given to some staff on 'breakaway techniques'. This is training that teaches staff how to avoid or how to 'break away' from a potential assault. Some, but not all, of the staff on the unit had received training on restraint the previous month and on physical intervention.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had made requests to the 'supervisory authority 'to make sure any restraint was agreed and appropriate. We checked at this inspection 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.

We found examples of where staff on a unit had received some training required for their roles but colleagues working with them were still waiting to do the planned training. This could impact upon people's care. For example, on the unit where people were living with dementia we examined the records for two people who were subject to a DoLs authorisation from a supervisory authority. One person's authorisation stated, "Kendal Care Home staff need appropriate training in low level restraint and for protocols around this to be clear in [person's] care plans, use of low level restraint needs recording in order that its use can be reviewed and evaluated to reduce risks to [person} and safeguard [person]". The staff supporting this person had not received training on the protocols required or on how to follow up, analyse and review incidents where authorised restraint was used. We asked the management team for the home's protocols in line with current guidance but these were not in place. We were told by management there was an incident form for staff to report when restraint had occurred. In this case the condition on the authorisation requiring protocols had not been met.

Staff confirmed that a person had been subject to low level restraint the previous week, although behaviour charts and daily notes did not reflect this. Staff we spoke with were not aware of the required protocols for the recording, monitoring and auditing physical intervention in the home after using restraint in line with national guidance and good practice. This had not been included as a necessary part of the training they had received to complete the process to promote a person's safety and rights. As a result of this there was not an effective care management structure in place to safeguard the person and review the use of the restraint.

This was a breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not demonstrated they had done everything possible to ensure the care and intervention provided was in line with nationally recognised guidance and that clear monitoring and analysis was being done to make sure people received appropriate intervention and prevent avoidable risks.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The care plans we looked at had records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a decision. Mental capacity assessments had been done concerning making a decision on 'do not attempt cardio pulmonary resuscitation' (DNACPR) and families had been involved in meetings about best interests. We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful.

All of the care plans we looked at contained information on specific dietary needs, preferences and intolerances. All had an individual nutritional assessment. We observed what was happening during meal times in the dining rooms and how people were supported as they had their lunch. We saw that staff offered people snacks and drinks throughout the day. This included soft drinks, and alcohol with their meals if requested.

To help us get a better understanding of people's experiences we used the Short Observational Framework for Inspection (SOFI). We did this on the three units. At lunch time we saw that people who required support with eating received this in a respectful way with staff prompting people with their meals and asking them what they wanted to eat and drink. A care assistant sat at the tables with people and there was some good and positive interactions between staff and people living there including encouraging people to help themselves to what they wanted. We noted that some staff engaged with people more easily and positively

than others.

Good

Is the service caring?

Our findings

We asked people who lived Kendal Care Home about how they were cared for and how staff supported them to live as they wanted. We were told us they were "happy" and "satisfied" with the care and support they received and that the staff were "lovely". One person said "No one has ever spoken out of turn to me, they [staff] talk to you like they have known you for years". We saw staff talking to people in a polite and friendly manner. They called people by their preferred names as stated in their care plans.

A relative we spoke with told us there were no restrictions on their visiting and that they had found the care staff to be "attentive and gentle with people" and that they had been "pleased with the staff attitudes". One relative told us they visited every day and found their relatives care was "very good". They told us," Nurses, cleaners, everyone I can't fault them, whatever we ask for they are there". " We were also told by a relative "The staff make me welcome and look after me as well".

We used the Short Observational Framework for inspection, (SOFI) to observe how people in the home were being supported and were spending their time. We sat with people living with dementia in a communal area of the home. We saw that people who could not easily tell us their views appeared relaxed with the staff that were supporting them.

People's privacy was being respected. We saw that staff protected people's privacy by knocking on doors to private rooms before entering and making sure doors were closed where care was being given. All the bedrooms in the home had ensuite toilet and shower facilities so people had privacy for their personal care needs. People we spoke with told us that they saw their doctors in their own room when they visited.

Bedrooms we saw had been personalised with people's own belongings, such as photographs and ornaments to help people to feel at home. Throughout the time we spent in the home we saw that people had free access to their own rooms at any time and some people chose to remain in their own rooms for a lot of the day. Where people were living with dementia there was signage to show people what different areas were for. This was to help people with memory problems to be able to move around their home more easily and more independently.

We saw that staff maintained people's personal dignity when assisting them with mobility and in using the mobility equipment they needed. This meant that people were able to spend their time in private if they wished to.

There were information leaflets and booklets available for people in the home to look at and inform and their choices. This included information about the home, the services offered and about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

The nursing and care staff we spoke with understood the importance of providing good care at the end of a person's life. Care plans contained information about people's care and treatment wishes should their

condition deteriorate. People were able to say what their preferred place for end of life care was and what was important to them at the end of life.

Requires Improvement

Is the service responsive?

Our findings

During our observations in the lounges and dining rooms we spoke with people who lived in the home. One group of three told us they were happy with their care and had "no complaints at present". They told us if they had any worries they would speak to whoever was in charge on the day. The service had a complaints procedure that was available in the home for people. People who lived on the residential unit told us they had not felt the need to make a complaint but would feel comfortable raising anything they were not happy about with the unit manager. People told us about activities they took part in. One person who spent a lot of time in their room told us that the activities person had been in to see them that day for a chat and had brought in a rabbit and guinea pig so they could "give them a stroke". They said they had enjoyed seeing the animals.

At our previous inspection 30 September and 6 October 2015 the registered provider had not made sure that each person received appropriate person centred care based upon ongoing assessments and reviews of their needs.

We found that improvements had been made on the reviewing and monitoring of care plans and gaps in information were being identified more frequently by using audits. However the timescales for making necessary changes was not always being made clear for staff and some had not been followed up to ensure they had been addressed. The improvements being made need to embed within the service so the systems become familiar to staff and demonstrate the improvements can be sustained.

We recommended that the service seek support and training on managing the follow up on audit results to make sure all care plans were updated promptly.

We noted that a personal emergency evacuation plan (PEEPs) had not been updated to reflect a person's new location and changed needs. This occurred when a person had moved from the residential unit to the nursing unit because their care needs had changed. We drew this to the attention of the management team to address promptly. The standard of the care plan record keeping and monitoring had improved since our last inspection. Some areas were less consistent than others such as making sure weights were regularly recorded and also oral hygiene. For example, it had not always been recorded when a person had received mouth care for their dental needs. Feedback from the dentist and our own observations indicated that the person's oral hygiene was good and helping to resolve the person's dental problems. However staff had not always recorded when they did it.

People's care records showed that their needs were being assessed prior to admission to the home. The information gathered was used to develop individual care plans. Where possible people were being supported to make their own daily choices and take part in activities outside the home as well as within. The plans that were developed indicated that people had their personal and health assessed and recorded following admission.

People had risk assessments in place to inform their care planning and the individual support they needed

from staff in personal care. The assessments included personal and daily care needs and preferences, their skin integrity and risk of falling, mental health, nutrition and mobility and moving and handling needs. We found some examples of good practice in people's challenging behaviour plans that contained good strategies for staff to manage people's difficulties.

We found evidence that people were being referred to their own GP's as well as other health professionals and services for treatment and assessment, for example, speech and language therapist, dentists, opticians, occupational therapy and dieticians.

People living at Kendal Care Home told us that staff helped them take part in activities and pastimes they enjoyed. People told us about going out, seeing their visitors and being able to attend religious services and follow their own faiths. The home had a programme of organised activities and dedicated activities staff to support this. We saw on the home's notice boards many pictures of social events, trips out and celebrations that people living there had taken part in. Activities were going on in the home during the visit. We spoke with one person who was on their way to the gardening session which that said they enjoyed along with the "handicrafts". Information on people's preferred social, recreational and religious preferences were recorded in their individual care plans.

A new activities supervisor who was an occupational therapist had been recruited to lead the team of three staff who supported people with activities. They had completed a 'train the trainer' course to teach and support staff in providing personal activities for people. The activities staff were spread over the three floors. There were 'activities boards' on all the units so people could see what was being organised for them if they wanted to take part. We saw that there were several activities organised around music that people could participate in.

Requires Improvement

Is the service well-led?

Our findings

One person who lived in the home told us "It wasn't that good at first, too many managers coming and going but since Christmas it's been much better. Relatives told us they had been kept informed about the recruitment of the new manager and that they had seen and spoke with them whilst out on the units. A relative said" I have met the new manager, they made a good impression and I have seen him walking around the home and units". Staff told us that so far they had found the new manager to be "approachable".

At our last comprehensive inspection 30 September and 6 October 2015 we found that the registered provider was not operating an effective system and processes to make sure the service maintained accurate records and practiced good governance.

During our focused inspection in January 2016 we found that the registered provider had improved on quality monitoring issues and was doing more quality audits. However for some there were not clear and detailed contingency plans and escalation systems in place for responding to emergencies and untoward events. At this inspection 3 May 2015 we found that clear contingency plans, information for staff and how to escalate action for emergency situations were now in place so everyone should be aware of their responsibilities and levels of delegated authority.

The service still used its 'resident of the day' programme to make sure that everyone received a full review as the resident of the day. There were also regular monitoring visits from the regional manager .The management team did a walk round of the home each day and checked on staffing levels and records and held daily meetings to respond to any issues or problems that had arisen. All of this was as stated in the action plans the registered provider had provided to CQC and showed a commitment to establishing a verifiable system of quality monitoring. We saw some issues that although highlighted during audits that were not being followed up in a timely manner and we raised that with the management team. These improved governance processes still need to become fully established and be maintained to demonstrate sustained improvement.

Audit and governance systems were being used to monitor that procedures were being followed by staff. For example we saw that the homes own audits were picking up on issues such as staff not recording some information and also checking on medication practices. To complete the monitoring process the issues found needed to be consistently followed up to ensure they had been addressed by staff. There were some occasions when a follow up check had not taken place, for example, when it had been identified that weights were not being monitored as required in people's care plan assessments.

We found that the registered provider had reviewed the training the home needed to implement. This enabled management to be able to plan ahead in order to provide what each staff member required for their role. This included the start of a programme of staff training on restraint and physical intervention. The registered provider had not put in place a system to monitor this activity. There was no evidence that restraint, when it was needed, had not been subject to rigorous monitoring to make sure the people were protected from any inappropriate care or treatment.

This was a breach of Regulation 17 (1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because registered provider had not made sure systems were in place to ensure an appropriate governance structure for all aspects of care being provided and seek to continuously improve the welfare of people.

We saw that the registered provider was displaying the home's current rating in the foyer. This is required by the regulations.

The home did not have a registered manager in post as required by their registration with the Care Quality Commission (CQC) since March 2015. The provider had recruited two managers in that time but they had not completed registration with CQC before they left. When we inspected a new and experienced manager had been recruited and was in the home on the day of the inspection. They were still undergoing their induction and would be applying to register with CQC. This lack of a permanent registered manager may have impacted upon the implementation of changes taking longer as senior staff had changed. However there had been a strong management presence as regional managers had been in the home on a regular basis to help manage and drive forward changes.

The management team had in place action plans to address the areas identified as requiring improvement and were working with commissioners, stakeholders and CQC to achieve and maintain the required improvements. Support was being given by those commissioning the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not demonstrated they had done everything possible to ensure the care and intervention provided was in line with nationally recognised guidance regarding the use of low level restraint and to ensure clear monitoring and analysis was in use to make sure people received appropriate intervention a to prevent avoidable risks

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not made sure systems were in place to ensure appropriate governance structures were in place for all aspects of care being provided and to continuously improve the welfare of people.