Mrs P Kent

Kent Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

We carried out this focused inspection on 30 April 2015. This focused inspection was carried out to check that the provider had made the improvements required following our comprehensive inspection on 13 and 17 February 2015 and our unannounced focused inspection on the 9 March 2015.

Following our previous comprehensive inspection in February 2015 and our focused inspection in March 2015, we asked the provider to take action to make improvements as we found evidence of major concerns at both inspections in relation to the quality and safety monitoring of the service. There was a continued failure to ensure that service users were protected from the risks associated with improper operation of the premises. This meant that the safety and welfare of people using the service was at risk and the provider was failing to provide a safe service. There was a continued lack of training and supervision support provided for staff. The provider was not meeting the requirements of the law as they did not protect people against the risks of receiving care or treatment that was inappropriate or unsafe.

We formally notified the provider of our escalating and significant concerns following our comprehensive inspection on 13 and 17 February 2015 and ongoing emerging risk and concerns shared with us by stakeholders. We informed the provider that we were in

Summary of findings

the process of making a decision with regards to their continuing failure to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the lack of management within the home. We placed a condition on their registration to stop them admitting any further people to their service. We asked the provider to inform us immediately of the urgent actions they would take with immediate effect to protect people and raise standards. We received a response to the urgent action letter on 6 March 2015. This contained a basic action plan but did not address all of the requirements of the urgent action letter. This was further evidence of our lack of confidence in the provider's ability to understand the issues and independently ensure that the service provided safe and effective care.

We carried out a focused inspection on the 9 March 2015 following further concerns identified by the local safeguarding authority and to check if improvements had been made as described in the provider's action plan. This inspection was unannounced. At this inspection we continued to have major concerns regarding the lack of action taken by the provider to safeguard people. There was a continued lack of leadership of the service as the service continued not to have a manager registered with the Care Quality Commission (CQC) as is required by law.

The provider continued not to provide staff with guidance in the actions they should take to deliver care in such a ways as to meet people's individual needs and to safeguard them from harm. People's safety had continued to be compromised in a number of areas. This included the continued lack for recording and analyses of accidents and incidents as well as a continued lack of guidance for staff in responding to emergency situations. The provider had failed to identify areas of the service that were unsafe and failed to take action to protect people from the risks of harm.

This report only covers our findings in relation to the previous breaches. You can read the reports from our comprehensive inspection carried out 13 and 17 February 2015 and our last focused inspection 9 March 2015, by selecting the 'all reports' link for 'Kent Lodge Care Home' on our website at www.cqc.org.uk

We carried out this focused inspection on 30 April 2015. This inspection was unannounced.

Kent Lodge provides accommodation and personal care support for up to 30 older people who require support including people living with dementia. On the day of our inspection there were 19 people living at the service.

At this focused inspection we found that improvements had been made with evidence that the service was working its way towards improvement. However, we continued to have major concerns regarding the lack of action taken by the provider to safeguard people in the management of their medicines as prescribed.

The service had employed a new manager since March 2015 who had been employed for just five weeks by the day of our visit and was not registered with the Care Quality Commission (CQC). This service has not had a registered manager for in excess of three years. 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.

All staff and people who used the service were complementary regarding the new manager. The manager's action plan demonstrated steps taken towards planning for improvement of the service.

However, we found the provider continued to fail to take action to manage people's medicines safely. There was a continued lack of systems in place which would enable effective monitoring of medicine stocks and audits of administration records. This meant that the provider that not taken steps to identify medicines administration errors and protect people from the risks of not receiving their medicines as prescribed.

Although we found some improvement at this focused inspection, we found the provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times.

Whilst action had been taken by the provider to rectify the lack of hot water to people's bedrooms and install heating to bathrooms, further action was needed to maintain standards of hygiene and improvement of the laundry area.

Summary of findings

Recent visits from environmental health inspectors and a fire officer highlighted a number of areas where action was required by the provider to improve the safety of the environment and protect people from the risk of harm.

Care plans had been produced and people at risk of malnutrition and pressure ulcers had these risks identified with action plans in place to guide staff in the steps they should take to mitigate and reduce risks to people's health, welfare and safety. However, action to support people at risk of inadequate nutrition and hydration was not consistent and this placed people at risk.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People had been placed at continued risk of not receiving their medicines as prescribed as medicines had not been managed safely.

We were not assured that adequate steps had been taken to prevent, detect and control the spread of infections. Not all areas of the service had been adequately maintained. This included the laundry room which was found not to be a safe, clean environment.

Recent visits from environmental health inspectors and a fire officer highlighted a number of areas where action was required by the provider to improve the safety of the environment and protect people from the risk of harm.

Is the service effective?

Requires improvement

The service was not consistently effective.

Care and treatment for people at risk of falls, dehydration and support to maintain their oral health was not effectively assessed, planned and responded to. This placed people at risk of not having their needs met.

Care plans had been produced and contained assessments of people's capacity to make decisions about their everyday lives. People had signed to say they consented to their care and treatment.

Is the service caring?

Requires improvement

The service was not consistently caring. The majority of people were complementary about the kindness of staff. However, concerns expressed about one member of staff were communicated to the manager for their investigation.

People's privacy and dignity was not always respected by staff when entering their rooms.

People's confidential information was not held securely.

Is the service responsive?

Inadequate

The service was not consistently responsive. Care plans had been produced and people at risk of malnutrition and pressure ulcers had risks identified with action plans in place to guide staff in the steps they should take to mitigate and reduce risks to people's health, welfare and safety. However, action to support people at risk of falls and inadequate nutrition and hydration was not consistent.

Summary of findings

People told us that they could freely raise any concerns with staff. The manager's action plan described plans to implement opportunities for people to express their views this included regular meetings with people who used the service and their relatives.

Is the service well-led?

Requires improvement 

The service was not consistently well led. The provider had continued not to be actively involved in carrying out any quality and safety monitoring of the service and continued not to engage

All staff and people we spoke with were complementary regarding the new manager who had been in post just five weeks.

The manager's action plan demonstrated steps taken towards planning for improvement of the service.

Kent Lodge Residential 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 carried out this focused unannounced inspection of Kent lodge on 30 April 2015.

The inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the service, this included the provider's action plan.

We spoke with the local authority safeguarding team and reviewed all other information sent to us from other stakeholders such as community nursing services.

We spoke with six people who were able to verbally express their views about the service and two people's relatives. We observed how care and support was provided to people throughout the day. Including the midday meal within the communal dining room. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at records in relation to five people's care. We spoke with five members of staff, including care staff, senior care staff and the manager. We looked at records relating to the management of medicines, staff training, staff rotas and systems for monitoring the quality and safety of the service.

Prior to our inspection we had received concerns about the service provided; these had been reported to and investigated by the local authority. The local authority had kept us updated with the support they were providing to the service to assist them to improve the care and support provided to people. During our inspection we checked to see what action had been taken as a result of these concerns.

Following our visit we spoke with the fire officer who had recently carried out an inspection of the service. They sent us a copy of the report sent to the provider with requirements and timescales for action.

Inadequate

Is the service safe?

Our findings

At our previous comprehensive inspection of Kent Lodge on 13 and 17 February and also on our focused inspection 9 March 2015. We found that the provider had continued to fail to take action to ensure people's health and welfare was not put at risk. People's health, welfare and safety had not been properly assessed. We identified continued significant concerns as medicines were not managed safely to ensure people received their medicines as prescribed. The premises had not been maintained and people safeguarded from the risk of harm.

Whilst we found some improvement at this focused inspection 30 April 2015, we found ongoing concerns and that further work was required to ensure the provider was meeting the legal requirements.

At this focused inspection we found the provider continued to fail to take action to manage people's medicines safely.

We looked at the medicine administration records and care notes for six of the 19 people who lived at the service. A check of stock against administration records indicated that people had not received their medicines as prescribed. The number of medicines remaining did not balance with the records of receipt and administration of these medicines. We were unable to account for all but one of the medicines in our audit because the amount of stock did not match the administration records. For example, two people were prescribed the anticoagulant Warfarin, a medicine used to thin the blood. Records showed that these people had not received their medicines as prescribed. This was confirmed by senior staff. Another person who had been discharged from hospital 10 days prior to our visit had not received one of their medicines as prescribed. This stock of medicine was found in the medication trolley but had not been recorded as received into the service on this person's medicines administration record (MAR).

Where people had been prescribed medicines on a when required basis, for example for pain relief, or when they were prescribed in variable doses, for example one or two tablets, we found insufficient recording of the amounts administered for all of the variable dose medicines we looked at. This meant we were unable to balance the items of stock against the MAR records. For example, one person prescribed Lorazapam a medicine used to treat anxiety disorders was prescribed this medicine up to three times a day when necessary. We found that there was 29 items unaccounted for. Senior staff told us they did not know what treatment this medicine was prescribed for. There was a lack of guidance for staff in care plans as to the reasons medicines had been prescribed and the circumstances when variable dose medicines were to be administered. We were not assured that staff had the guidance they needed to ensure the proper and safe management of people's medicines.

The metal trolley where medicines were stored was not secured to the wall as is required by law. The steel lead was broken and in need of replacement. We brought this to the attention of the manager and senior carer who told us they would arrange for a new lead and bracket to be ordered and fixed as a matter of priority.

There was a continued lack of systems in place which would enable effective monitoring of medicine stocks and audits of administration records. This meant that the provider that not taken steps to identify medicines administration errors and protect people from the risks of not receiving their medicines as prescribed.

The provider did not have in place a policy and procedural guidelines for staff in the actions they should take to ensure that safe handling and management of people's medicines.

The majority of staff including night staff had received training in the use of the providing pharmacists monitored dosage system. However, the manager confirmed that this training did provide staff with the knowledge and guidance required in the proper and safe management of people's medicines. Staff did not receive regular assessment of their competency to administer medicines to people.

Administration records, for prescribed creams and lotions were found to have been completed appropriately to show that people had been administered with their prescribed creams when needed.

These shortfalls demonstrated a continued breach of Regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our comprehensive inspection 13 and 17 February 2015 we found shortfalls in the numbers of suitability qualified staff and competent staff available at all times. Although we found some improvement at this focused

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Is the service safe?

inspection, we found the provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times.

People we spoke with and their relatives told us, there was not always enough staff available at all times. One person told us, "They come when they can but they are short sometimes, particularly in the afternoons. The staff complain about this to us." One relative told us, "It is more noticeable in the afternoon that there is not always enough staff around. You have to look for them."

Staff told us that there was currently three care staff and one senior carer allocated in the mornings. They also told us the number of staff available in the afternoon and evening had been reduced down to two care staff and one senior carer. We discussed this with the manager who told us that the provider had chosen to increase the number of staffing hours allocated to kitchen staff. This meant that senior care staff were no longer expected to prepare and cook the tea time meal and justified the reduction in care staff needed. However, staff told us this reduction in care staff meant there were fewer opportunities for staff to provide people with one to one and group social and leisure activities.

We observed nine people who ate their meals in their rooms. Staff told us that at least three of these people required support from staff to eat their meals. We found there was a lack of a coordinated approach and instruction from senior staff with regards to the deployment of staff to support people to eat their midday meal. This resulted in insufficient staff being available in the dining room to support people whilst others were supported in their rooms. We brought this to the attention of the manager who stepped in to support people with eating their meal and deployed staff to support people appropriately.

Staffing rotas viewed were confusing and it was not always clear as to which staff members were actually at work and which staff were absent from work. We discussed this with the manager who recognised our findings and confirmed that the rota did not reflect the deployment of additional or agency staff and those staff currently absent from work. We were not assured that there was sufficient numbers of suitably qualified, competent staff available to meet people's care and treatment needs.

This demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspections 13 and 17 February and 9 March we found that bathrooms and some bedrooms were without heating and hot water. The provider had taken action to rectify this. Bedrooms had access to hot water and new heaters had been installed to bathrooms. Care staff confirmed that there was now always hot water and heating whenever this was needed.

The manager told us that the kitchen had recently had a deep clean, a service provided by an external contactor. The broken tiles in the kitchen identified as a hazard at our previous inspections had been replaced.

We observed the communal areas, bathrooms and people's rooms to be clean. However, domestic staff told us there were no cleaning schedules in place to ensure a systematic clean of all areas and no audit checks in place to check the cleanliness and suitability of areas such as regular checks of commodes, beds and mattresses.

We looked at the laundry room and found that this was not a safe clean environment and improvements were needed. There was provision of one washing machine and no facility for tumble drying clothes. Staff continued to struggle to find places to dry people's laundry. The laundry room floor and walls were not sealed and therefore could not be effectively cleaned. We saw soiled clothing soaking in a bucket. The provider had purchased laundry bags that had a dissolvable seam when laundered, designed to contain soiled laundry and prevent cross infection by sealing in the bags before transporting to the laundry room from people's rooms. However, care staff told us they did not use them as they were designed to be used but instead used a bucket to transport from bedrooms to the laundry room, soak and then transfer to the laundry bags. This increased the potential for cross infection. On the day of our visit four people were known to have diarrhoea and sickness. The laundry room did not have liquid soap and paper towels available. This meant that staff did not have the facilities to wash and sanitise their hands before leaving the area.

We saw a number of commode chairs in people's rooms that were unable to be effectively sanitised as they were corroded and rusty. A toilet stand in one bathroom had rubber feet which had perished and presented a risk to

Inadequate

Is the service safe?

people from slips and falls as well as the risk of bacteria harbouring as they were difficult to clean. We were not assured that adequate steps had been taken to prevent, detect and control the spread of infections.

This demonstrated a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During both our previous comprehensive inspection in February 2015 and our focused inspection in March 2015 the provider had continued to fail to assess the risks to people's health, welfare and safety. At this focused inspection we found there had been some improvement. Individual risk assessments had been produced which identified risks in relation to people's medical conditions such as those diagnosed with diabetes and epilepsy. We saw from a review of care plans that people's health care needs and moving and handling risks had been assessed and the delivery of care had been planned to meet their health, welfare and safety needs.

Care plans had been produced and people at risk of malnutrition and pressure ulcers had these risks identified with action plans in place to guide staff in the steps they should take to mitigate and reduce risks to people's health, welfare and safety. Equipment was in place to provide people who could not mobilise without support with access to safe moving and handling. Staff had been trained in the use of this equipment. One person told us, "I feel safe in the hoist". In addition we saw that risk assessments relating to moving and handling had been completed.

We saw that the front door now had a key coded lock with the code written above. The front door was un-locked when we arrived and the manager took action to lock the door. We later saw that visitors requested staff to activate the security key pad system to the door for them to leave. When we came to leave we could not easily use the code as the key pad was at waist height and not easily seen. The manager opened the door and said the key pad was not always used and that the door was locked with the key in it. Whilst security of the building had improved people could freely exit, and this had been identified by a recent visit from a fire officer as a potential hazard in the event of a fire.

Requires improvement

Is the service effective?

Our findings

During our comprehensive inspections of Kent Lodge on 13 and 17 February and also at our focused inspection 9 March 2015 we found that the provider had continued to fail to put in place suitable arrangements for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided to them.

At this focused inspection we found some improvement. However, further action was required to ensure the provider was meeting the legal requirements.

The provider's action plan had identified that staff had still not received training in a number of areas which included safeguarding, understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). The manager told us they had been in consultation with the local authority and Suffolk Brokerage who were currently supporting the provider to access this and other training opportunities for all staff but as yet no dates had been agreed. Apart from training for staff in meeting the needs of people with diabetes which was planned for September 2015. We were not assured that staff had received appropriate training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The manager had produced an induction check list which they planned to use for all new staff employed in the future which included guidance for staff in the protection of people from the risk of abuse, MCA and DoLS, personal and pressure area care.

All the staff we spoke with and the manager told us that staff had not received any one to one supervision. However, the manager had implemented weekly team meetings. We reviewed the minutes from these meetings and found they covered a number of subjects which included raising standards in support to people with their personal care, team working, training and maintaining standards of cleanliness. All staff we spoke with told us these meetings were beneficial to team working and had improved communication amongst the staff team.

The shortfalls identified demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where we had continued concerns at our previous comprehensive inspections in February and March 2015 we found some improvements to assessment and planning for people at risk of inadequate nutrition. Risk assessments had been produced and specific plans for people at risk of malnutrition and health related conditions such as diabetes. However, this was not consistent. We found that one person had lost 5kg in the last three months. This had not been identified as a risk and no action had been taken to access specialist advice and neither action to monitor this person to ensure their eating and drinking was sufficient to meet their needs.

People were complimentary about the food and knew the choice of meals available that day. One person told us, "The food is good. I enjoy it". Another person told us, "The food is like in a restaurant", they also went on to say that the chef visited them daily to ask them their preference for that day. We observed the chef speaking to one person, offering a choice of meal and respected their decision.

We observed the midday meal. People were relaxed and chatted in a friendly manner to one another, but there was little staff interaction. People were presented with their choice of meal and people appeared to enjoy the food. One person said upon completion of their meal, "That was nice, I liked that". There were no jugs of drink made available on the tables and only a glass of water was provided.

We observed one person being offered a drink in a specially adapted cup. We saw that this person's fluid intake was monitored and recorded on a fluid intake chart. However, it was evident from discussions with staff that they did not know how much this person was required drink to ensure they were sufficiently hydrated. We noted that the amount of fluid consumed within a 24 hour period was never calculated; therefore the effectiveness of these charts was in question. We calculated the amount drunk in the last 24 hours and found that one and a half beakers and several sips (as recorded) may have left the person dehydrated.

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

Records and discussions with people who used the service showed us that people had been supported with recent access to opticians, dentists, dieticians and continence advice. However, it was evident from a review of people who experienced falls on a regular basis that access to the

Requires improvement

Is the service effective?

falls prevention team for assessment and advice had not been actioned and provided. We saw from a review of staff meeting minutes and discussions with the manager that a visiting dentist had highlighted their concerns that people were not being consistently supported to maintain adequate standards of oral hygiene. This put people at risk of not having their oral health needs met.

We observed one person who was experiencing difficulty talking to us as their dentures were ill fitting and moving freely in their mouth as they tried to talk. This affected not only their speech but impaired their ability to eat and drink with ease. A review of this person's care plan stated they had a diagnosis of epilepsy. Their risk assessment guided staff to prevent the risk of choking, 'ensure a clear airway and remove false teeth'. However, given that care staff may not always be with the person during a seizure this posed an unacceptable risk. We discussed our findings with the manager who told us they would update this person's care plan and guide staff appropriately.

Another person and their relative told us that they had waited several months despite repeated requests to staff for broken dentures to be fixed and described how this had affected their ability to eat and drink properly.

Community nursing staff told us they were currently providing health care services to nine out of the 19 people living at the service. The majority of these people required treatment for pressure ulcers, skin tears and skin ulcers. We discussed with the manager our view that this percentage of people was high and asked if there was any management analysis as to why this would be the case and what if any preventative action could be taken to improve this. The manager told us that as yet there was no analysis of incidents of skin deterioration in place. They also told us they were trying to access training for staff but this had been unsuccessful so far.

These shortfalls demonstrated a continued breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans had been produced and contained assessments of people's capacity to make decisions about their everyday lives. We saw people had signed to say they consented to their care and treatment. This included one person who had their movement restricted by the use of bed rails.

Requires improvement

Is the service caring?

Our findings

The majority of people we spoke with were complementary about the care they received. However, we also received some mixed views. One person who spent a considerable amount of time in their room said, “No one cares about us.” One relative told us, “The care here is basic but good.” Another person and their relative both told us that they were happy with the care and support they received. The relative said, “They look after my relative much better than the hospital did. They have really improved since being here.” However, one person told us when asked if they felt safe with all staff, “They are all kind but there is one member of staff who is too sharp and lacks any compassion. I do not feel comfortable when I know they are working.” We informed the manager and they were able to identify the member of staff. They assured us they would investigate this person’s concerns.

We noted that in the staff room where the door was kept open throughout the day that people’s personal information was on display and easily accessible to people. For example, people’s medical notes with regards to results from blood tests and warfarin prescriptions were on display. Care records were not locked away and on display. This room was directly opposite people’s bedrooms and the door was not closed when staff discussed people’s care. This meant that action had not been taken to protect people’s confidentiality at all times.

The shortfalls identified demonstrated a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People’s privacy and dignity was not always respected by staff. When we were shown around we were introduced to people and peoples consent to our presence was gained, but staff did not routinely knock on peoples bedroom doors to gain permission to enter and on one occasion a person had their privacy and dignity compromised as they had not been given the opportunity to consent to our entering their room.

We saw that people were offered choices about care throughout the day and were able to make decisions that were respected. We saw that in records people had signed to agree to care support being given. A relative told us, “If we had any concerns about the care [our relative] receives we would speak to the office. I find them very obliging.”

People who were able, could access the local town and we saw people that did so. For these people they told us their independence was promoted and maintained.

Inadequate

Is the service responsive?

Our findings

During our comprehensive inspections of Kent Lodge on 13 and 17 February and also at our focused inspection 9 March 2015 we found that people did not always receive personalised care that was responsive to their needs. Care plans did not contain enough information about people's needs for staff to deliver responsive care.

At this focused inspection we found some improvement as care plans had been produced for the majority of people. However, we found further work was need to provide suitable systems to ensure care and treatment needs were monitored and reviewed and ensure people's health, welfare and safety needs were met at all times.

Prior to our inspection we received information of concern from stakeholders that one person previously identified by us as at risk of not having their health, welfare and safety needs met had died without having seen a GP for 19 days prior to their death, even though their death had been expected. We were not assured that action had been taken to consult appropriately with health care professionals and review this person's care including a review of their need for pain relief medicines. This person's care and treatment needs had not been monitored and reviewed in a timely manner to ensure their health, welfare and safety needs were met at all times.

Some people had contributed to their initial assessment of need and the planning their care. We observed that people were asked their preferences on a daily basis.

One person told us about a fall they had recently had. We could see that their injuries had been attended to by the community nurse and an accident record completed. We looked at this person's care records and found that they had five falls since January 2015. No analysis had been completed and no referral to a specialist health person had been made. We discuss this with the manager who told us he was planning to implement a new format for recording accidents and incidents which would lead to analysis to determine trends and action plans in response.

We were not clear as to how one person communicated their wishes. One staff member described to us how this person presented and how they personally supported the person, but did not have a good understanding of their diagnosis of dementia or how their plan of care instructed staff in providing their care. We found the care plan lacking in detail to guide staff as no assessment and plan was in place with regards to providing personal care, or how this person communicated or how this person's dementia impacted upon their health and well-being.

We asked staff how they were made aware of changes in people's needs. They told us now that care plans were in place this had improved their awareness of people's needs. However, the manager told us that work was ongoing to ensure that everyone had an up to date care plan. A communication book recorded changes and actions taken to support people with access to health care professionals. Staff also told us daily handovers took place where people's changing needs had been discussed. A new daily record format had been produced which provided a good description of how each person had spent their day and the care staff had provided.

These shortfalls demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people how they had been supported to explore their personal leisure and social interests. One person told us, "I'm happy here. My window is like a film set. I like to look out and see what's going on. There is not much else." Another told us, "We do occasionally have a quiz or bingo and sometimes a visiting musician but the staff do not have the time always to site and talk with you." We did not see any individual hobbies and interests being pursued whilst we visited, apart from people independently accessing the town. People listened to music or watched television in the communal lounge on in their rooms. One person had knitting, but told us they were not up to it at the moment. We saw several visitors at the home on the day of our visit.

People told us that they could freely raise any concerns with staff. The manager told us of their plans to implement regular meetings with people who used the service and their relatives. People and their relatives told us they had been getting to know the new manager and found that any concerns they had were listened to and responded to appropriately.

Requires improvement

Is the service well-led?

Our findings

Kent Lodge was registered with the Care Quality Commission on 1 October 2010. As part of their condition of registration the provider is required to have a registered manager at this location. This service has been without a registered manager for in excess of three years.

At our comprehensive inspections of Kent Lodge on 13 and 17 February and also on our focused inspection 9 March 2015 we found that the provider had failed to sustain any improvements in the quality and monitoring of the service. This had placed people who used the service at risk of receiving inappropriate and unsafe care.

Whilst we found some improvement at this focused inspection 30 April 2015 we found that further work was required to ensure the provider was meeting the legal requirements.

At our previous comprehensive inspection 13 and 17 February and our focused inspection on 9 March 2015 we found that there was a lack of action taken by the provider to assess environmental risks to people and others. A review of the service's fire risk assessment had been carried out and staff provided with emergency evacuation procedures to follow in the event of a fire. Personal evacuation plans had been recorded for each person who used the service with actions to take in the event of a fire, flood or power failure. However, further work was required to risk assess all areas of the service which posed a risk to people including staff and others. For example, hazards in relation to the laundry area, sluice room and kitchen.

The provider visited the service on a weekly basis. However, they did not carry out any quality and safety monitoring of the service.

Further work was needed to provide robust quality monitoring of the service. For example, obtaining the views of people regarding the care they received. In addition further work was needed to provide for robust monitoring of the health, welfare and safety of people in relation to the management of people's medicines, identifying medication errors and monitoring and review of care plans.

Following our visit we spoke with the fire officer who had recently carried out an inspection of the service. They sent us a copy of the report they had sent to the provider with requirements and timescales for action to be completed by January 2016. A number of areas had been identified where action was required by law. For example, the fire alarm system was found to be inadequate for the type of premises, emergency routes and exits from some bedrooms was in excess of the recommended distance for escape in event of a fire and a number of exit doors were key-operated and not easily opened without the use of a key or keycode. Testing of emergency lighting and firefighting equipment had not been tested as is required by law. Following our inspection the manager informed us that steps had been taken to service the fire alarm system, emergency lighting and electrical portable appliance testing.

A recent visit from environmental health officers (EHO) had resulted in two enforcements notices having been issued to the provider. These related to a lack of food safety and nutrition training to staff and inconsistent management of food safety and hygiene monitoring by kitchen staff. The manager told us that one enforcement notice had since been removed following action taken by the provider to provide kitchen staff with the required training. However, one enforcement action remained as there was a continued lack of action by kitchen staff to complete cleaning schedules and insufficient monitoring to protect people from the risks of hazards in relation to the storage and handling of food.

This demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As of 1 April 2015 the public has a right to know how care services are performing. To help them to do this, the Government has introduced a requirement for providers to display CQC ratings. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The manager told us they were aware of the requirement to display the rating from previous inspections but the provider had instructed them not to do so. The manager told us they would discuss this with the provider and take appropriate action to comply.

This demonstrated a breach of Regulation 20(A) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our focused inspection 9 March 2015 the provider had employed a new manager who had been in post for

Requires improvement

Is the service well-led?

five weeks on the day of our visit. The manager showed the action plan they had produced. This recorded a plan of action with timescales for monitoring and improving the quality and safety of the service. This also described what action they would take to provide for continuous improvement of the service and ensure they were meeting legal requirements.

All of the staff and people we spoke with were complimentary about the new manager. Comments included, “We feel much safer now with him”, “We don’t just get to do what we want but we have more direction, he keeps us doing the right thing. We are all much happier now and we have had a pay rise” and “The new manager is very nice, he has brought calm about the place and things get done.”

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014** **Person-centred care** **The provider did not always take action to access specialist advice and plan to meet the nutritional and hydration needs of people at risk of losing weight, and inadequate intake of fluid.** **The oral health needs of people had not been met.** **People's care and treatment needs had not been monitored and reviewed in a timely manner to ensure their health, welfare and safety needs were met at all times.** Regulation 9(1) (a) (b) (e) (2) (3) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014** **Safe care and treatment.** **The provider failed to implement systems to ensure proper and safe management of people's medicines. People did not receive their medicines as prescribed.** **The provider failed to implement a policy and procedural guidelines for staff in the safe handling and management of people's medicines.**

This section is primarily information for the provider

Enforcement actions

The provider has failed to monitor risks and ensure that the premises are safe to use for their intended purpose and prevent risks to the health, welfare and safety of people who use the service.

Regulation 12(1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014** **Staffing** **The provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times.** **Staff had not received appropriate training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.** **Regulation 18(1) (2)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014** **Good governance** **The provider did not maintain securely people's care records.** **Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs People at risk of inadequate nutrition and hydration had not been identified as at risk and no action had been taken to access specialist advice and neither action to monitor people effectively to ensure their eating and drinking was sufficient to meet their needs. Regulation 14 (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2014 Duty of candour The provider did not display the ratings following previous inspections as is required to provide the public, with a clear statement about the quality and safety of the care provided. Regulation 20 (A) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.