Abbey Healthcare (Westmoreland) Limited

Kendal Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection of Kendal Care Home took place between 6 and 24 January 2017 January. The pharmacist visited unannounced on 6 January and we began the inspection unannounced on 20 January 2017. We returned to the home to continue the inspection on the 23 and 24 January 2017 when the registered manager was aware we would be returning. This was a planned comprehensive inspection to follow up on requirement notices made at the previous inspection and to monitor the improvements made at the last inspection. We had also received some concerns from relatives of people living in the home and professionals coming into contact with the service.

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 has 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 car parking for visitors. At the time of the first day of the inspection there were 81 people living in the home.

The service had 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.

We had inspected the service on 30 September and 06 October 2015. At that inspection, the registered provider had not met with all of the requirements of the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. We found significant concerns in relation to person centred care, the safe management of medicines, safeguarding people, the correct application of the Mental Capacity Act (2005), meeting people's nutritional and hydration needs, maintaining accurate records and good governance, staffing levels, training and recruitment procedures for fit and proper persons. As a result, the service was rated as 'inadequate' and 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.

We last carried out a full comprehensive inspection of this service on 3 May 2016. At that inspection, we found that improvements had been made and the service was meeting the fundamental standards with the exception of two regulations. There was a breach of Regulation 12, safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the registered provider had not demonstrated that clear monitoring and analysis was being done to make sure that avoidable risks were prevented. There was also a breach of Regulation 17 regarding good governance because the registered provider had not made sure systems were in place to ensure an effective governance structure to monitor the safety and quality of the service provision. As a result of the improvements that had been made, the service was rated overall as 'requires improvement' and the service was taken out of the 'special measures'

it had been placed in following an inspection in September and October 2015.

At this inspection in January 2017, we reviewed actions the provider had taken against the breaches in regulations identified at the previous inspection in May 2016 and how they had maintained the improvements that had been seen at that inspection. We found that the registered provider had not met the requirements from our previous inspection. There was a continued breach of Regulation 12, safe care and treatment and Regulation 17, Good governance of The Health and Social Care Act 2008 (Regulated Activities Regulations) 2014. We also found that improvements noted at the inspection in May 2016 had not been sustained and developed. During this inspection we found there were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 that could have an impact upon the safety, health and wellbeing of the people who lived there.

We found breaches of regulation in relation to person centred care, safe care and treatment, safeguarding people from abuse and improper treatment, obtaining consent from people or the correct relevant persons, staff training and good governance. The overall rating for this service is 'Inadequate' and the service has been placed in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We received mixed feedback from people who lived in the home. Some told us they felt safe living there and others told us they did not feel secure in the bedrooms as other people living there came in and invaded their privacy. We were also told that people often had to wait for staff to be available to help in the way they wanted We also received mixed feedback from relatives. We spoke with the relatives of a person who were living with dementia who told us they were considering moving their relative and that they felt staff did not have time to give people the care they wanted or needed. Another relative told us they had found no faults with the home and told us, "I have found the staff to be lovely and friendly". We observed some good interactions and friendly banter between staff, visitors and people who used the service.

We found that the registered provider had not made sure that the procedures and processes within the home were effectively safeguarding people from receiving improper treatment or unlawful restraint. In addition, staff did not demonstrate a good understanding of how and when to raise a safeguarding concern, if they believed someone was at risk in some way. The management of accidents and incidents was not robust and incidents were not being reported to management by the staff on the units.

We found that the registered provider had not ensured care and treatment was always provided with the

consent of the relevant person. We saw that care and intervention provided was not consistently in line with current legislation, nationally recognised guidance or good practice.

Medicines were not being safely managed and monitored and could place people at risk of not receiving their medicines as prescribed. It was unclear from the records we looked at whether creams had been applied to people as they had been prescribed. It was unclear if fluids had been thickened properly in order to reduce risks associated with swallowing difficulties.

There were not always enough staff available to meet the needs of people who used this service and sometimes people had to wait for help, we found that day shifts were staffed according to the dependency levels within the service however staff were not always responsive when people called for help. Staff levels on night duty were not always in line with meeting people's assessed needs and should evacuation be needed in the event of an emergency.

Care plans and risk assessments had not always been developed to meet the individual needs of people who used the service. We observed that much of the support provided by staff was 'task orientated' rather than centred on people's individual preferences and needs.

We have made a recommendation that the service finds out more about training for staff in relation to supporting the needs of people living with dementia and its different presentations.

At this inspection we found that staff were still not acting in line with legislation, national guidance or good practice. On the dementia nursing unit restrictive practices had been recorded, and used, for people that were not in line with the Mental Capacity Act (2005) and its codes of practice. We found care plan reviews had not highlighted there was insufficient, incorrect or out of date information in some plans and lacked information around managing different behaviours and restraint.

The registered provider had not made sure all staff had training relevant to their roles and to meet people's individual needs. The records of staff training were not being kept up to date and contained conflicting data so we could not assess with any accuracy what training or induction training had been provided for staff.

We found care plans in relation to the management of skin integrity that lacked review of assessments and care plans that did not reflect the current situation. We noted that people with specific individual needs were being denied a choice about their bathing and toileting arrangements because the registered provider had not provided the correct equipment to support them to bathe and access the bathroom as they wished.

People who were able to participate in the organised activities and events whilst living at Kendal Care Home told us about things they enjoyed doing, such as seeing their visitors and being able to attend religious services and follow their own faiths. We saw on the home's notice boards many pictures of social events, trips out and celebrations that people who were more able had taken part in. Some people who could not join in group activities, due to their conditions, were at risk of social isolation if they were being cared for in bed or stayed in their rooms. We noted that the environment for people living with dementia had not been developed to make it as supportive and enabling as possible for them.

We observed some issues with infection control on the dementia care unit. These included, unlocked sluice rooms, open top clinical waste bins and staff not using of personal protective equipment (PPE) appropriately. We also saw the communal use of moving and handling slings for multiple people and their inappropriate storage in the sluice rooms. This placed people at risk of cross infection and the spread of

infections.

We looked at the complaints policies and procedures along with information provided to people living there and relatives. Relatives we spoke to told us they knew whom to complain to in the home. The complaints log was being completed and complaints were being followed up by the registered manager to find a resolution.

We saw evidence of the lack of good governance and oversight in quality and safety monitoring within the service. The systems in place had not ensured an appropriate governance structure for all aspects of care being provided and to continuously improve the service for the people living there.

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.

There was poor management of accidents and incidents and the management of risk that placed people who used this service at risk from harm and injury.

Medicines were poorly managed and people who used this service did not always receive their medicines as their doctor had prescribed.

The registered provider had not ensured that the environment facilitated the prevention and control of infections in line with current legislation and guidance.

We found a poor level of understanding in relation to how and when to raise a safeguarding concern.

Staff deployment on night duty was not always in line with people's assessed needs and sufficient should evacuation be needed in the event of an emergency.

Staff had been recruited with relevant checks in place for fit and proper persons being employed.

Is the service effective?

Inadequate

The service was not effective.

Staff, of all levels, had not received adequate support, training, supervision and performance reviews to enable them to carry out their roles and responsibilities. Not all staff were up to date with fire training and evacuation procedures for the home.

Staff at the home showed a lack of understanding of, and an inconsistent approach to, the application of the requirements of the Mental Capacity Act 2005. This placed people at risk of inappropriate restraint and of receiving care and treatment that they had not consented to.

Care plans we looked at contained assessments of specific dietary needs, preferences and intolerances and oral hygiene

assessments. Meal choices were available.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People who used the service told us that they thought the staff were kind and helpful.

People were supported with personal care needs to protect their privacy however, they did not always receive support to help protect their dignity.

Unit managers in the home had been able to attend some training on end of life care provided by a local hospice but this was not being provided to all nursing and care staff.

Relatives and friends said they felt welcome to visit the home at all times.

Is the service responsive?

Inadequate

The service was not always responsive.

Care plans were not always focused on people's individual preferences, choices, needs and abilities.

People received inconsistent care because staff needed to focus on tasks
rather than supporting people with their individual needs.

Activities took place in communal areas and had not taken into account people's personal interests and those who were unable to attend organised activities.

A complaints procedure was in place and this was advertised around the home

Is the service well-led?

Inadequate

The service was not always well led.

Staff were not adequately supported and trained to understand their job roles and what was expected of them.

Quality assurance systems were poorly maintained and operated and lacked oversight by the registered provider.

There was a registered manager in post. There was little evidence

of senior management oversight to help provide support and development of the registered manager and senior staff in the home to help ensure they had the skills and knowledge to sustain the improvements previously identified by CQC.

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place between 6, 20, 23 and 24 January 2017 and was unannounced. Three adult social care inspectors and a pharmacist inspector undertook the inspection. During the pharmacy inspection that took place on 6 January 2017, the pharmacist spoke with the registered manager, a senior carer, four registered nurses and a relative of one of the people living in the home.

During the other three days of our inspection, we spoke with twelve people who lived in the home. We spoke with people in the communal areas and in private in their bedrooms. We spoke with ten relatives and visitors to the home.

We spent time in communal areas of the home observing staff working and supporting some of the people who used the service. Some people who lived at the home could not easily tell us their views about their care. In order to help us to gain an understanding of people's experiences of the service we carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. It is useful to help us assess the quality of interactions between people who use a service and the staff who support them.

We looked in detail at the care plans and records for ten people and tracked their care. We looked at records that related to how the home was being managed and looked at the staff training and supervision records. We looked at the recruitment records for new staff working in the home and the staff profiles of agency staff who worked in the home.

We looked at medicines records, medicines storage 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.

Before our inspection, we reviewed the information we held about the service. We looked at the information we held about statutory notifications sent to us about incidents and accidents affecting the service and people living there. A statutory notification is information about important events which the provider is required to send to us by law. We looked at the information we held on safeguarding referrals and applications the registered manager had made under deprivation of liberty safeguards.

We also contacted local commissioners of the services provided by Kendal Care Home to obtain their views of the home. We made contact with external specialist healthcare professionals who came into the home to support and give specialist advice. We looked at the comments made to us via the CQC website and concerns that had been raised by people coming into contact with the service. We looked at information sent to us by health care professionals involved in providing care and support to the people living there to get their views on the service provided.

Inadequate

Is the service safe?

Our findings

We spoke with people living at Kendal Care Home and visiting relatives on all three units. We received mixed feedback from people who lived in the home. One person told us "Without a doubt I feel safe here". A person living on the residential unit told us, "I believe I am quite safe while I live here, nothing has happened to make me think otherwise". Another person who lived there told us," It has been a better place to live since just before Christmas last. I was disappointed at first, it wasn't very good, but lately with this new bloke [registered manager] it's been better".

However, another person said "I don't always feel safe when the staff ignore my buzzer, it is worse at night time". We were also told by a person on the unit where people were living with dementia that, "Another resident comes in my room, takes chocolates and my belongings, this really upsets me. I am happy with my bedroom; I would just like it to be more secure". They also told us, "Carers develop hostility towards me because I don't always let them have their own way".

During the inspection we did not observe any hostility from staff member's towards people who lived at the service, however we did observe people living with dementia enter other people's bedrooms and take their belongings.

We also received mixed feedback from relatives. On the nursing unit where people were living with dementia a relative told us, "We are considering looking for another home for [relative], we don't like how people invade their privacy and take things from the bedroom". Another relative visiting the unit said, "Staff turnover is high and we don't always feel like [relative] is getting enough care from people who know their needs, [relative] is sometimes left in day clothes over night because [relative] isn't familiar with the night staff". However, another relative told us they could not fault the care their relative had received.

The medicine administration records (MARs) we looked at had photographs and people's allergies had been recorded on their medicines records. This helps to reduce the risk of medicines being given to the wrong person or to someone with an allergy and is in line with current guidance. At the comprehensive inspection in May 2016, we found that staff were not recording the exact time tablets were given, and therefore there was a risk of people receiving doses too close together. We made a recommendation that the service seek advice and guidance from a reputable source on how this could be better managed and times recorded. We found during this inspection that staff were still not documenting the time when medicines had been given and it was unclear whether four hours had been left between paracetamol [painkiller] doses for example.

At this inspection, we found that the refrigerator temperatures, where medicines requiring refrigeration were stored, were not being monitored properly. At the last inspection in May 2016, we found that the maximum and minimum temperatures were not being recorded. At this inspection, we checked the refrigerator temperatures recorded on the middle floor nursing unit and the ground floor residential unit. The middle unit recordings were not completed on two days in the first week of January and the maximum temperature

on both the bottom and middle floor were recorded as being above the safe recommended temperature of eight degrees Celsius. We asked the nurse and senior carer to reset the thermometer; however, they were unaware of how to do this. If the thermometer is not reset after a reading is documented, the thermometer will always show the previous highest temperature and is not a true reflection of the temperatures reached from one day to the next. Medicines can become less effective or even harmful if they are kept at the wrong temperature. This meant that the service did not ensure that refrigerated medicines were being stored at the recommended safe temperature and were fit for use.

We found at this inspection that one person on the nursing unit did not have a medicine for their blood pressure for three days as it was out of stock. The same person did not have their MAR completed on one day for all of their medicines. As staff had not written the quantity of medicines received into the home for this person on their MAR it was unclear whether medicines had been missed or given but not signed for.

We checked how carers recorded when creams had been applied and when a person had received thickened fluids. The documentation of the application of creams on the Topical Medicine Administration Record (TMAR) was not being completed regularly. We also found that staff had not recorded every time a person with swallowing difficulties had their fluid thickened. It was unclear from the records whether creams had been applied and fluids thickened accurately. Failure to record when people's fluids had been thickened as prescribed exposed them to the risk of choking. Failure to record when a person had been administered topical medicines meant that it was not always clear if the prescribed treatment had been given.

We noted that there was conflicting information in a care plan about the consistency of food for people. An assessment for the person said they had their food 'pureed', but their preferred daily routines said their food was 'fork' mashed. The information needed to be updated and accurate to avoid confusion by staff and prevent the person receiving food that was not appropriate.

We found care plans in relation to the management of skin integrity that lacked review of assessments and plans that did not reflect the current situation. On the first day of the inspection we looked at the care plans for a person with a wound area being dressed. An initial assessment of the wound had been undertaken and a review date for the dressings to be changed was "three -four days". We found that ten days post initial assessment there was no recorded evidence that the dressing had been changed and that the wound had been evaluated and reviewed for progress or further action. We spoke with the unit manager immediately about the failure to assess and evaluate this wound, we were assured that an assessment would be undertaken as priority. On review of the person's wound records on the second day of the inspection, we found that the wounds were re-assessed the day after we had asked for this to be done. This was a delayed response time given the concerns raised by inspectors and placed the person at risk on further damage to their skin.

We found during the inspection that other risks to people's health and safety had not always been appropriately assessed and action taken to mitigate. For example, we looked at the care records of one person and found that their personal emergency evacuation plans (PEEPs) were not accurate. Their mobility needs had changed and they had become more dependant and they had been moved to the nursing unit. The PEEP did not reflect their current needs and placed them at risk should they need to be moved in an emergency.

We found that some bedrail risk assessments had not been completed. Bed rails are 'medical devices' and when used the registered provider must ensure that it is done so correctly. There was no record of safety checks having been carried out to make sure the devices in use throughout the home were in safe working

order. We observed that a person had a lap strap on their wheelchair that had not been risk assessed for use and was not in use to prevent falls. Care records showed that the person had attempted to stand unaided to get out of wheelchair. This meant there was a risk that people may not receive safe care and treatment.

We looked at care records in relation to the management of accidents and incidents. We saw that one person had had experienced two falls but no accident/incident record had been completed by staff concerning the details of the incidents. The registered manager had not been informed of the falls and it was not clear from the care records what action had been taken to ensure that they properly assessed for any injury and that action was taken to reduce the risk of it happening again.

We observed some issues with infection control on the dementia care unit and fed back these findings to the registered manager the same day. These included; unlocked sluice rooms, open top clinical waste bins and staff not using of personal protective equipment (PPE) appropriately. We also saw the communal use of moving and handling slings for multiple people and their inappropriate storage in the sluice rooms. This placed people at risk of cross infection and the spread of infections. This was in breach of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections.

This was a breach of Regulation 12(2) (b), (g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. This was because the registered persons had not demonstrated that all that was reasonably practicable was being done to assess and mitigate and review the risks to the health, welfare and safety of people living at Kendal Care Home and had not ensured that appropriate arrangements were in place to ensure the proper and safe management of medicines within the home.

We looked at staff rotas in use and looked at the way staff were being deployed. Agency staff were still required on some shifts to cover sickness and staff vacancies on the night shift. Recruitment was continuing to try to achieve a full permanent staff establishment on both day and night shifts. Staff we spoke with told us that they felt there were not sufficient staff at night time on the dementia nursing unit. Staff told us he registered nurse had to do the medicine round on the unit at night that took time to do safely. Staff said that meant that three care assistants have to assist potentially 40 people, living with dementia to get ready for bed or to monitor people's whereabouts if they did not want to go to bed. Staff also told us that sometimes the nurse from the middle floor nursing unit also did the medicines on the residential unit if needed. This meant that the nurse could be responsible for administering medicines for 46 people at the present occupancy level and so they were not available to assist the care to get people ready for bed or supervise them whilst carers were occupied elsewhere on the unit.

We observed suitable staffing levels during the inspection as night staffing on the general nursing and dementia nursing units was increased during the week of the inspection. The registered manager has confirmed the increased staffing levels on nights would be continued.

We noted that on the night shift the deployment of staff was not always in line with people's assessed needs. We found that there were insufficient staff on night duty on the nursing unit to be able to move people with specific moving and handling needs. Some of the people living on the unit required four staff to assist them in the event of an emergency to move people to the next fire zone for safety. The staffing levels did not cover this. Inspectors requested immediate action to be taken to make sure that the service had sufficient staff on the night shift and that staff had received fire warden training, as staffing records indicated there were no staff due on duty who had received this.

The inspection team also noted significant delays in the time taken for staff to respond to call bells on the

unit where people were living with dementia. An inspector had to prompt staff to respond to call bells on the dementia care unit. One person living with dementia had been calling for staff support for 15 minutes and had been left unattended on the toilet while staff were busy elsewhere. On another occasion on the residential unit, the inspector had to find a staff member to assist another person to their bathroom. Delayed response times as staff were occupied elsewhere placed people at risk of injury and impacts upon their well-being and dignity. We asked the registered manager for a print out of the call bell use on each of the three days of our visit but did not receive it during or after the inspection.

A staff member on day duty said, "The manager has brought in a lot more staff and I think there are plenty if people did not keep going off sick, it's always the same ones and then we have to have agency, if we can get them".

This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014, Staffing. This was because the individual needs of people using the service were not being promptly and consistently met at all times with the numbers of staff on duty.

We had received information that a safeguarding alert had been made by a health care professional because a person had not been provided with suitable moving and handling equipment to meet their needs. This was placing them at risk of injury and negatively affecting their well-being. We were told by the registered manager that the specific equipment had been requested by them but not been purchased by the registered provider. The registered manager was trying to access alternative funding to get the equipment required to properly and safely meet the person's needs. We raised a further safeguarding concern to the local safeguarding authority for their investigation into this failure to provide essential moving and handling equipment to meet the individual needs of people living there and to keep them safe.

Records for one person showed a body map that indicated bruising. We asked the registered manager if this had been reported. We found that no accident/incident record had been done by staff and so the manager was not aware of the bruising. No safeguarding referral had made to the local authority about the bruising. We examined the care records for two people and found an incident that detailed an unlawful restraint. We asked the registered manager about this incident and they confirmed that a safeguarding referral had not been made. The registered manager agreed to raise a safeguarding alert on the first day of inspection.

The inspection team spoke with care staff of all grades and found a poor level of understanding in relation to how to raise a safeguarding concern.

This was a breach of Regulation 13, safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.The registered persons had not made sure that the procedures and processes within the home were effectively safeguarding people from receiving improper treatment or unlawful restraint.

We looked at the staff files for all staff recruited since our last visit. All the required checks of suitability had been completed when staff had been employed.

Inadequate

Is the service effective?

Our findings

We spoke with people who lived at Kendal Care Home and visiting relatives on all three units to get their views and experiences of the service. We received a mixture of views. One person who lived there told us, "It's alright here, except for the food, it's awful". Another person told us "Can't fault the food really, the chef is considerate in what they make, but I think they have some problems with supplies and have to get it [food] where they are told, I suppose it's down to budgets". We were also told by a person living there "The food is okay most of the time, I guess". A relative said, "I feel everything's going okay, they [staff] give [relative] a lot of fluids, really good that way". A relative told us "I cannot fault the staff, [registered manager] is very careful when introducing new staff, the new ones work with an experienced one".

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection in May 2016 we had found staff had not been aware of protocols for the recording, monitoring and auditing of any intervention involving restraint in line with legislation, national guidance and good practice for managing behaviours that might challenge the service.

At this inspection we found that staff were still not acting in line with legislation, national guidance and good practice. On the dementia nursing unit, we saw that restrictive practices had been recorded and used for some people that were not in line with the requirements of the Mental Capacity Act (2005). A DoLS application had been completed for one person and included information about restrictive practices. However, we found no evidence to show that some people's mental capacity had been assessed or to show best interests meetings had been held to make decisions for the person who did not have capacity to consent to care and treatment they were receiving. We reviewed the care plans of people who lived at Kendal Care Home and found that some relatives who did not hold Lasting Power of Attorney (LPOA) had signed consent 'permissions' documents. Lasting Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs. We noted that people's mental capacity had not been assessed prior to these decisions being made. This was not promoting people's individual rights and meant that consent to care had not been provided in accordance with the requirements of the Mental Capacity Act 2005 and associated Codes of Practice.

This was a breach of Regulation 11,need for consent, of the Health and Social Care Act Regulated Activities Regulations 2014. This was because the registered provider had not ensured care and treatment was always provided with the consent of the relevant person and that the care and intervention provided was not in line with current legislation nationally recognised guidance and good practice.

We looked at the records held at the service for staff training and spoke to staff about the training they had received. We found during the inspection that the registered provider had not made sure all staff had received training relevant to their roles and to meet people's individual needs. The records of staff training were not being kept up to date and contained conflicting data so we could not assess with any accuracy what training had been provided for staff. The training data we accessed via an electronic and paper copy system indicated that training statistics were low for all areas of mandatory training including safeguarding, dementia care, understanding mental health, dealing with distressed reactions, moving and handling, Mental Capacity Act/DoLS, fire safety awareness, health and safety and infection control. This meant that people living at Kendal Care Home could not be certain that the staff providing nursing and personal care to them had received suitable training to enable them to have the knowledge and skills to provide safe and person centred care.

We looked at training records for all staff who administered medicines in the home. Records showed there was 20 staff employed at the service who administered medicines, including the management team. We found that not one member of staff had undertaken both theory and competency training in relation to safe administration of medicines. Senior staff assessing competencies had not been suitably trained or assessed for their own competency prior to testing other staff.

We asked staff about their understanding of safeguarding. Staff told us "I have not received any information about safeguarding since I started working here" and "I have not had any training in safeguarding". All of the night staff we spoke with demonstrated limited knowledge of the MCA, safeguarding or DoLS. We looked at the training records in the home and found that the registered provider had not ensured all staff had received training in safeguarding vulnerable adults. The records in the home indicated that there was less than 11% of care and nursing staff who had completed the training safeguarding training.

On the first day of the inspection we had to make sure staff were made available on the night shift who had received fire warden training. This was because the records available indicated there were no staff due on night duty who knew what to do in the event of a fire. We passed this matter to the Fire Officer for Cumbria Fire and Rescue Service so they could follow this matter up with the registered provider and visit the service to advise and make sure the training and risk assessments were fit for purpose.

We asked staff if they had undertaken induction training, and night staff told us that they had received an induction. However, when we looked at induction records we found that six out of eight staff members did not have a completed induction record. Staff told us "I have not been provided any specific training in dementia". "I have done moving and handling training but nothing else" and "I have done basic training but nothing in relation to dementia or mental health".

We were also told by staff that they had not received any supervision that supported them in their roles. Staff told us that the registered manager was approachable but had limited time to spend with staff on an individual basis to discuss their learning and development. There was no recorded evidence that all staff received regular, effective supervision necessary to enable them to carry out duties they are employed to perform.

We also reviewed the induction, training and supervision records for the registered manager and both

deputy managers. No evidence of mandatory training in preparation for their roles provided to them was available. We noted that the registered manager had only received individual supervision from their line manager once in the six months of their employment. The registered manager did not have a development plan in place, agreed with the regional manager, to support them into a new post as manager nor did the two new deputy managers to help make sure they were developing the skills and knowledge required by the registered provider. The registered provider had not been provided with detailed induction training or a management handover that had prepared the registered manager for their role.

This was a breach of Regulation 18 (2) of the Health and Social care Act (Regulated Activities) Regulations 2014- Staffing. This was because the registered provider had not made sure that there were suitably competent, skilled and experienced staff available at all times to meet the needs of the people using the service. The registered provider had not made sure that staff of all levels had received support, training, professional development, supervision and performance reviews to enable them to carry out their roles and responsibilities.

The care plans we looked at contained assessments of specific dietary needs, preferences and intolerances. All people living in the home had an individual nutritional and oral hygiene assessment. We observed staff assist people at lunch time on the general nursing and dementia nursing units. We saw staff sat with people and observed staff holding friendly conversations with people whilst assisting them to eat their meal. On the nursing unit we saw staff adopted the same friendly and supportive approached to people whom they sat with to assist them enjoy their meal.

We found evidence that people were being referred to their own GP's when they needed this. There was also records of people having been seen by other health professionals and services for treatment and assessment, for example, the speech and language therapist, their dentists, opticians, occupational therapist assessments and dietician advice.

Requires Improvement

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 the way they wanted. We received mixed feedback from people who lived at Kendal Care Home and this included, "I find living here ok" and "As far as I see, all of the carers are pretty good and helpful". We were also told, "Staff are kind". A relative visiting on the residential unit told us, "I have found the staff to be lovely and friendly; they have been very good and patient with [relative]".

A relative of a person who lived on the nursing unit told us "Since [relative] came in it's been excellent here, cannot fault anything that has been done". Another relative of a person living with dementia told us, "The staff are fantastic, go over and above what you would expect; they're not paid enough for what they do". Another relative told us, "I think they [staff] do their best and care for people, but there is room for improvement".

We were told by a person living at Kendal Care Home, "Some carers don't care and have a bad attitude". One person who lived in the home told us "I have waited for a long time, in the bathroom, and staff do not respond to my buzzer". We had also noted, and alerted staff during the inspection, to a person living with dementia that had been calling for staff support for 15 minutes and had been left unattended on the toilet whilst staff were occupied elsewhere. This did not promote that person's dignity and autonomy whilst receiving care. We observed delays in staff responding to call bells during the inspection, as they were busy elsewhere.

We observed a meal time on the dementia nursing care unit where we saw an organised environment was provided and people told us that they enjoyed their meal. People were offered a choice of meal, however, this was done verbally. There were no pictorial menus available for people to see the food being offered. Using pictures of the food offered would help people living with dementia to make independent choices. On the nursing unit we saw staff adopted the same friendly and supportive approached to people who they sat with to assist them enjoy their meal.

We carried out an observation in the lounge of the dementia nursing unit. We were with ten people who were sat in the lounge. We saw four of the people were brought into the lounge in wheelchairs and remained in them for the 35 minute observation before being taken out of the room by staff to the dining room, still in the wheelchairs, for their lunch. Spending long periods sat in a wheelchair can have a detrimental effect upon a person's skin integrity. The wheelchairs were placed facing the television without anyone being asked if that was where they wanted to be sat. There were no activities or visual or tactile diversions for people some of whom were shouting out and showing signs of distress. We recommend that the service find out more about training for staff, based on current best practice, in relation to the support needs of people living with dementia and its different presentations.

We did see that that staff protecting people's privacy on other occasions by knocking on doors to private rooms before entering and making sure doors were closed when care was being given. All the bedrooms in the home had ensuite toilet and shower facilities so people could have privacy for their personal care needs.

People we spoke with told us that they saw their doctors in their own room when they visited and could see their visitors in there.

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. This allowed people were able to spend their time in private if they wished to. Relatives of people who lived at the home told us they could visit anytime of the day or week, there were no restrictions and they felt welcomed. This meant that people were able to continue maintaining important relationships in their lives.

We saw evidence that unit leads in the home had been able to attend some training on end of life care for people. This had been provided by a local hospice and covered assessments at the end of life.

Inadequate

Is the service responsive?

Our findings

We asked people who lived at Kendal care home and their relatives about how they felt their care was being assessed and managed for them. A relative told us that not all staff are aware of their relative's needs. They told us, "Some staff do not know to elevate [relatives] legs or how to encourage them to go to bed at night time. They told us that they felt this was due to a high turnover of staff who did not know the care needs of the people who lived there. We did not find evidence of people or their representatives being involved in developing their own care plans and reviewing and updating them.

We asked people what they would do if they had any worries or complaints. We were told by one person "I would go to see [registered manager] if there was a problem". Relatives we spoke to told us they knew whom to complain to in the home. Some of the relatives we spoke with had raised complaints with the registered manager and felt the registered manager did take action and responded to their comments.

We reviewed how the service responded to complaints. We looked at the policies and procedures along with information provided to service users and relatives. The complaints procedure was on display in the home. Relatives we spoke to told us they knew whom to complain to in the home.

We asked for and reviewed the complaints log. We found there had been 18 complaints recorded in the previous 12 months. We saw that the registered manager had recorded all they had received and responded to by the registered manager in an appropriate manner in line with the service's policies and procedures. Relatives told us that the registered manager or deputy managers did look into any concerns they had raised.

At our last inspection in May 2016 we had 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 could see that unit managers were checking some care plans. However, the timescales for making necessary changes and updates to assessments and care plans was still not always being followed promptly up to ensure they had been addressed so people received the care they needed and preferred.

We made contact, before our inspection with specialist external health care professionals, involved in different aspects of care for people outside hospital and we asked for their experiences of working with the service. We had mixed feedback. One professional told us they had contacted the home by telephone every month for the last four months for updates on the progress of people's wounds that they had been asked about, without getting any information back. This meant they could not support staff in monitoring wounds and progress or to advise if a different approach might be better. This healthcare professional had also been asked to call back another time, as all staff were too busy. In this case communication with the support services had been poor and that might affect the treatment a person receives.

Another specialist involved in the care of people with diabetes had found the service receptive to working with their service. They told us that where there had been concerns regarding diabetes management, the home staff had contacted them for advice and had follow the plans they had devised.

We noted that people with specific individual needs were being denied a choice about their bathing and toileting arrangements because the registered provider had not provided the correct equipment to support them to bathe and access the bathroom as they wished. The service had carried out an assessment of these people's needs prior to admitting them. This was done in order to make sure they could meet them before offering accommodation. The people had required the equipment from the time they came to live at the home but the registered provider had failed to provide the resources needed to make sure people received the care that was personalised specifically for them.

The environment for people living with dementia had not been developed to make it as supportive and enabling as possible for them. Research and current good practice in dementia care highlights that attention needs to be given to establishing environments that enable people who are living with dementia to find their way around independently and confidently and have opportunities for visual and tactile stimulation. The environment had not been assessed and developed to support the specific needs of people living with dementia and what they needed to help them participate in a fulfilling and more independent daily life.

During an observation on the nursing unit where people were living with dementia, we observed that some people in the lounge were showing signs of distress throughout the observation. One person wailed and looked around with an anxious expression, another tapped repeatedly on the arm of their chair and cried. One person in the room was getting annoyed with this behaviour and began shouting at them. Staff came in and out of the room to carry out their tasks, such as give out medication and write up care plans but did not spend time with those who were anxious or agitated to engage with them on an individual level and try to comfort or distract them. While staff spoke to people in passing to give verbal support they were engaged in completing other tasks at the same time so did not give the person full attention. This was more of a 'task orientated' approach rather than a 'person centred' approach to supporting people living with dementia and did not recognise their individuality and wellbeing.

We observed during the inspection that some people were at risk of social isolation, as activity planning was not being implemented in a person centred way We found that some people living with dementia or who were physically frail spent long periods of time in their bedrooms without the opportunity for social stimulation. We saw that many bedroom doors on the dementia nursing unit were kept closed due to other people living on the unit regularly going into people's bedrooms and removing personal belongings. People who lived there and their relatives told us that this was affecting the people's wellbeing as their privacy was often invaded and they would have preferred to be able to leave their doors open and "be able see what was going on".

These approaches and actions by the registered provider did not demonstrate a person centred approach to treatment that was being based upon a continuing assessment of a person's individual condition, needs and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act Regulated Activities Regulations 2014 - Person-centred Care. This was because the registered provider had not done everything practicable to make sure the people living at Kendal Care Home received personalised care and treatment that met their individual conditions and needs and reflected their personal preferences and accepted best practice.

We saw that the registered manager had taken on additional activities staff to provide organised activities in the home. On the day of the inspection a religious service was taking place in one of the lounges during the afternoon for people to attend from all of the units. There was a quiz in the lounge of another unit during the morning. Some people told us that they were going to attend a pantomime later in the month that was

being put on locally. We could see that the registered manager was taking steps to develop the opportunities for communal activities in the home.

People living at Kendal Care Home told us about things they enjoyed, such as seeing their visitors and being able to attend religious services and follow their own faiths. We saw on the home's notice boards many pictures of social events, trips out and celebrations that people who were able to had taken part in.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the Care Quality Commission (CQC). Staff said they felt supported by the registered manager and that he "Listened to them" and "Things have definitely improved with [registered manager], morale is much better and he motivates us". A member of staff also told us "[Registered manager] has made us feel we can have pride in our unit and our work. It's a much better atmosphere now, less blaming". Another staff member said, "I have confidence in the manager now, I think he can be trusted".

People we spoke with told us that the registered manager was "approachable" and "Always around to talk to." The people who lived at Kendal care Home, and some relatives we spoke with, told us they felt they would be able to take concerns and complaints to the registered manager and that he would "Do his best to sort it out". A person's relative commented that the registered manager had really improved the mood of staff and had made significant improvements in the little time they had been in position. However, other visitors we spoke with had not found the registered manager to be as approachable and helpful.

At our last inspection in May 2016, we found that the registered provider had not made sure that appropriate governance structures were in place for all aspects of care being provided and to continuously improve the safety and quality of the service for the people who lived there. At this inspection, we again found the quality assurance systems in operation had not identified and addressed shortfalls in service quality, safety and the management of risk in the service. We saw that the clinical manager was carrying out some care plan audits and had identified shortfalls in care plans but these had not been followed up to ensure action had been taken.

We saw evidence of the lack of good governance and oversight in the monitoring of medicines administration, medicines recording and the storage. At the inspection in May 2016, we had found that medicine audits on the middle floor were not always being completed. We saw that audits on the middle floor were still not being completed as frequently as the other two floors and so had not highlighted there were missed medicines or missing signatures on the medication records.

We found that training requirements and staff attendance was not being monitored and recorded. There was not reliable evidence that the registered provider had made sure that staff working and supporting people in the home were competent, skilled and experienced enough to meet the needs of the people living in the home. Staff in the home, including the management team, who were not being supported by the registered provider to develop professionally with supervision and performance appraisals so that they could understand and carry out their roles and responsibilities. We asked staff if they attended staff meetings. None of the staff we spoke with could recall the last time they had attended a staff meeting.

We found care plan reviews did not identify insufficient, incorrect or out of date for example around managing different behaviours and restraint. Therefore, the systems were not being effective in identifying where aspects of the service were not performing to the required standard or identifying all risks.

The management of accidents and incidents was not robust and incidents were not being reported to management by staff. However the registered manager was making notifications to CQC of incidents and events and they were aware of. There was no evidence that incidents involving restraint been subject to rigorous monitoring to make sure the people were protected from any inappropriate care or treatment. We noted that unit leads had not been given dedicated time to attend to unit management issues and carrying out checks to make sure staff were following procedure and follow up on issues they had identified. One person told us they had only just been told they could have this, but it had yet to start. Unit leads responsible for quality monitoring had not been given the time allocated to do this important task.

We looked at staff file records for the registered manager. The registered manager had been in post since 25 July 2016. A record of the manager's induction programme showed a management induction had been undertaken over a period of two days 27 July and 1 August 2016. This appeared to be a tick box induction to the home. We saw evidence of only one recorded supervision meeting between the registered manager and their line manager, the regional manager since the registered manager had taken up post. There was no management development plan agreed by the regional manager and registered manager in place to support the new manager to make sure they were developing the skills and knowledge and meet the objectives required by the registered provider.

We found there was a systemic lack of good governance and oversight throughout the service by the registered provider that exposed people who used the service to the risk of harm. This was a continued 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 too continuously improve the welfare and safety of the people who lived in the home.

Staff spoke with us told us about their concerns about being paid. Throughout the inspection, different levels of staff told us they had not been paid in full for the work they had done or had not been paid for working overtime or for agreed expenses. We also received information from other agencies that a significant number of staff had told them they were not being paid correctly and or as stated in their contracts. We spoke with a night worker who had only received 50% of their wages due and this had a major impact on their personal life, financial commitments and motivation to work. A number of staff said the registered manager was contacting the head office and was trying to get their pay corrected but they were still being underpaid. This could have a significant effect upon the people living in the home if those supporting them did not receive the correct remuneration for their work. Following the inspection the provider has informed us that they have employed a new office manager to assist with payroll queries and to help staff understand their pay slips and amendments made.

Staff also told us they had not been provided with uniforms or replacement uniforms as required under the service's policies and procedures. Staff told us they believed this was because the supplier had not been paid by the registered provider.

We saw that the registered provider was displaying the home's current rating as required by the regulations.