Stonehaven (Healthcare) Ltd

Kent House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 31January and 2 February 2018. At our last inspection in June 2017 we found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'Good governance'. This was because we found that some audits and checks had not identified issues around staffing levels at handover times and care records lacked details about people's preferences. Following the last inspection in June 2017, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of 'well-led' to at least good. This inspection found improvements had been in these areas. However, we found new concerns linked to whether the service was safe and well-led.

Kent House is a 'care home' providing personal care and accommodation to a maximum of 27 older people who may live with dementia or physical disability in one adapted building. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Kent House does not provide nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection there were 26 people living at the service.

This inspection was prompted in part by concerns raised by visiting safeguarding nurses. These concerns related to a lack of detailed risk assessments and care plans; lack of detail in daily records; no check charts in place to monitor people's general well-being; suitability of equipment; incident reporting; staffing levels; issues about medicines not being given as prescribed and staff understanding of the procedure in the event of an emergency.

There was a registered manager in post. 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.

Risk management was not always robust. People's individual risks were identified and the necessary risk assessments were carried out. For example, risk assessments for falls management, moving and handling, personal care, nutrition and skin integrity. However, care plans lacked sufficient detail to ensure appropriate care and treatment. We discussed our concerns about care plans with the registered manager. They explained that staff knew people very well. For people identified with complex and high needs their care plans and risk assessments had been updated with more detail in response to concerns raised by visiting professionals. In addition, the registered manager was in the process of reviewing all care plans to ensure sufficient detail for staff to follow. Also, following a serious incident in November 2017, the service had purchased additional equipment to keep people safe whilst in bed.

Aspects of infection control were not safe. We found that the sluice was not clean; Control of Substances Hazardous to Health (COSHH) were not stored securely and staff were not wearing aprons when carrying out

personal care. However, by the second day of our inspection, we found that the sluice room had been thoroughly cleaned; staff were wearing aprons appropriately and COSHH products were stored safely out of reach of people.

Medicines were not always managed safely. The medicine policy and procedure for the service stated that there should be specific plans for medicines that were to be given 'as required' available within the service user's care plan and with the MAR charts. No plans were available for any of these medicines; therefore there was insufficient information for staff to give these medicines in a consistent manner.

The service had made improvements in relation to the concerns raised at our previous inspection in June 2017 particularly in relation to the deployment of staff at handover times and the documentation of people's personal preferences. However, this inspection highlighted new risks for people relating to a lack of sufficient detail on measures needed in relation to falls, skin care, mobility, continence and nutrition risks; infection control procedures and a lack of guidance for 'as required' medicines. These findings demonstrated the systems in place to assess and monitor the quality of the service provided were still not fully effective. This was because the audits were not identifying, and minimising some risks relating to the health, welfare and safety of people using the service. Further improvements in quality monitoring were still needed.

Six people said they were not aware of what was in their care plan. However, they trusted the staff to know what they needed. Two people said they had seen their care plan, but they thought the staff would know their needs anyway. They said they would speak up if they were not getting what they needed. Care records evidenced a record of monthly reviews. We discussed people's involvement in care planning with the registered manager. They explained that people and/or their families were always encouraged to have input in planning care needs and stating their likes and dislikes.

There were effective staff recruitment and selection processes in place. Staffing arrangements met people's individual needs. Staff received a range of training and regular support to keep their skills up to date in order to support people appropriately. Staff spoke positively about good communication within the staff group and how the registered manager worked well with them and encouraged an open culture.

People felt safe and supported by staff. However, some staff were not confident to state who outside of the organisation they should contact, such as the local authority if they had safeguarding concerns. People's rights were protected because the service followed the appropriate legal processes. People's individual needs were met by the adaptation, design and decoration of the premises.

People were supported to maintain a balanced diet, which they enjoyed. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff relationships with people were caring and supportive. Staff were motivated and inspired to offer care that was kind and compassionate.

We found two breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risk management was not always robust.

Aspects of infection control were not safe.

Medicines were not always managed safely.

People felt safe and supported by staff. However, some staff were not confident to state who outside of the organisation they should contact, such as the local authority if they had safeguarding concerns.

Staffing arrangements met people's individual needs.

There were effective recruitment and selection processes in place.

Is the service effective?

Good

The service was effective.

Staff received a range of training and supervision which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well through regular contact with community health professionals.

People's rights were protected because the service followed the appropriate guidance.

People's individual needs were met by the adaptation, design and decoration of the premises.

People were supported to maintain a balanced diet, which they enjoyed.

Is the service caring?

Good

The service was caring.

Staff relationships with people were caring and supportive.

Staff spoke confidently about people's specific needs and how they liked to be supported.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care files included personal information and identified the relevant people involved in people's care.

Activities formed an important part of people's lives.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Systems in place to assess and monitor the quality of the service provided were not fully effective and therefore areas for improvement had not been identified.

Staff spoke positively about communication and how the registered manager worked well with them and encouraged an open culture where they could express their opinions.

People's views and suggestions were taken into account to improve the service.

Kent House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by concerns raised by visiting safeguarding nurses about a lack of detailed risk assessments and care plans; lack of detail in daily records; no check charts in place to monitor people's general well-being; suitability of equipment; incident reporting; staffing levels; issues about medicines not being given as prescribed and staff understanding of the procedure in the event of an emergency.

This comprehensive inspection took place on 31 January and 2 February 2018 and was unannounced.

The inspection team consisted of two adult social care inspectors; a pharmacy inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses older people care services.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

We spoke to 12 people living at the home, three relatives and eight members of staff, which included the registered manager.

We reviewed four people's care files, four staff files, staff training records and a selection of policies, procedures and records relating to the management of the service. After our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from two professionals.

Some people living at the service were unable to communicate their experience of living at the home in detail with us as they were living with dementia. 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 comment directly on their experience.

Requires Improvement

Is the service safe?

Our findings

People's individual risks were identified and the necessary risk assessments were carried out. For example, risk assessments for falls management, moving and handling, personal care, nutrition and skin integrity. These were not meaningful because care plans lacked sufficient details for staff to follow to ensure appropriate care and treatment. For example, the four care plans we looked at did not have detailed information for staff to follow with regards to falls prevention, skin care, mobility, continence and nutrition. One care plan under the mobility domain stated 'needs help with transferring' but did not state the number of care staff required to complete the transfer and what equipment was needed. Another example stated 'manage pad and change frequently.' Staff would need to know how frequent and what pad to use. The organisation's 'falls prevention and risk assessment policy was also not being followed. This stated: 'each person has an individualised plan of care, which takes into account significant risks of falling identified in the risk assessment and includes interventions designed to reduce or eliminate those risks.'

Aspects of infection control were not safe. There was only one sluice room which was located on the middle floor. The washing of all soiled pots and commodes was completed in this room. On the first day of our inspection, the room was unlocked, had a very strong pungent smell, the sink was very dirty and there was evidence of non-compliance with The Control of Substances Hazardous to Health (COSHH). Hazardous liquids were not securely stored as required by COSHH to prevent harm by people who used the service. There were five decanted spray bottles and toilet cleaner left out in this room. We observed a cleaning trolley being left on another floor and a bucket in a bathroom on the top floor containing chemicals. We noted that the trolley and bucket were left unattended for some time by staff. Accessibility of cleaning products to vulnerable people meant there was a risk of harm. For example, contact with the skin or eyes and vulnerable people may try to drink the substance.

Most areas of the home looked clean. Staff told us they had undertaken infection control training. However, six members of staff had yet to do the infection control training according to the training matrix provided by the registered manager.

We noted that staff were carrying out domestic duties such as laundry tasks and they were not wearing correct personal protective clothing, such as an apron. Wearing an apron would help prevent the spread of infection and can be disposed of after use. The same practice applies when providing personal care to people. Staff were not wearing aprons although we did observe some staff wearing plastic disposable gloves to reduce the risk of cross infection. There were paper towels and hand gel in all rooms, toilets and bathrooms to assist staff in the good practice of preventing cross infection.

We looked at the systems in place for managing medicines. The medicine policy and procedure for the service stated that there should be specific plans for medicines that were to be given 'as required' .These were to be made available within the service user's care plan and with the MAR charts. No plans were available for any of these medicines; therefore there was insufficient information for staff to give these medicines in a consistent manner.

The service audited the MAR charts every two weeks to ensure that medicines were given in accordance with the prescriber's instructions. The quantities of medicines remaining were noted on the MAR sheets. There was no formal documentation for recording discrepancies. However, any gaps in administration were noted in a communication book so they could be discussed with the person administering the medicines.

These were breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12.

We discussed our concerns about care plans with the registered manager. They explained that staff knew people very well. For people identified with complex and high needs their care plans and risk assessments had been updated with more details in response to concerns raised by visiting professionals. In addition, the registered manager was in the process of reviewing all care plans to ensure sufficient detail for staff to follow. Also, following a serious incident in November 2017, the service had purchased additional equipment to keep people safe whilst in bed.

By the second day of our inspection, we found that the sluice room had been thoroughly cleaned; staff were wearing aprons appropriately and COSHH products were stored safely out of reach of people. This demonstrated that the registered manager was responsive to concerns raised and acted upon these, although their own audits should have recognised these areas for improvement.

Medicines were stored safely at Kent House. Staff monitored and recorded temperatures of storage areas to make sure the medicines were fit for use. Medicines that had a reduced expiry date once opened were dated on the day of opening to ensure that they were fit for use. There were suitable arrangements for storing medicines which required extra security. Regular checks had been made for these medicines and they had not identified any issues.

When staff made handwritten entries or amendments to MARs they were signed by a second member of staff to show that they had been checked for accuracy. Medicines were administered in a caring way and encouraging manner. Care workers completed the MARs to show what medicines people had received. People's allergies or sensitivities to medicines were recorded on their medicine profile and MARs. Care workers applied simple creams to people and recorded their application on charts which were kept in people's rooms. These records were checked on a daily basis by the deputy manager to ensure that these preparations were applied as prescribed.

Staff had completed Mental Capacity Act and Best Interest medicine documentation for people who lacked the mental capacity to make decisions about their medicines. A pharmacist had checked to make sure that the medicines were safe and effective when administered covertly (given to people without their knowledge often mixed with food and drink).

All the staff who administered medicines had completed electronic on-line training for the use of medicines and had also received training from their local pharmacy. The registered manager was in the process of checking the competency of staff who administered medicines.

People felt safe and supported by staff. Comments included: "I feel safe living here"; "I have no concerns. If I did I would speak to the staff"; "I can always speak to staff if I am worried. They are lovely" and "I feel safe here and the staff are nice." A relative commented: "I can always go to the registered manager if I had any concerns."

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns

they might have within the organisation. However, three members of staff were not as confident to state who outside of the organisation they should contact, such as the local authority. The safeguarding policies and procedures also did not contain the contact details of the local authority safeguarding team. Staff records confirmed staff had received safeguarding training to ensure they had up to date information about the protection of vulnerable people.

The registered manager explained that during the daytime there were a minimum of four members of care staff in the mornings and three care staff in the afternoon. They were in the process of recruiting additional staff in order to increase day staffing to five in the morning and four in the afternoon. Rotas showed that on occasions these new staffing levels were in place. At night there was two waking night staff. In addition, the organisation employed an activities coordinator, two part time cleaners, two cooks, a general assistant and a maintenance man. We asked how unforeseen shortfalls in staffing arrangements due to sickness were managed. They explained that generally regular staff would fill in to cover the shortfall so people's needs could be met by the staff members that understood them. If regular staff were unable to cover, the service used agency staff. In addition, the service had on-call arrangements for staff to contact if concerns were evident during their shift.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

The premises were adequately maintained through a maintenance programme. Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. People had personal emergency evacuation plans (PEEPs), which are individual plans, detailing how people will be alerted to danger in an emergency, and how they will then be supported to reach safety. Staff had received health and safety and fire safety training to ensure they knew their roles and responsibilities when protecting people in their care. People were protected because the organisation took safety seriously and had appropriate procedures in place.

Good

Is the service effective?

Our findings

All the people we spoke with said they were happy with the skills and knowledge of the staff who cared for them well. One person told us "staff are knowledgeable and have good skills." A new member of staff said they were made aware of their roles and responsibilities when starting their employment at the home. Staff demonstrated their knowledge and skills in caring for people they looked after. They explained how they applied the knowledge gained through training in every day practice. People looked comfortable and at ease with staff. The way staff spoke with people showed they had an understanding of the needs of people. They were patient, gave eye contact and took time to provide information in different ways to help people understand and be involved in decisions.

Staff knew how to respond to specific health and social care needs. For example, recognising changes in a person's physical or mental health. Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. For example, how people preferred to be supported with personal care.

People were supported to see appropriate health and social care professionals, to meet their healthcare needs. There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. For example, GP, district nurse and occupational therapist. Records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved to encourage health promotion.

Staff had completed an induction when they started work at the service, which included training. One member of staff told us "I have completed a three day induction, which I enjoyed very much." The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. The induction enabled the organisation to assess staff competency and suitability to work for the service.

Staff received a range of training, which enabled them to feel confident in meeting people's needs and recognising changes in people's health. They recognised that in order to support people appropriately, it was important for them to keep their skills up to date. Staff received training on subjects including, safeguarding vulnerable adults, the Mental Capacity Act (2005), dementia awareness and first aid. Staff had completed nationally recognised qualifications in health and social care, including the care certificate. The care certificate equips care staff new to health and social care with the knowledge and skills which they need to provide safe, compassionate care. Staff had also recently completed basic life support training to ensure they were fully aware of how to deal with emergency situations. Additional information was displayed for staff about who to contact in the event of an emergency situation.

The organisation recognised the importance of staff receiving regular support to carry out their roles safely. Staff received on-going supervision and appraisals in order for them to feel supported in their roles and to identify any future professional development opportunities. Staff confirmed that they felt supported when it came to their professional development. Staff files and staff confirmed that supervision sessions and

appraisals took place on both a formal and informal basis. Appraisals were structured and covered a review of the year, overall performance rating, a personal development plan and comments from both the appraiser and staff member.

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People's individual wishes were acted upon, such as how they wanted to spend their time.

People's legal rights were protected because staff knew how to support people if they did not have the mental capacity to make decisions for themselves. People's capacity to make decisions about their care and support were assessed on an on-going basis in line with the Mental Capacity Act (MCA) (2005). For example, where staff were concerned about a person's behaviour and their lack of capacity to make decisions and manage their emotions, they had worked closely with other health and social care professionals. People's capacity to consent had been assessed and best interest discussions and meetings had taken place. For example, for the suitability of the placement, personal care and medicines. This demonstrated that staff worked in accordance with the MCA. The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had liaised with appropriate professionals and made an application for a person who required this level of support to keep them safe. Two people had authorised DoLS in place at the time of our inspection.

People were supported to maintain a balanced diet. People were very happy or extremely happy with the quality of the food provided. They said it was plentiful and appetising and the menu choices suited their needs and preferences. They reported that they looked forward to meal times and were able to take meals in their own rooms or in a lounge chair using a tray table if they preferred. Snacks and cold drinks were available between meals, or hot snacks and drinks on request. Comments included: "I have a healthy appetite and I like my food, but I never feel I haven't had enough to eat. I am finding I have to be careful about putting on weight. I can't praise the cook enough"; "Mum doesn't eat much now, but that's been her way for some years and she is healthy despite this. The staff encourage and assists her at meal times so that she gets what she needs, food-wise" and "Choice can be limited, but the staff know our likes and dislikes. They will make sure there's always something on that we like." People's weights were monitored. Staff recognised changes in people's nutrition and, if necessary, consult with health professionals involved in people's care. Speech and language therapists worked closely with people with speech, language and communication problems, and with those with swallowing, drinking or eating difficulties. As a result, people were prescribed specific diets to reduce the risks and staff followed the guidance.

People's individual needs were met by the adaptation, design and decoration of the premises. The home was set over three floors and was accessible by a lift and stair lifts. These were regularly serviced. People had a variety of spaces in which they could spend their time, such as the lounge and dining room and their bedrooms were personalised.

Good

Is the service caring?

Our findings

We spent time talking with people and observing the interactions between them and staff. Interactions were good humoured and caring. We observed how staff were attentive to people and were kind. People said that there was a friendly atmosphere and a real sense of warmth and human kindness. People and their relatives commented: "The staff always notice if someone is upset or not their usual self and they let us know what's going on. If someone gets ill, or falls, or hurts them self somehow, the staff let us know straight away"; "The staff are always cheerful, helpful and although they are busy they are never too busy to attend to the service users"; "Whenever I come to visit I always speak to the senior person on duty and they always give me their time so that I can be sure I know everything that's been happening, or I can tell them what's needed" and "I had to make some difficult decisions about coming into care but I am pleased I made the right decision."

Staff treated people with dignity and respect when helping them with daily living tasks. People's bedrooms gave them privacy and space to spend time on their own if they wished. Bedrooms reflected people's specific interests, through pictures and ornaments. Staff told us how they maintained people's privacy and dignity when assisting with intimate care. For example by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. Staff promoted people's equality, diversity and ensured their human rights were upheld. For example, staff recognised how choice of staff gender when providing personal care was important to people to ensure their individuality.

Staff adopted a positive approach in the way they involved people and respected their independence. For example, supporting people to make specific activity decisions. People were engaged in a coffee morning on the first day of our inspection and others chose to watch television either in the lounge or their bedrooms. Staff supported people in an empathic way. They demonstrated this empathy in their conversations with people they cared for and in their discussions with us about people. Staff showed an understanding of the need to encourage people to be involved in their care. For example, one person enjoyed staff talking to them about subjects of interest to them; this provided them with reassurance.

Staff gave information to people, such as when activities were due to take place and when lunch was ready. Staff communicated with people in a respectful way. Staff relationships with people were caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported. Staff were motivated and inspired to offer care that was kind and compassionate. For example, staff demonstrated how they were observant to people's changing moods and responded appropriately. For example, if a person was feeling anxious. They explained the importance of supporting them in a caring and calm manner by talking with them about things which interested them and made them happy. Staff recognised effective communication as an important way of supporting people, to aid their general wellbeing.

Staff spoke about the importance of involving people in their care to ensure they felt consulted, empowered, listened to and valued. They were able to speak confidently about the people living at Kent House and each person's specific interests.

The service had received several written compliments. These included: 'Thank you so much for all your care and kindness to both my mum and dad. I am very grateful to you all and particularly to those who were with each of them when they passed away'; 'Our heartfelt thanks for looking after (relative) with such loving care and attention'; 'I am sure you have more qualifications than you know what to do with, but each of you has something far more important – you really, really care for your residents' and 'Thank you for all the love, care and compassion shown to mum during her time with you all.'

Good

Is the service responsive?

Our findings

Care plans were up-to-date and clearly laid out. They provided an overview of people's physical and mental health needs. Six people said they were not aware of what was in their care plan. However, they trusted the staff to know what they needed. Two people said they had seen their care plan, but they thought the staff would know their needs anyway and they would speak up if they were not getting what they needed. Care records evidenced a record of monthly reviews. We discussed people's involvement in care planning with the registered manager. They explained that people and/or their families were always encouraged to have input in planning care needs and stating their likes, dislikes and preferences.

Care files included personal information and identified the relevant people involved in people's care, such as their GP. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate. Relevant assessments were completed, from initial planning through to on-going reviews of care. Staff commented that the information contained in people's care files enabled them to support them appropriately in line with their likes, dislikes and preferences. Care files included information about people's history, which provided a timeline of significant events which had impacted on them, such as their physical and mental health. People's likes and dislikes were taken into account in care plans. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Staff were able to communicate with, and understand each person's requests and changing moods as they were aware of people's known communication preferences. Care records contained communication details explaining how people communicated and the need to speak clearly to ensure they could communicate their wishes.

Activities formed an important part of people's lives. People engaged in activities if they wished. For example, board games, arts and crafts, pamper sessions and trips out in the minibus, which was shared with other of the organisation's homes. Staff were actively approaching and conversing with people throughout our inspection, including playing catch with a large, soft ball and ground level basketball hoop. People were encouraged to maintain relationships with their friends and family. For example, care plans documented the importance to people of seeing their family.

There were regular opportunities for people, and people that mattered to them, to raise issues, concerns and compliments. This was through on-going discussions with them by staff on a regular basis. Relatives were also made aware of the complaints system. The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint. Where a complaint had been made, there was evidence of it being dealt with in line with the complaints procedure.

People were supported at the end of their life. However, at the time of the inspection there was no-one receiving this type of service. The registered manager said, in the event of this type of support, they worked closely with the community nursing team; GP's and family to ensure people's needs were met in a timely way.

Requires Improvement

Is the service well-led?

Our findings

The service had made improvements since our previous inspection in June 2017. This was in relation to the deployment of staff at handover times and the documentation of people's personal preferences. However, this inspection highlighted new risks for people relating to a lack of sufficient detail on measures needed in relation to falls, skin care, mobility, continence and nutrition risks; infection control procedures and a lack of guidance for 'as required' medicines. These findings demonstrated the systems in place to assess and monitor the quality of the service provided were still not fully effective. This was because they were not identifying, and minimising some risks relating to the health, welfare and safety of people using the service. Further improvements in quality monitoring were still needed.

At a safeguarding strategy meeting on 11 December 2017 it was agreed for the Care Homes team safeguarding nurses to visit Kent House to follow up on the actions set at this meeting. They visited on 8 and 9 January 2018. The main concerns highlighted were around a lack of detailed risk assessments and care plans; lack of detail in daily records; no check charts in place to monitor people's general well-being; suitability of equipment; incident reporting; staffing levels; issues about medicines not being given as prescribed and staff understanding of the procedure in the event of an emergency. Following their visit, the local authority quality improvement team visited on 16 January 2018. At this visit some actions had been taken to address the concerns raised by the safeguarding nurses. These include:

- Additional equipment purchased to safeguard people in bed
- Staff were to receive extra emergency procedure training on 17 January 2018
- For people with complex and high needs their care plans and risk assessments had been updated with more details
- Charts had been put in place to monitor people's general well-being, such as food and fluid intake, repositioning in bed and elimination

When we visited on 31 January and 2 February 2018, we saw that the registered manager had responded to the concerns raised by the safeguarding nurses and were gradually updating all risk assessments and care plans. People now had folders in their bedrooms for staff to complete for personal care provided, creams applied, continence care, night checks, skin checks and air mattress checks. The registered manager explained that they were monitoring these charts on a daily basis, but as they were new to practice they had not found any themes or concerns as yet. Therefore, it was too early to tell whether auditing was effective.

Accidents and incident forms were used to document any accidents or adverse incidents. We asked the registered manager how they monitored these. They explained they looked at them on individual merit. However, we looked at the incident forms for December 2017 and found that 16 falls had occurred, of which 14 were unwitnessed by staff. We looked at the times of day these were occurring and found three were in the morning; five in the evening and eight at night. We asked the registered manager what measures had been put in place due to the amount of falls occurring at night. They explained that those people identified as at risk of falling out of bed, their beds were lowered to the floor and sensors were in situ to alert staff. Other measures had not been considered, for example increased checks.

The provider had a range of internal and external audits which were undertaken regularly. These included audits of hygiene and infection control, health and safety, complaints, staffing levels, activities, training, medicines management and care records. A director also visited and spoke with people, staff and checked and reported on a range of areas, although not all areas were checked each time. These audits had picked up certain things which needed improving such as more detail needed in care plans about how to support people when they became distressed, how often people needed to be checked at night and environmental issues such as wear and tear which had led to the redecoration of certain areas. However, despite these methods the audits had not picked up and addressed the concerns raised by the safeguarding nurses, quality improvement team and the Care Quality Commission. This meant that the systems in place to assess and monitor the quality of the service provided were not fully effective.

This is an on-going breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we met with the provider's representative on 23 February 2018 to discuss our findings. They accepted our findings and explained they were in the process of reviewing their systems to assess and monitor the quality of the service. In addition, the registered manager had continued to address care plans ensuring a greater level of detail, care plans specific to 'as required' medicines were now in place and falls were being analysed more closely, with them proactively liaising with health professionals when falls occurred to reduce risk.

Staff spoke positively about communication and how the registered manager worked well with them and encouraged an open culture. Staff felt able to raise concerns and would be listened to. Various staff meetings occurred on a regular basis. Staff confirmed they were kept up to date with things affecting the overall service via team meetings and conversations on an on-going basis. Additional meetings took place on a regular basis as part of the service's handover system which occurred at each shift change.

People's views and suggestions were taken into account to improve the service. Surveys had been completed by people using the service and relatives in January 2017, further surveys had just been sent out in January 2018. The surveys asked specific questions about the standard of the service and the support it gave people. Where actions were required these had been followed up by the registered manager. For example, people had recently raised concerns about clothes going missing once they had been laundered. The registered manager had raised this with the provider and was awaiting agreement to employ a person specific to manage the laundry service. In addition, a newsletter was made available to people periodically throughout the year. This provided information about the activities which had taken place and provided details of the activities available to people living at the service.

The service worked with other health and social care professionals in line with people's specific needs. This also enabled the staff to keep up to date with best practice, current guidance and legislation. Staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together with the staff. For example, GP and district nurse. Medical reviews took place to ensure people's current and changing needs were being met. Professionals confirmed that the service was prompt in referring to them and took on board advice and guidance.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment due to: • Risk management was not always robust. • Infection control procedures were not entirely safe. • Medicines were not always managed safely. Regulation 12 (1) (2) (a) (b) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess and monitor the quality and safety of the service provided were not fully effective. Regulation 17 (1) (2) (a) (b) (c)