

Shaw Healthcare (Group) Limited

Kent Lodge

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

The inspection took place on 17 March 2016 and was unannounced. The service was inspected on 24 April 2014 and at the time was not meeting one of the regulations we inspected in relation to the safety and suitability of the premises. The service was inspected again on 12 February 2015 and at the time was found to be meeting the regulations we looked at.

There was a registered manager at the service at the time of our inspection. 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.

Kent Lodge provides accommodation and personal care for up to 38 older people. The home is divided into two units, one on each of the two floors. The home provides a service for older people who have a range of needs including dementia care needs. There were 37 people living at the service at the time of our inspection.

Most of the home was in need of upgrading and redecoration. Not all the communal toilets had emergency cords that were accessible from the floor as they had been tied up or placed out of reach. A cupboard containing cleaning materials had a broken lock and another was secured with a bolt rather than a lock, so both could have been opened by people using the service. We made the manager aware of the safety issues and they told us they would address this without delay. The home was clean and tidy and free of hazards.

During the inspection, we saw that people were consulted and consent to their care and support was obtained verbally. However we found no evidence in people's care records that they had consented to their care and treatment except for 'consent to photos' forms.

None of the care plans we looked at were signed by people or their relatives, and there was no evidence of review of care or involvement in care planning process beyond records of discussions with relatives, usually single issue discussions.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. However there were gaps in recording in some files and some care plans had not been updated correctly to reflect people's current status. Some monitoring charts were not always consistently maintained and at times were disordered.

Care plans contained assessments of people's needs and information on how care was to be provided. Care plans contained information about people's daily routines and preferences.

Medicines were stored securely and staff followed the procedure for recording and safe administration of

medicines. Staff received training in the administration of medicines, and this was refreshed annually. The management team undertook regular audits of medicines.

The provider had processes in place for the recording and investigation of incidents and accidents. Risks to people's safety were identified and managed appropriately.

There were enough staff on duty to meet people's needs in a timely manner.

People felt safe when staff were providing support. Staff had received training and most demonstrated a good knowledge of safeguarding adults.

People's capacity to make decisions about their care and treatment had been assessed. Processes had been followed to ensure that, when necessary, people were deprived of their liberty lawfully.

Staff received regular supervision and an annual appraisal, and told us they felt supported by their manager. There were regular staff meetings and meetings with people and their relatives.

Staff had received training identified by the provider as mandatory to ensure they were providing appropriate and effective care for people using the service.

Recruitment records were thorough and complete and the provider had ensured that staff had a Disclosure and Barring Service (DBS) check prior to starting work.

There was a complaints process in place and people told us they knew who to complain to if they had a problem. Relatives were sent questionnaires to gain their feedback on the quality of the care provided.

People told us they felt safe at the home and trusted the staff. They told us staff treated them with dignity and respect when providing care. Relatives and professionals we spoke with confirmed this. We saw people being cared for in a calm and patient manner. There was a relaxed, unrushed atmosphere which facilitated good communication between staff and people using the service.

The service employed one activity coordinator and we saw there were organised activities on the day of our inspection. Activities were recorded in daily activities log in people's care files which detailed for each person the type of activity they engaged in.

People gave positive feedback about the food and we observed people being offered choice at the point of service. People had nutritional assessments in place. People had access to healthcare professionals as they needed, and the visits were recorded in their care plans.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to the need for consent and safe care and treatment. You can see what actions we told the provider to take at the back of the full version 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?

Some aspects of the service were not safe. Not all the communal toilets had emergency cords that were accessible from the floor as they had been tied up or placed out of reach. A cupboard containing cleaning materials had a broken lock and another was secured with a bolt rather than a lock.

Medicines were securely stored and staff followed the procedure for recording and safe administration of medicines.

The provider had processes in place for the recording and investigation of incidents and accidents. Risks to people's safety were identified and managed appropriately.

There were enough staff on duty to meet people's needs in a timely manner.

People felt safe when staff were providing support. Staff had received training and demonstrated a good knowledge of safeguarding adults.

Requires Improvement ●

Is the service effective?

Some aspects of the service were not effective. There was no evidence in people's care records that they had consented to or had been involved in their care planning. None of the care plans we looked at were signed by people or their relatives

There were gaps in recording in some files and some care plans had not been updated correctly to reflect current status. Some monitoring charts were not always consistently maintained and were disorganised.

Staff received the necessary training to deliver care to people, and were suitably supervised and appraised by their manager.

People were protected from the risks of inadequate nutrition and dehydration. People had a choice of food and drink for every meal, and throughout the day.

Requires Improvement ●

Is the service caring?

Good ●

The service was caring. Staff interacted with people in a friendly and caring way. People said they felt well cared for and had good and caring relationships with all the staff. Relatives and professionals told us the people using the service were well cared for.

Care plans contained people's likes and dislikes and identified the activities they enjoyed, people who were important to them, their cultural and religious needs, and needs relating to their identity. People were supported by caring staff who respected their dignity.

People were able to make choices and told us the staff respected these.

Is the service responsive?

Good ●

The service was responsive. Assessments were carried out before support began to ensure the service could provide appropriate care. Care plans were developed from the assessments and reviewed regularly.

People and their relatives were sent questionnaires to ask their views in relation to the quality of the care provided. The manager analysed these to ensure that action was taken where concerns were raised.

Activities were planned and took place at the home. The activity coordinator and all staff engaged with people to deliver these.

Is the service well-led?

Good ●

The service was well-led. The provider had a number of systems in place to monitor the quality of the service and put action plans in place where concerns were identified.

People, relatives and professionals we spoke with thought the home was well-led and the staff and management team were approachable and worked well as a team.

The staff told us they felt supported by their manager and there was a culture of openness and transparency within the service.

Kent Lodge

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.

This inspection took place on 17 March 2016 and was unannounced.

The inspection was carried out by two inspectors, a clinical advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert on this inspection had experience of residential and nursing services for older people including those living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, including notifications we had received from the provider and the findings of previous inspections.

During the inspection, we spent some time observing care and support being delivered to help us understand people's experiences of using the service. We also looked at records, including six people's care plans, three staff records and records relating to the management of the service. We spoke with 14 people who used the service, 12 staff, including the operations manager who represented the service provider and the registered manager, the activities coordinator and two domestic workers. We also spoke with a healthcare professional and a social care professional who were visiting people at the time of our inspection.

Following our visit, we spoke with four relatives and one healthcare professional who was regularly involved in the care of people using the service to gather their views about the service.

Is the service safe?

Our findings

We looked around the service and found that not all the communal toilets had emergency cords that were accessible from the floor as they had been tied up or placed out of reach. This meant that should a person have a fall, they may not be able to reach the cord and call for help. We mentioned this to the manager who told us that some of the people who used the service removed the cords which is why they sometimes looped them around the handrails. The manager told us they would address this immediately.

A cupboard containing cleaning products was unlocked. We saw a notice on the door saying that the lock was broken, however nobody had removed the products inside it. We informed the manager who told us that they had only just been informed of it and would address it without delay. Another cupboard also containing cleaning products was secured with a bolt rather than a lock. This meant that both cupboards could have been accessed by people who used the service. The manager informed us the day after the inspection that both cupboards had been fitted with a secure lock.

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. However records were not always up to date and accurate. We saw in one care record that a person was at risk of pressure ulcers and required frequent re-positioning. Staff we spoke with told us that this monitoring was no longer required but the care plan had not been updated and there was no reference to this change in monthly evaluations. A person with a chronic wound had no wound care plan. Although the district nurse visited regularly to dress the wound, these visits had not been recorded consistently and there was no reference to the wound in the care plan except on the body map. There was no documentation on how the person's wound was being managed or any record of progress/evaluation or dressing changes. There was no documented direction for staff on signs/symptoms to be aware of, such as signs of infection and what to do if the dressing needed changing, although staff were aware of this when asked. The district nurse indicated that a care plan had been provided but documentation was blank.

Monitoring charts were not always consistently maintained and were disordered in some cases, such as loose forms left on top of the care plan trolley. We checked a selection of re-positioning charts and although two of those were up to date, the chart for one person requiring two-hourly turning had not been updated since the previous day (at 8pm).

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

People told us they felt safe at Kent Lodge. One person said, "The staff here look after me, no complaints about them... they do their best." Another person told us, "I feel very happy and safe and comfortable." When asked whether they are ever made to do anything they don't want to do, one person said, "Not at all, that's not happened, I do what I want."

All areas of the home were clean and tidy and free of any hazards. However most of the home was in need of upgrading and redecoration with fixtures that were outdated and shabby. In particular communal toilets and bathrooms were in need of refurbishment and upgrading. Sanitary fittings were old and worn and, although not unclean, most toilet bowls were stained. Some bathrooms were not readily accessible and were being used as storage for wheelchairs and hoists (despite a notice on the door of one bathroom indicating that wheelchairs should not be stored there). We saw that there was a development plan for the refurbishment of the home and areas had already been refurbished. The provider told us that the whole of the building was not going to be refurbished due to major unexpected work having to be carried out. However they told us they would ensure that they would deal with the stained toilets and would make the bathrooms more pleasant and accessible to people.

The manager raised alerts of incidents of potential abuse to the local authority's safeguarding team as necessary. They also notified the Care Quality Commission (CQC) as required of allegations of abuse. The manager worked with the local authority's safeguarding team to carry out the necessary investigations and management plans were developed and implemented in response to any concerns identified to support people's safety and wellbeing. A social care professional, and the records we viewed, confirmed this.

Staff had completed training in safeguarding adults and records confirmed this. Some of the staff we spoke with were unsure when they had the last safeguarding training or exactly what safeguarding meant. However, most were able to give some definitions of abuse/neglect. They told us they would report any concerns to their manager, or would refer to the information and phone numbers available in the duty office. We saw information and posters on notice boards referring to whistleblowing and safeguarding and numbers to contact for complaints including CQC and the local authority.

Accidents and incidents were clearly recorded and included details such as time and place, action taken, outcome and steps taken to prevent re-occurrence. This included fifteen minute observations for a person who had fallen and a check-up by their GP. We saw that the care plan and risk assessment were updated appropriately.

The provider had a health and safety policy in place, and staff were aware of this. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. A general risk assessment was in place which included medicines administration, infection control and manual handling. Equipment was regularly serviced to ensure it was safe, and we saw evidence of recent checks. This included fire safety equipment such as fire extinguishers.

The service had taken steps to protect people in the event of a fire, and we saw that a risk assessment was in place. The service carried out regular fire drills, including unannounced drills carried out during the night and weekly fire alarm tests. This ensured that all staff were able to follow the fire procedure in the event of a fire. All drills and tests were recorded and included any actions taken if a fault was found. A recent fire inspection had highlighted some areas that needed improvement and we saw that the manager had addressed and rectified all areas. People's records contained Personal Emergency Evacuation Plans (PEEPS) which took into account people's abilities and needs, how many staff were needed to support them and any specialist equipment they needed.

People and relatives told us they were happy with the staffing levels, and we saw that there were enough staff on duty on the day of our inspection to meet people's needs. Staff had mixed views about whether staffing levels were adequate. Some felt that when staffing levels were correctly maintained they were fine. However, two staff members commented that the home needed to use agency staff to cover for absences. Our observations indicated adequate staffing levels, and there were no indication of any staff being rushed

except at lunchtime when staff had to serve and rinse dishes in addition to assisting people when required. Staff were available to attend to people and spend time supporting and talking to people.

Recruitment practices ensured staff were suitable to support people. These included checks to ensure staff had the relevant previous experience and qualifications. Checks were carried out before staff started working for the service. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a criminal record check such as a Disclosure and Barring Service (DBS) check was completed.

Arrangements were in place for the management of people's medicines and all medicines were stored securely. Senior staff were trained in the administration of medicines and received annual updates. Medicines policies and procedures were in place and staff demonstrated a good understanding of the procedures they followed when they supported people with their medicines. The service has started using an electronic medicines administration record. This was a system approved and recommended by pharmacists to improve and simplify medicines management and reduce the risk of errors. We asked the team leader to show us a range of medicines charts and found that the amount of medicines recorded matched the amount in stock. Each staff member was allocated a code which identified them when they administered people's medicines. The team leader told us that the system highlighted in red if a medicine was running low or if staff had not given or signed for a particular medicine. The manager conducted regular medicines audits and we viewed a sample of these. They told us that errors were very rare and records confirmed this. This meant that people were protected from the risk of not receiving their medicines as prescribed.

Is the service effective?

Our findings

During the inspection, we saw that people were consulted and consent to their care and treatment was obtained verbally. However we found no evidence in people's care records that they had consented to their care and treatment except for 'consent to photos' forms.

None of the care plans we looked at were signed by people or their relatives, and there was no evidence of review of care or involvement in care planning process beyond records of discussions with relatives, usually single issue discussions.

Only one of the care records we checked contained a 'Do Not Attempt Resuscitation' (DNAR). These are decisions that are made in relation to whether people who are very ill and unwell would benefit from being resuscitated if they stopped breathing. This had been authorised by the GP with evidence of consultation with the next of kin as the person who used the service lacked capacity. The person's capacity in relation to this particular decision had not been assessed. This meant that people were at risk of not being appropriately supported when decisions about their care were made.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The Mental Capacity Act (MCA) 2005 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. We found that the provider understood the principles of the MCA and had followed its requirements. The manager had identified people for which restrictions had to be put in place and had taken appropriate action to make sure these were in people's best interest and were authorised by the local authority as the Supervisory Body.

All staff employed at the service had received training in MCA and were able to provide examples of where they had assessed someone's capacity to make a decision and how decisions could be made in people's best interest if they lacked capacity. We saw information and posters in various areas of the home about MCA and access to Independent Mental Capacity Advocates (IMCA).

People were supported by staff who had appropriate skills and experience. Staff told us they had received a

thorough induction when they started to work for the service. This included training and working alongside other staff members. One newer member of staff confirmed that their induction program had consisted of a range of training modules and a period of supervision and shadowing. The subjects covered during the induction included safeguarding, health and safety and medicines administration as well as training specific to people who used the service, such as MCA and dementia awareness. Most staff had obtained a National Vocational Qualification (NVQ) in care at level 2 or 3 and the service had started to introduce the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Training records confirmed that staff training was delivered regularly and refreshed annually. This meant that staff employed by the service were sufficiently trained and qualified to deliver care to the expected standard.

During the inspection we spoke with members of staff and looked at staff files to assess how they were supported within their roles. Staff told us and we saw evidence that they received supervision from their line manager regularly. The manager told us that this provided an opportunity to address any issues and to feedback on good practice and areas requiring improvement. Staff also received a yearly appraisal. This enabled staff and their line manager to reflect on their performance and to identify any training needs or career aspirations.

Care files had a separate care plan dedicated to eating and drinking which recorded nutritional status and dietary needs such as the need for fortified or pureed food, swallowing difficulties and assistance required to eat and drink. Food and fluids were monitored for some people at risk of malnutrition and samples seen were well completed and up to date. Malnutrition Universal Screening Tool (MUST) scores were recorded and updated monthly to show weight and BMI but had not always been completed consistently. We saw one form which had not been completed between September 2015 and February 2016.

People had a choice of food at each meal. There were laminated cards with pictures of different meals available to show people in case they were unclear. In addition we saw that people were shown the different food available at meal times so they could choose what they wanted at the point of service. We viewed all menus for the week and saw that they changed daily and were rotated across the month. The food served was hot, nutritious and looked appealing. All meals were cooked using fresh ingredients and were served in bright and cheerful dining rooms on each floor. People had adequate amounts to drink. Tea and coffee was served mid-morning and mid-afternoon and jugs of juice and water were available in lounge throughout the day. People were also served hot or cold drinks on request. This meant that the service recognised the importance of food, nutrition, hydration and a healthy diet for people's wellbeing generally, and as part of their daily life.

The service was responsive to people's health needs. A healthcare professional told us that the service was very good at calling them whenever someone needed them. They said, "We have a good relationship. They call me whenever somebody needs treatment and I come." One relative told us, "They keep me informed of all appointments and doctors' visits. I know they are checked regularly." Records showed that people's health was monitored and any concerns were recorded and followed up. This included a person whose health had deteriorated. There was evidence that they had been referred to the relevant healthcare professional, and appropriate treatment had been offered. Care plans contained individual health action plans. These detailed people's health needs and included information about their medical conditions, mental health, medicines, dietary requirements and general information. This showed that the service was meeting people's health needs effectively.

Is the service caring?

Our findings

People and relatives were complimentary about the care and support they received. One person told us, "I am happy here, they are so kind." One relative said, "I have nothing but admiration for the staff. They are universally patient, helpful and kind." Another relative told us, "The staff are great. My [relative] does very well here, all because she is so well-cared for. If it wasn't for Kent Lodge staff, my [relative] would not be here today." A healthcare professional told us that carers were "very attentive" and that people living at the service were "very well cared for". Another confirmed that staff were always caring and attentive to people, and that communication with the home was good.

The staff and management team spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. We saw a large board in the reception area which said, "Our residents do not live in our workplace, we work in their home."

All staff displayed a gentle and patient approach to caring throughout the day when caring for people in the home. We observed that staff communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people. They were attentive when people needed assistance and understood how best to talk with different people according to their communication needs. This included ensuring that somebody's hearing aids were working and using signs and gestures to communicate with a person for whom English was not their first language.

Staff demonstrated a very good level of engagement with people on an interpersonal as well as practical level. They were cheerful and good natured and took time to speak with people, interacting and chatting with them throughout the day, not only when they were performing physical care tasks.

Staff offered choices to people throughout the day including choice of what to watch on TV, and showing choices of different food options to people at lunchtime.

Staff encouraged people to be as independent as they could be and mobilise by themselves as far as possible while taking care to supervise their safety. We saw one staff member gently encouraging a person to transfer from a walking frame to a chair without assistance while remaining close at hand in case help was required.

Staff were seen to knock on closed doors before entering and said they always respected privacy and dignity by ensuring that people's choices were respected and closing doors when delivering personal care.

Staff were clearly aware of people's needs, routines and behaviour and were able to explain how they supported different people. We saw evidence of kind and empathetic care. One person who had recently been admitted to the home was introduced to other people who used the service and was provided with reassurance and company all day. We saw that people who spoke the same language were introduced to each other to facilitate conversation and encourage positive relationships.

There were some evidence of information on lifestyle and background in care files we reviewed such as personal history, past employment, hobbies and family background, although this was not very detailed and staff were less familiar with this aspect of people's care.

Is the service responsive?

Our findings

People's care and support had been assessed before they started using the service. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care, support and any risks that were involved in managing the person's needs. People and their relatives told us they had been involved in the initial assessment. One relative said, "There was an assessment done prior to admission. I am very involved. No complaints about the service at all." The manager told us that people were referred from the local authority and they had obtained relevant information from them. This included background information for most people which helped understand each person and their individual needs. One social care professional told us that the service was always responsive to people's needs and gave us an example where a person's needs had exceeded what the service normally offers, however they had been able to meet their needs completely. This included ensuring that appropriate care and pressure-relieving equipment was in place to prevent pressure ulcers from developing.

The care plans were comprehensive and contained sufficient information to know what the care needs were for each person and how to meet them. Each person's care plan was based on their needs, abilities, likes, dislikes and preferences. This was particularly evident for a person who had specific needs in relation to their identity. This showed that staff accepted people for who they were and celebrated people's differences and diversity.

We observed throughout the day that individual staff member's style of interaction with people changed based on who they were speaking with. This seemed to be a strength of the staff group as a whole, and showed them to be responsive to people's needs rather than having a 'one size fits all' approach.

We saw that staff supported and encouraged people to maintain their independence. This included encouraging a person to walk rather than using the wheelchair. Although this took more time, the staff member was patient and encouraging and rewarded the person with praise.

The service employed a full time activities coordinator. Some staff thought that this was not adequate given the number of people using the service, particularly as the activities coordinator often accompanied people when they went out on external visits or appointments, or worked as a staff member on occasions. However we saw that staff on duty engaged in activities with people throughout the day. These included playing dominoes, painting nails and discussing contents of the daily newspaper. Activities undertaken by people were recorded in a daily activities log in care files which detailed for each person the type of activity engaged in. This was mainly a record of participation and did not include much detail on mood or social engagement.

There was a schedule of activities for each day on the noticeboard but this was simply a small typed sheet which would have been difficult to read for people using the service. The activities coordinator told us that one to one sessions were held with people in their rooms if they were unable or unwilling to participate in group activities. They told us that external entertainers visited the home on a regular basis but organised group outings were rare as they did not have transport. Other events took place throughout the year such as

an annual barbecue and people were looking forward to a party coming up to celebrate the Queen's 90th birthday.

There were sensory displays in the corridors and good signage around the home. Photographs of people using the service were displayed in art work they had been supported to create during activity sessions. This showed that staff understood and took steps to develop the environment to meet the needs of people living with dementia and sensory impairment. Throughout the home, there were photographs displayed of parties and fetes that had been organised at the home.

The service had a complaints procedure in place and this was available to staff, people who used the service and relatives. A record was kept of all the complaints received. Each record included the date, nature of the complaint, action taken and outcome. Where complaints had been received, we saw that they had been investigated and the complainants responded to in accordance with the complaints procedure. This included a complaint from a person using the service against a member of staff. We saw that the staff member was appropriately disciplined and additional training was offered.

People were supported to feedback about the service through meetings and quality questionnaires. These questionnaires included questions relating to how they felt about the care and support they received and whether their needs were being met. It also included questions about the quality of the food, the environment and their social needs. We saw that the results showed an overall satisfaction. Some comments included, "Thanks for all your care and kindness", "Thank you for your loving care, he was back to the dad I knew" and "Thank you for caring for my lovely [relative] so well, God bless you all."

Is the service well-led?

Our findings

People and relatives we spoke with were complimentary about the staff and the manager. They said they were approachable and provided a culture of openness. People thought that the home was well managed and the staff worked well as a team. One relative told us, "Management is brilliant! Great atmosphere, happy place! I would choose it for myself, happy as Larry!" A healthcare professional informed us that, "The manager has always been kind and courteous, very well managed place." A social care professional said, "The manager is contactable and greet us so well. Always smiling and responsive, there is no doubt the residents are well-cared for."

Staff commented that there was an open and positive culture at the home. They felt supported by senior staff and management and were confident that they could raise concerns or queries at any time. Most staff we spoke with were long standing and happy working at Kent Lodge. They were complimentary about the manager whom they felt was 'hands on', visible and approachable. Care staff said that the manager was on the floor every day to observe care and speak with staff, people who used the service and their relatives. They said that the manager was very supportive and accommodating and worked with staff so that their shifts were arranged to suit their needs.

The manager had put in place a number of different types of audits to review the quality of the care provided. These included medicines audits, environmental checks, health and safety checks and care records. Audits were evaluated and when necessary, action plans were put in place to make improvements in the service. Records were kept of safeguarding concerns, accidents and incidents. We viewed a range of audits which indicated they were thorough and regular.

Staff told us they had monthly meetings and records confirmed this. The items discussed included rota, teamwork, whistleblowing, care plans, activities and health and safety. Outcomes of complaints, accidents and incidents were discussed so that staff could improve their practice and implement any lessons learnt from the outcome of investigations. Staff meeting minutes confirmed this. There were also regular managers meetings, team leader meetings and meetings for people who used the service and their relatives. Some of the subjects discussed included staffing, food, activities and outings. The minutes of a recent residents and relatives meeting were displayed on the notice board.

Service user guides were issued to all people living at the service. They included an introduction to the manager with their photograph, and information about the service, the organisation its aims, objectives and values.

The service worked closely with healthcare and social care professionals who provided support and advice so staff could support people safely at the service. Records showed that professionals visited people at the home and had established good working relationships with staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person. Regulation 11(1)(2)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people using the service. Regulation 12(2)(a)(b)(d)