

Abbey Healthcare (Westmoreland) Limited

Kendal Care Home

Inspection report

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20 December 2015
07 January 2016
11 January 2016
01 February 2016

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

This focused inspection took place over the period of time from 20 December 2015 to 1 February 2016 and all the visits made during that period were unannounced. We last inspected this service on 30 September and 6 October 2015 where there was a breach of regulation 17 (Good Governance) when we found that there were not effective operating systems in operation to protect people against the risks of inappropriate or unsafe care. There had not been regular assessment and monitoring of the quality of the services provided to people including in medication management where we found the service to be in breach of Regulation 12(2)(g) the proper and safe management of medicines; We carried out two visits to the home on 7 January and 11 January 2016 to follow up on the warning notice issued as a result.

We found during this focused inspection that the home had made improvements since the inspection in September 2015 in some aspects of quality monitoring and had introduced and maintained more quality assurance audits, including regular medication audits since the last visit. There were now daily walk rounds by a member of the management team covering the home to monitor staff practices on each floor and check staffing deployment. Care plans had been subject to reviews and had been updated to reflect any changes in people's needs or preferences. Risk assessments had been carried out for people living there to help identify risks and audits had been carried out to monitor that nutrition and weights were being reviewed. The registered provider had improved the overall systems in place to monitor and report back on quality monitoring issues and assurance monthly. The acting manager had carried out audits, including for medication procedures and medication training for staff and had also completed. However there was still room for improvement in the consistency of monitoring of medication management and adherence to clear procedures.

There continued to be a breach of Regulation 17 (Good Governance). This was in relation to the lack of accessible and known procedures being in place for staff to refer to regarding the scheme of delegation within the home in the event of an emergency situation that could impact upon the service provision to people living at Kendal Care Home. As a result staff did not follow a recognised procedure they knew and understood when they encountered difficulties such as the adverse weather affecting travel and staff. The rotas and logging in systems within the home were not always clear and accurate records of the staffing situation. As a result there was not a clear audit trail of the process to show what staff were on which unit and in what capacity they were working. During the course of this inspection we found that operating systems were not being effective in ensuring the safe running of the home in the event of emergency situations. There were not clear and detailed contingency plans and escalation systems in place for responding to emergencies and untoward events. We issued a warning notice in relation to the continued breach that required the registered provider to make improvements to ensure operating systems were being effective in ensuring the safe running of the home in the event of emergency situations.

We had visited on 20 December 2015 out of normal working hours and again on 1 February 2016 as part of the inspection to monitor the service after CQC had received concerns from other agencies, health care professionals and individuals in relation to the levels of suitably qualified nursing and care staff and the

levels of management staff being deployed in the home to make sure meet people's needs were being safely met. We visited to make sure there was effective management oversight in the home at all times and to check that there would be sufficient staff on duty period over the Christmas holidays. Rotas showed that sufficient staff would be on duty and that there would be management on call. Staff levels were safe during the times we visited.

We found over the course of the inspection that there was a breach of Regulation 18 (Staffing) that had an adverse impact upon some of the people living there. At all the visits made people living there we spoke with told us they felt staff were not always available when they wanted them and specifically on Boxing Day 2015. People living in the home and their relatives told us there had not been any one with overall management authority in the home or easy access to managers who were on call for the service and that there was no one coordinating overall staffing deployment. We had seen that there was an on call contact list available for management cover over the Christmas period but relatives told us that the number given as first point of call was not always being answered. People living on the nursing unit and their relatives told us that a lack staff availability and management presence had impacted negatively upon the care and support on Boxing Day. For example, on the nursing unit one person told us that there had not been staff available to help them get up, washed and dressed until 3pm that afternoon. They told us this was not their choice. We issued a warning notice in relation to the breach of the regulation that required the registered provider to make improvements to ensure there were always sufficient competent and experienced staff in a management position or with delegated responsibility to make sure that the service was being run to meet the requirements of the regulations.

People also told us that they believed that the staff on duty had worked hard to try to meet their needs and were helpful and supportive. We were given examples of how staff had worked hard to make sure that everyone enjoyed Christmas Day and that there were entertainments and a festive atmosphere with the same level of staffing as Boxing Day. Rotas were provided to us and staff we spoke with, people living in the home and their visitors told us that staff in the home had been moved around the units and had worked additional hours to make sure people's needs were met and adequate staff were in place. We were told by some people staff were available for them to be able to take part in and enjoy the day as they wanted and one person told us they "could not fault it". The management team had undertaken an investigation as to what might have caused such differing experiences over the two days when staff levels had been the same.

Kendal Care Home provides nursing and residential care for up to 120 older people, some of whom are living with dementia. The home is on three floors and has a passenger lift for access to these. The ground floor is a residential suite, the first floor is a general nursing suite and the second floor is a suite for the nursing care of people living with dementia. All the bedrooms in the home are for single occupancy and have ensuite toilet and shower facilities. Each of the three units have their own communal dining and lounge areas and there is a cinema room for people to use. The home is set back from the main road, with level access grounds and ample car parking for visitors.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The home had not a registered manager in post since March 2015. One manager had left before registering with CQC. Another manager had since been recruited and was on duty during some visits but had yet to register with CQC. This lack of management stability and continuity had significantly impacted upon the progress in implementing changes and improvements in the service.

This report only covers our findings in relation to the warning notice and the concerns raised about staffing and management availability. We have not revised the rating overall. We will review our overall rating for the service at the next comprehensive inspection of the service. You can see what action we told the provider to take at the back of the full version of the report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kendal Care Home on our website at www.cqc.org.uk.

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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 always safe.

There were not always sufficient competent and experienced staff in a management capacity or with delegated responsibility on Boxing Day to make sure that the service was being run to meet the requirements of the regulations.

There was no one with designated responsibility on site during the Christmas holiday in charge of the building with delegated authority to put contingency plans into operation should an emergency situation arise.

Is the service well-led?

Inadequate 

The service was not well- led.

There was no registered manager in post at the time of the inspection. The home had not had a registered manager since March 2015.

There were systems to assess the quality of the service provided but some aspects of the improvements made still needed to be embedded in order to be show consistency in the long term.

There were not clear and detailed contingency plans and escalation systems in place for responding to emergencies and untoward events. We found this was in relation to the adverse weather conditions experienced locally.

Kendal Care Home

Detailed findings

Background to this inspection

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

We visited the home four times during the period of 20 December 2015 and 1 February 2016. Our visits took place on 20 December 2015, on 7 and 11 January 2016 and on 1 February 2016. Our inspection visits were unannounced and the inspection team over the period of the inspection consisted of two Adult Social Care (ASC) Inspectors, an inspection manager and a pharmacist inspector.

During the course of our inspection we spoke with 13 people who lived in the home, 10 relatives/visitors, six registered nurses, eight care staff, five agency staff, three ancillary staff, including domestics and activities staff. We spoke with visiting health care professionals, the acting manager, the Operations Director and the unit managers.

We observed the care and support staff provided to people in the communal areas of the home and at meal times. We spoke with people in communal areas and in private in their bedrooms. We looked at records that related to how the home was being managed.

We looked in detail at the records relating to the use of medicines and the care plans for 11 people living on all three units. We observed medicines being handled and discussed medicines handling with staff and a pharmacist from the local clinical commissioning group.

Before the inspection we reviewed the information we held about the service, including information we had asked the registered provider to send to us on daily staffing levels. We also looked at the concerns and comments that had been made to us by the relatives of people living at the home and sent anonymously. We looked at the information we held about notifications sent to us about incidents and accidents affecting the service and people living at the home. We looked at the information we held on safeguarding referrals and applications the manager had made under Deprivation of Liberty Safeguards. We looked at information sent to us by local commissioners of the services provided by Kendal Care Home, from local medical

practitioners and other health care professionals involved in providing care and support to the people living in the home.

Is the service safe?

Our findings

When we last visited this home in September 2015 and October 2015 we found the service to be in breach of Regulation 12(2) (g) (the proper and safe management of medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider did not have systems in place to make sure the home's policies and procedures regarding recording and managing medicines were followed. At this inspection we checked the medicines records for 11 people to see if this aspect of management had been improved. We spoke with the operations director, the acting manager, a senior carer, four registered nurses and a pharmacist from the local clinical commissioning group.

The medication records for all the people we looked at had their photographs and recorded any allergies. This reduced the risk of medicines being given to the wrong person or to someone with an allergy and is in line with current guidance. We saw that the service was making some progress with improving medication management but that there was still work to be done to embed improvements and ensure procedures were consistently followed. This will be fully assessed at the next comprehensive inspection.

We spoke with people living in the home about the staff working there and staffing levels on the three units. At all the visits people we spoke with told us they felt there was not always enough staff available when they wanted them. One person on the nursing unit told us, "They have some good staff but they could do with more". We were told, "I can't stand by myself now and it depends on how busy they are on how long I will have to wait for help. It also depends who is on, some are excellent, but some lack experience". Another person told us "The home has changed a lot staff wise since I first came in and a lot of good staff have come and gone. It was a lovely place when I first came in".

We asked people living on the nursing unit about staff levels and specifically over the Christmas period. We asked people if there had been enough staff available for them to be able to take part in and enjoy the Christmas festivities as they wanted. Some people we spoke with had gone to relatives that day but we spoke with five people who had been in the home on Christmas Day and Boxing Day. One person living on the nursing unit told us "Christmas day was fine, we had a band in and choirs, the food was good and I was up and dressed quite quick. Couldn't really fault it but Boxing Day they seemed short, it was chaotic, I was got up alright but I saw some did not get up that day. They needed more nurses I think".

Another person told us, "Christmas Day was excellent, I really enjoyed it, couldn't fault it in any way. One of the carers in particular really made an effort to make it good for us all. Boxing Day let us down badly, though; I did not get up until 3pm, and not out of choice. They seemed to be short of staff, there were three carers down this end but they seemed to be run ragged. I felt sorry for them". Another person told us that on Boxing Day "I only saw the nurse when she gave me my pills and they seemed in a state. It's been alright since, I think it depends which staff are on, some work better than others and some are better organised".

Two of the people living at the home we spoke with and three relatives told us that the call bells "were ringing constantly" and one person said they had waited 25 minutes for attention. Another relative told us, "The call bells can take a while to be answered but [relative] care needs seem to be met, they're clean, tidy

and well fed". We asked the regional manager for records of call times from their call bell system but they were not able to access this information on the system as it did not allow this. Therefore we could not verify the time being taken to answer call bells, One person living on the nursing unit told us, "I have had to wait for help to the toilet on occasion when I ring the call bell, but it's not their [staff] fault, there are just too few to deal with helping quickly for everyone here needing them, they definitely need more [staff]". They also added, "I think I get the care I need, I don't feel neglected or anything like that". Another person on the nursing unit told us they had been out on Christmas Day but Boxing Day had been "fine". They told us two staff came to help them to get up and dressed when they were ready to and that staff had answered their bell in good time.

We received information and concerns from relatives about the staffing levels on the nursing unit and about their difficulty in speaking to senior management on call about their concerns on Boxing Day. They told us that there "seemed to be no one in charge of the home" and the on call number was not being answered when they called it. However a relative had been able to speak to the regional manager during the day to raise their concerns.

We spoke with four groups of relatives who had been in the home visiting over the Christmas period. They had visited their relatives on the nursing unit. We were told there had been two nurses on duty on Boxing Day, as there had been on Christmas Day and there had been three care staff working where their relative was on the unit. They told us that staff had not been available to help their relative get up until late afternoon on Boxing Day. They told us that the two nurses "seemed to be panicking" about staffing and were "upset". They told us the following day that "Everything seemed to be back to normal, it was calm, and [relative] was up, washed and dressed in the morning and with no more staff than the day before. At the moment everything is back to normal and we are quite happy". The registered provider was investigating why people had not been satisfied with their care on Boxing Day when there had been adequate staff on duty both days.

We looked at the copies of the staff rotas used to plan staffing over Christmas. We found that records of staff rotas were not clear and had been altered several times. On the nursing unit there were two staff names still on rotas of people who had left the service and this had caused some confusion over who was on duty on the nursing unit. Staff we spoke with confirmed that "The rotas were all messed up on nursing" and the names of staff who had left were still on the rota.

The 'care blox' signing in system used by the service did not have all staff clocked in so the information could not be relied upon for verification. According to 'care blox' staff had also left the building at times not as stated on the rota. So the records were not accurate in this respect and staff levels on Boxing Day could not be easily verified.

On the residential unit rotas on Boxing Day there were three care staff assigned to provide safe cover. One of the care staff came on duty at 8am and was sent to assist on the nursing unit for the day, leaving two on duty on the residential suite. One of the care staff was rostered to work on the residential from 8am to 2pm and 'care blox' showed they left at 12.15 pm leaving the senior carer as the only care staff remaining on the unit to provide care for the 14 people living there. The senior carer was due to work from 8am to 8pm but 'care blox' print outs indicated they left at 10 minutes to 6. The print out showed that a member of night staff came in early at 6 pm instead of at 8pm to start their night shift meaning there was only one staff member on the unit. At 8pm on Boxing Day the second member of night staff came on duty to provide staffing as on the rota although they did not log in on 'care blox'. There had been a period of time between 12.15 until 8.00pm on Boxing Day, when staffing levels fell short of the required level shown on the off duty rota.

One care assistant on night duty should have finished work at 8 am on 27 December 2015 but worked until 9.23am the next day as a care assistant due to come in at 8am came in at 9.05 am. There was nothing on the rotas to indicate if that was expected. The 14 people living on this unit did not have high levels of dependency and no one we spoke with on the unit said they had experienced poor care. They said they had enjoyed the Christmas period. However having a period of time with only one staff member on duty on the residential unit was not in line with the services own dependency tool and safe practice.

The nursing unit where people were living with dementia had eight staff on duty on Boxing Day. There were two registered nurses on duty from 8am to 8pm and a third nurse who was still receiving preceptorship during the morning. Preceptorship is period of transition for newly qualified nurses that serves as a bridge during their transition from student to practitioner. Another registered nurse came on duty at 2pm. Staff we spoke with told us they had not encountered staffing problems over the Christmas period. They said they had three nurses on duty on Boxing Day and one had gone down to the nursing unit to "help out" on Boxing Day morning as they were "struggling". They also confirmed that there was no one in overall charge on site to make on the spot decisions about staffing or getting agency staff during the Christmas period. Staff told us they knew there were on call numbers for the senior management but no one on site who could make a decision. This contributed to delays and confusion about making a decision on if addition staff were needed

We looked at the rotas in place for the nursing unit where 28 people were living. We could see from changes to the rotas that staff had been moved around to try to make sure there would be sufficient staff over the Christmas holiday period. We looked at the rotas and referenced them against the 'care blox' to see what staff had been recorded on duty and how long they had worked. A member of the management team went through the rotas and the logging in records with us. We saw that rotas had been altered, not always with the knowledge of management, and some staff had not logged in and this had to be added manually making verification harder. As far as we could tell from the records there were two registered nurses on duty on Boxing Day supported by six care assistants during the morning. Two care assistants had been moved from other units to cover for staff absences. We could see that rotas had been done by management to provide adequate staffing levels prior to the Christmas period. However, due to staff leaving or going sick these had been altered and staff moved around. Management had made the changes as a short term plan to try to maintain adequate levels of staffing. Consequently some staff might have been less familiar with people's needs than if they had been permanently working with the people living there.

On night duty an agency nurse who was scheduled to work a night shift on the nursing unit could not get to the home due to the local flooding. The two registered nurses remained on duty until midnight to provide cover. The agency registered nurse working the night shift on the dementia care unit came down to take charge. On their floor the registered nurse who had been on duty during the day stayed to work the night shift so there was adequate nursing cover. The rotas indicated that there would have been two registered nurses in charge if the rota had been followed and no permanent nursing staff on nights on Boxing Day.

It was evident talking to people living at the home and visiting family members that the staff deployment on the nursing unit had made an impact on their care and enjoyment. It was evident from relatives accounts that they had found difficulty getting in contact with a senior manager on call. Relatives told us there was no one on site with authority to answer their concerns fully and that there was no one who had the delegated responsibility..

The levels of skilled and accountable management required during the holiday period had not been kept under continuous review. It could not be adapted to the changing circumstances and emergency situations within the home when staff concerns were raised and emergency responses were needed. The management team told us they believed that the system for 'on call' management was robust. However, but this did not

reflect the experiences of the relatives we spoke with, who had experienced difficulty in making contact with senior management on Boxing Day, and had not had their concerns resolved at the time.

There were no formal procedures in place to make sure sufficient and suitable people in a management or delegated management capacity were deployed. We found that on 26 December 2015 the registered provider did not take steps to be sure that there were sufficient staff available or in a management position with delegated responsibility to take action to make sure that the service was being run to meet the needs of the service and the people living there and the requirements of the regulations. There was no one in charge of the building with authority to put contingency plans into operation or monitor staff activities or difficulties. This was in breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

At the last comprehensive inspection in September 2015 and October 2015 we found that the registered provider had not made sure that there were assessments of risk factors and reviews of people's care and nursing needs. During this inspection we found that risk assessments had been carried out for people living at the home that better identified and managed risks and that these were being reviewed and updated regularly.

At the inspection in October 2015 we had found that the quality monitoring processes in use had not been effective in relation to maintaining records. This was in respect of the recruitment records, medication records and audits of procedures, monitoring for the correct use of the refrigerator and the processes for ensuring specimens were sent promptly for investigation. The operating systems and processes to make sure the service maintained accurate up to date records and practiced good governance had not been effectively and continuously reviewed.

We found that improvements had been made in making sure recruitment processes were robust. Consideration was also being given to making any reasonable adjustments an employee might require.

At our visit on 11 January 2016 we were accompanied by a pharmacist inspector. We found that the monitoring of medication practices and procedures had been improved. The management team had been carrying out regular medication audits. We found that the home's pharmacy [BOOTS] had provided medication training for staff and had also completed an audit of medication within the home.

However, there was still room for improvement in the consistency of monitoring of medication management and adherence to procedures. We found that signatures were missing from some medication records. Practices around maintaining correct timescales for medication administration, where a dose had been delayed, were not clear to all the staff we spoke with and they did not have procedural guidance to refer to. We found that the fridge temperatures were still not being consistently recorded every day on one of the units. However, this had been highlighted in the homes audit. The home had introduced more medicine audits since the last visit, and a daily walk round by the managers had been started so there was greater oversight on the three units.

We found at our visits in January 2016 that the registered provider had improved the system in place to monitor and report back on quality monitoring issues and assurance. This was being done on a monthly basis. The acting manager carried out audits and the findings of their checks were sent to the provider as part of a larger organisational quality monitoring system and acted upon within the home. There were also frequent visits from regional management.

However, during the course of this inspection we found that operating systems were not being wholly effective in ensuring the safe running of the home, in this case in the event of emergency situations. There were no clear and detailed contingency plans and escalation systems in place for responding to emergencies and untoward events. We found this in relation to the adverse weather conditions experienced

locally on 26 December 2015 that had affected the service. There was no clear contingency plan in place for all staff to be aware of and follow in such emergencies and when staff levels were affected by such events.

We found that the service had an on call system of telephone contact with senior managers but that this had not been found to be effective on 26 December 2015. Three relatives we spoke with said they had tried to use the on call numbers and speak with the first person on call initially but had been unable to speak with them. We were told they had difficulty making contact with other members of management to raise their concerns about events within the home that day but one had eventually done so and relayed their concerns.

We spoke with relatives who had been concerned about the situation on Boxing Day who had tried to contact the manager on call by telephone to seek assurances. They told us that they "Just got an answering machine". One relative said they had gone to a nearby home, run by the same registered provider, to see if there was anyone from management who could "take some charge" at Kendal Care Home but there was no registered manager on duty there either. One relative told us that as they came into the home on Boxing Day they spoke with other relatives who were trying to get hold of a manager and they told them, "it's chaos on nursing".

One person's family told us that there was no one in a home in a management capacity to talk with or in a position to "take charge" when they visited again on 27th December. They told us that they had not been able to get in touch with the on call manager as the mobile telephone number they had for management was not being answered.

There were no accessible procedures in place for staff to refer to regarding the scheme of delegation within the home in the event of an emergency situation. As a result staff did not follow a recognised procedure they knew and understood when they encountered difficulties such as the adverse weather affecting travel. The rotas within the home were not always up to date records of the staffing situation meaning we could not confirm with certainty who was on duty at any one time and in what capacity they were working. A management review meeting was held to assess information from the inspection and as a result the warning notice issued in November 2015 following the inspection in September 2015 and October 2015 will be extended.

The home did not have a registered manager in post which is a condition of the providers registration with CQC. The previous registered manager had resigned in March 2015 and had deregistered with CQC. Another manager had been recruited and took up the post in June 2015 but left the service in September 2015 before completing registration with CQC. The registered provider had recruited another manager who took up their post in November 2015 but who had not registered with CQC at the time of the inspection. The home had not had a registered manager in post since March 2015. This lack of management stability and continuity had significantly impacted upon the service's progress in driving forward planned changes and improvements in the service.

The service was not taking new admissions whilst the quality improvement and safety issues were being addressed.