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Kiln Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We recently received a number of significant concerns telling us people were not cared for appropriately. We responded to these concerns by conducting an unannounced comprehensive inspection. On the first day of our inspection we visited Kiln Lodge at 0530. The inspection was carried out by three inspectors. We were unable to substantiate the concerns raised, however, we found several areas that required improvement

Staff did not always receive effective support, supervision and appraisal.

The provider did not have robust quality assurance systems in place to identify and implement actions needed for improvement.

The culture within the home was not always person centred, appeared to be task focused and at times was institutionalised.

The provider had robust systems in place to recognise report and investigate any possible allegations of abuse.

Staff had received appropriate moving and handling training to enable them to reposition people effectively. Healthcare professionals had no concerns about how people were repositioned.

The provider had appropriate arrangements in place to ensure people were not unlawfully deprived of their liberty.

People were able to get up and go to bed when they chose.

Staff were knowledgeable about people's care needs and delivered care with compassion.

People's privacy and dignity was respected.

People and relatives told us staff were caring.

People received care and support that had been appropriately assessed.

The provider had good arrangements in place to deal with any complaints.

Healthcare professionals, relatives and people told us they were happy with the care provided in the home.

Appropriate equipment and measures were in place for people who required assistance during the night and day.

People were satisfied with the quality of food they received and told us they had choice in what they had to eat.

We found three breaches of the Health and Social Care Act 2008.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service safe.

Relatives and healthcare professionals told us people received safe care.

The provider had robust arrangements in place to respond, investigate and report any allegations of possible abuse.

Accidents and incidents were appropriately investigated and recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive effective support, supervision and appraisal.

The provider had appropriate arrangements in place to ensure people's freedom was not unlawfully restricted without authorisation.

The registered manager worked effectively with other organisations to ensure people's healthcare needs were met.

Is the service caring?

Good

The service was caring.

Staff were knowledgeable about people's care needs and delivered care with compassion.

People's privacy and dignity was respected.

People and relatives told us staff were caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always provided with meaningful activities.

People received care and support that had been appropriately assessed.

The provider had good arrangements in place to deal with any complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have robust quality assurance systems in place to identify and implement actions needed for improvement.

The culture within the home was not always person centred, appeared to be task focused and at times was institutionalised.

People, relatives and healthcare professionals found the registered manager to be approachable and a positive role model.

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

This comprehensive inspection took place on 19 and 20 of September 2017. The inspection was unannounced and started at 0530 on the first day.

Before our inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information sent to us by the general public and the local authority.

During our visit we spoke with the registered manager, the provider, 12 members of staff, four relatives and four healthcare professionals. After our visit we spoke with the local authority and the police.

We pathway tracked five people using the service. This is when we follow a person's experience through the service and get their views on the care they received. This allows us to capture information about a sample of people receiving care or treatment. We looked at staff duty rosters, six staff recruitment files, feedback questionnaires from relatives, complaints, safeguarding incidents, quality assurance records, training records, supervision and appraisal records, daily care notes and checked the provider's policies and procedures. We also looked at the provider's fire evacuation arrangements and health and safety documents. We last inspected the home on 1 November 2016 where no concerns were identified.

Good

Is the service safe?

Our findings

Relatives and healthcare professionals told us people were safe and said the manager had good systems in place to protect people from possible abuse. One person said, "I am safe here, If I felt worried I would tell someone but I am honestly just fine here". A healthcare professional said, "I am genuinely telling you I would be happy to live here".

We were advised staff had been sleeping during their night shift and had been smoking cigarettes in the home. Staff told us they had not smoked in the home and said a designated smoking area was available to them if they needed it. Relatives, healthcare professionals and people told us they had never observed staff smoking in the home. We did not observe any member of staff asleep and could not see or smell any smoke in the home. Records of unannounced checks carried out by the registered manager found no concerns about the quality of care people received.

We were advised staff frequently forced over 20 people to get up out of bed at 0500 and were made to get dressed ready for the day staff coming to work in the home. We visited the home at 0530 to check if this was taking place. Upon entering the home two inspectors immediately walked around the building to check if people were in their bedroom whilst one inspector spoke with the member of staff who answered the door. We found everyone apart from one person to be in their bedroom and uninterrupted. One person was sat in the living room, was dressed and had a drink. They told us they were up and awake due to being an early riser in their previous job. They said, "I am always up nice and early" and "It's usually just me here for a while until they (other people) get up".

We were advised the provider did not have robust procedures in place for identifying, investigating and reporting possible abuse. Records relating to complaints and possible abuse demonstrated concerns were taken seriously, reported to the appropriate governing bodies, such as the Care Quality Commission (CQC), the local authority safeguarding team and the police. All staff we spoke with were knowledgeable about how to report any concerns and said they would not hesitate to notify the CQC or the police if they had suspected any form of abuse. All healthcare professionals told us they had never observed any form of abuse taking place in the home and said they were always satisfied with the care people received. One healthcare professional said, "I'd be very surprised if any abuse took place here". When asked if they had ever been abused or observed any form of abuse one person said, "The staff are good; they don't just wheel you in and leave you. I'd be gone if I thought anyone had hit anyone". A member of staff said, "I've been here 20 years and I've seen nothing of the kind". Another member of staff said, "Once I reported something about a wheelchair, I told the manager and it was sorted. The staff member then had to do some shadowing" and "I'd be happy to live here, I do nights and I've never seen anything bad happen". All staff members told us they had never observed any form of abuse taking place at any time. Accidents and incidents were appropriately investigated, recorded and reported to the relevant organisations.

We were advised sensory mats were turned off during the night. We checked this during our inspection and did not find it to be the case. All staff we spoke with told us they had never observed any other staff member switch a sensory mat off. Electronic records sent to us from the provider supported staff feedback. Relatives

told us this was not a concern. On relative said, "She (person) can't even use it but staff always put the call bell button beside her just in case, I have no reason to think they (staff) would ever turn any buzzers off".

Requires Improvement

Is the service effective?

Our findings

Staff told us they felt supported by their manager. Comments from staff included, "I love working here, and I have been here a long time. We don't have many supervisions or team meetings but I can knock on the door and get help if I need it". Another member of staff said, "I don't really have a training plan as such but I've done some stuff on the computer in the past".

Staff did not always receive effective support, supervision and appraisal. The provider was honest and open about areas that needed improvement and said, "If staff had had more supervisions we would probably have resolved some of these issues before it got to this". Records for one member of staff identified they had received four supervisions sessions from 22 September 2010 to 12 September 2017. The supervision records for another member of staff showed they had received six supervisions from 22 September 2013 to 1 April 2017. Supervision records for a third member of staff showed they had not received supervision between 16 September 2013 and 11 July 2017. The records we viewed did not contain robust detail about staff learning and development needs and we could not see they had received frequent competency checks with regards to their performance and ability to carry out their role. Documents for one member of staff showed they had not received training in fire safety, safeguarding, health and safety or the Mental Capacity Act 2005. Whilst staff told us they felt they could obtain support from their line manager at any point, they told us more regular supervision would help their development and understanding in areas of dementia, moving and handling and end of life care. One member of staff said, "We have a really lovely manager but it's been pretty tough the last while and I think some areas have slipped a bit, including the supervisions and team meetings".

The failure to ensure staff received on-going support and training to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008.

We were advised people were not provided with meals they had chosen. All of the people we spoke with told us the food in the home was of good quality and well balanced. One person said, "If I don't like something I can just tell them and they make me something different". A relative said, "Mum has really not been well and the kitchen staff have had to mix things up a bit, they have been great" During lunch we observed people enjoying their meals. We checked records associated with people's meal preferences and found people were not given food they disliked.

We were advised people were inappropriately restrained. We were told staff placed chairs around people's beds to restrict their movement. When we checked people's bedrooms we did not find any chairs placed beside people's beds to restrict their movement. We found no evidence to suggest people were being unlawfully restricted without authorisation from the local authority. The registered manager was able to show us documentation which showed people who were unable to consent to particular aspects of their care or accessing the community had been referred to the local authority for assessment.

We were advised staff had not received adequate training in relation to moving and repositioning people. Training records showed staff had received support and training in how to look after people who had limited

mobility and frail skin. The equipment used to support people with their mobility was regularly checked to ensure it was fit for purpose and safe to use. During our visit we observed safe moving and handling practices. Records showed any unexplained bruising or skin damage had been investigated and where required referred to the relevant external organisations. A healthcare professional said, "This is one of the better homes, I have total confidence in the staff here and we have never had any worries when we have checked people over".

People's healthcare needs were met. A healthcare professional said, "I am in here a lot, I know the girls (staff) look after everyone really well and the manager takes on board everything we ask including repositioning, nutrition and the fluids" and "The manager is forward thinking, we are happy as a team, she (Registered Manager) gets the meds in place, the syringe drivers sorted and the training. (The Registered Manger) talks to us about people's skin tears and we work together really well". During our inspection we heard two healthcare professionals having a handover meeting about one person's care. We spoke with the person's relative who said, "I can't fault them one bit, I am so lucky to have mum here, the staff and the manager are amazing" and "(Person) was ill at the weekend and everything is in place already, it's just brilliant".

Good

Is the service caring?

Our findings

People, relatives and healthcare professionals told us staff were caring and said they were compassionate when delivering care. One person said, "They do a lovely job and they work so hard, I am happy as I can be" A relative said, "This place is just perfect for us as a family, we visit a lot and we are so happy with the care. All they staff are lovely; they smile, laugh and sing with the residents".

People were treated with dignity during personal care. One relative said, "I have seen them come in and help (Person) with personal care. They are really enthusiastic when they need to be and calm when they need to be". Staff gave us lots of different examples of how they respected people's dignity during personal care. One staff member said, "I treat people they way I would treat my mum, I try to smile, be happy and I use blankets to cover people up" Another member of staff said, "I always ask permission first before I do anything, I talk to the person whilst I am doing it so they know what's going on otherwise it could be a bit scary for them".

Our observations during the inspection were that staff were respectful when talking with people. Staff referred to people using their preferred names. Staff knocked on people's doors and waited before entering. This meant staff respected people's privacy and dignity. Each staff member we spoke with appeared very caring and they were knowledgeable about people's personal circumstances, health needs and histories. They were able to tell us about jobs people previously had, relationships they had been in and holidays they had with their families.

People received medical treatment in response to accidents and investigations were conducted in accordance with the providers safeguarding procedures. For example, a recent incident record showed how staff responded effectively after one person had a fall. Their care plans and risk assessments had been reviewed and updated to reflect their change in care needs. Relatives told us the staff were responsive to incidents, one relative said: "I visit the home a lot and I see how the staff treat people, they are so patient when it comes to bringing people in the lounge and the dining room". A healthcare professional said, "I have worked with the home around their moving and handling assessments and I have no issues in how they are meeting people's personal care needs. The contact us if treatment is needed so I am happy with that".

Requires Improvement

Is the service responsive?

Our findings

Healthcare professionals and relatives told us people's needs were met. One healthcare professional said, "I have no worries about how people are treated here and I am confident people's needs are met. Anything to do with nursing needs we work great together and I am always happy leaving here knowing people are ok". A relative said, "Mum had a fall once and they told me about it and they dealt with it well".

The culture within the home was not always person centred, appeared to be task focused and at times was institutionalised. We observed a member of staff giving out drinks who had a list they were following and said, "Here's your coffee" and then walked away. We saw the same member of staff place a cup of tea in front of another person who was asleep and shouted, "(Person) your tea is there". We found activities to be chaotic and not fit for people who were living with dementia. For example, from 10.24 am to 10.54 am we observed staff attempting to carry out a memory game. During this period of time the subject matter changed 15 times. This included, encouraging people to state different occupations, members of the Royal Family , animals, drinks, words beginning with the letter F and the letter R. Due to the layout of the lounge and people being sat in a large circle staff regularly had their backs towards people when running the memory session. Some people were unable to take part due to their health or because they were asleep in their chair. The television was on but nobody appeared to be interested in watching it.

The failure to create a consistent person centred culture in the home was a breach of Regulation 9 of the Health and Social Care Act 2008.

The registered manager and the provider had responded appropriately to complaints. Documentation showed issues raised by staff; relatives and people were investigated and referred to the relevant external organisations when needed. One relative said, "I have never had to complain but I know if I did it would be dealt with properly". People told us they were happy with the care they received.

Staff completed daily records which were used to record what each person had been doing and any observations regarding their physical or emotional wellbeing. These were completed regularly and staff told us they were a good tool for quickly recording information which gave an overview of the day's events for staff coming on duty. Care files identified people's likes/dislikes and interests which the home then attempted to accommodate. Staff accurately described the care and support people required.

Prior to moving into Kiln Lodge people were appropriately assessed with the support of healthcare professionals and relatives. Each person's needs were identified and a plan was put in place to guide staff in how best to meet their needs. A member of staff said, "I know our paperwork needs to be a bit better but we all know what people need because we are always talking to each other and we have a lot of chats with the relatives too".

People who required support to physically move around Kiln lodge were supported in line with guidance detailed in their moving and handling assessment. For example, we observed two members of staff supporting one person from their bedroom into their chair in the living room. The members of staff spoke

with the person the whole time and explained what they were doing and gave encouragement.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and healthcare professionals consistently provided positive feedback about the registered manager and told us the leadership in the home was strong. One relative said, "The manager is amazing, she is so so caring. I have seen her get upset when people have been unwell and to me that tells you how much she cares". A healthcare professional said, "The registered manager is really caring and she really wants the best for everyone, she is knowledgeable about people and she knows exactly what they need. We have managed to get everything sorted for (Person) within a couple of days and it's spot on".

The provider did not have robust quality assurance systems in place to identify and implement actions needed for improvement. For example, in one person's documentation we found reasons for the administration of paracetamol were not recorded on four occasions between 10 August 2017 and the 19 August 2017. A medication administration record for another person explained Lactulose and Memantine had been stopped, however the person's care plan had not been updated to reflect this change. (Memantine) is a drug used to treat moderate and severe Alzheimer's disease). In another person's file, we found a capacity assessment had not been fully completed to assess the risks and legality of implementing bed rails. We also found a care plan provided a lack of nutritional detail for someone who had been diagnosed with diabetes. On another occasion we found care plans did not accurately reflect people's preferences. For example, one person's care record stated, "(Person) goes to bed at 9pm and gets up at 7.30 am" However, the record also detailed how the person "tends to start getting up at 4.30". After we fed this information back to the registered manager it was clear people did not come to any harm or receive unlawful or inappropriate care. The registered manager told us the last two months had been a "very difficult period" and said the "paperwork had slipped" because people's care was the priority. The registered manager and the provider were very open about the challenges they had faced and told us they were determined to resolve the concerns we identified during our inspection. They were proactive in providing us with additional information and supporting evidence which showed they had responded positively to our feedback.

The registered manager acknowledged the content and accuracy within records needed to improve. They told us people's care plans were being transferred to an electronic system and said, "I totally accept we are behind on paperwork". At the time of our inspection the provider and registered manager could not demonstrate how they robustly assessed and accurately recorded the quality of care people received. The provider did however share a file with us which showed a large number of compliments they had received from relatives and professionals. Comments included, "Thank you for the care and your kindness looking after our beautiful mother" and "Words are not enough to thank you all for the care and dedication you gave mum". After the inspection visit the provider sent us a number of documents which showed us how they monitored the service and the actions they had taken since our feedback.

The failure to implement robust quality assurance systems was a breach of Regulation 17 of the Health and Social Care Act 2008.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did consistently apply a person centred approach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality assurance systems in place to recognise and drive improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have robust arrangements in place for the supervision, learning and the development of staff.