Stonehaven (Healthcare) Ltd

Kent House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 29 June and 11 July 2017 and was unannounced on the first day.

The home provides accommodation and personal care for up to 27 older adults. At the time of our inspection 25 people were living at Kent House. Some of these people were living with dementia or had a physical impairment.

The home is situated close to Dartmoor in a quiet cul-de-sac near Okehampton town centre. Bedrooms are located over three storeys including the ground floor. The first and second floors are accessed via a lift and stair lifts. There is a communal lounge, conservatory and dining room all located on the ground floor.

The home had a registered manager. 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.
The service was previously inspected in April 2015 when the service was rated as Good overall. However the effectiveness of the service was rated as requiring improvement. This was because the home environment did not always promote independence for people living with dementia. At this inspection, we found improvements had been made to support people with dementia.

People and their relatives were very positive about the home and said they felt safe at Kent house. They said the care provided by staff and the registered manager was good. Comments included "It's lovely."; "They look after me well." and "I am very happy and want to come in myself when the time comes." Throughout the inspection, we observed staff interacting with people in positive and caring ways. People appeared very relaxed and happy, laughing and joking with staff.

The registered manager had been in post for a number of years and led by example. They spent time working alongside staff. People and staff were involved by the registered manager in improving the service. Resident meetings, staff meetings and surveys were undertaken and provided people and staff a means to make suggestions. There was a complaints procedure and people said they knew how to complain. Complaints were managed in line with the provider's complaints policy.

There were sufficient staff to support people safely, although at times staff were not present in communal areas for extended periods of time. Staff worked with people in a calm and unrushed manner and knew people well. People were supported to do a range of activities both inside and outside the home, which they said they chose to do and enjoyed. Staff understood people's individual communication skills, abilities and preferences and ensured they took these into account when providing care.

People's health was monitored and, where necessary, staff ensured that health professionals were

contacted for advice and support. People were supported to attend appointments with the GP, their dentist and other health professionals.

People were provided with a healthy balanced diet with food of their choice. People said they enjoyed the food and could have alternatives if they did not like the meal on offer. Specialist diets, including pureed food, coeliac and diabetic diets, were catered for. Where people required support with eating and drinking, staff made sure that people were encouraged and helped to eat and drink. Comments about the food included "home cooked, good food." and "Very nice."

Staff were recruited safely as checks were carried out before they started working at the home. Staff completed an induction to ensure they were competent to work with people. Staff also received refresher training and were supported to undertake nationally recognised qualifications in care. Staff administered stored and managed people's medicines safely. Staff had regular meetings with their supervisor.

Staff were aware of how to protect people from the risk of abuse and knew how to report concerns to the relevant authorities. The registered manager understood their responsibilities to ensure vulnerable adults were protected. The registered manager and staff worked within the requirements of the Mental Capacity Act 2005. This included applying for Deprivation of Liberty Safeguard authorisations when necessary.

There were quality assurance and governance systems in place to monitor the quality and safety of the home. Checks and audits were carried out by the registered manager and staff from the provider organisation who visited the home every two months. However these checks had not identified some issues, for example some care records did have information to support staff with how to manage particular risks.

The home was well maintained, clean and had comfortable communal areas. People were encouraged to personalise their rooms with furniture, ornaments and pictures of their choice. Relatives and friends were welcomed to the home and could visit when they wanted. Checks were carried out to ensure that the home and the equipment used were safe. Contingency plans for staff to follow in the event of a catastrophic event, such as fire or flood affecting the home were not in place, however the registered manager arranged for these to be drawn up after the inspection.

Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work at the home.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not completely safe.

There were sufficient numbers of suitable staff to ensure people were kept safe and had their needs met. However staffing levels at hand over times were not always deployed to meet people's needs.

People were protected from the risks of abuse by staff who understood their responsibilities.

Medicines were stored, recorded and administered safely. However the home was not fully complying with all the national guidance on medicine administration.

Emergency plans had not been drawn up to ensure staff knew what to do in the event of a catastrophic event. After the inspection, plans were put in place.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the necessary skills and knowledge.

Staff were provided an induction when they first joined and refresher training as required.

People were supported to maintain a healthy, balanced diet, with food of their choice. Specific dietary requirements were catered for.

Staff understood their responsibilities in terms of legislation. Where people's liberty was restricted, staff had ensured they worked within the Mental Capacity Act 2005.

People were supported to access health services.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate.

Staff knew people well and showed concern for their well-being

People were involved in making decisions about their care.

People were treated with dignity and respect.

People's families were able to visit when they wanted.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People received care that met their needs, preferences and aspirations.

People were supported to do activities of their choice.

Care records did not fully reflect people's risks, needs and preferences. Guidance for staff to support people with particular risks had not been developed.

Care records were updated when there were changes to people needs.

The service routinely listened to people. There was a complaints policy and procedure. People said they knew how to complain. There was evidence to show that complaints had been dealt with in a timely way.

Is the service well-led?

Requires Improvement

The service was mostly well–led.

Checks and audits to ensure the quality of the service were undertaken and actions were completed to make improvements where issues were identified. However care record audits had not identified that appropriate information was in place to support some people's needs.

The home promoted a positive culture and involved people, their relatives and staff in developing the service.

Staff and people knew the registered manager and said they felt they were supported by them.

Kent House

Detailed findings

Background to this inspection

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

This inspection took place on 29 June and 11 July 2017 and was unannounced on the first day.
The inspection was carried out by one Adult Social Care inspector.

Prior to the inspection we reviewed information we held on our systems. This included reviewing whether any statutory notifications had been submitted to us. A notification is information about important events which the service is required to tell us about by law. We had asked the provider to complete 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. The provider had completed this in March 2017.

At the time of this inspection, 25 people were living at Kent House. We met most people living in the home and spoke with eight of them about their experiences. However, some other people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also met and spoke with four relatives during the inspection.

We spoke with seven staff working at the home on the days of inspection, as well as the registered manager. We also spoke with two volunteers who regularly visit the home.

We looked at a sample of records relating to the running of the home and to the care of people. This included seven people's care records, including risk assessments, care plans and four medicine administration records. We reviewed two staff records. We were shown policies and procedures and quality monitoring audits which related to the running of the service.

During the inspection we met one social care professional. After the inspection we contacted GPs and

district nurses at a local GP surgery and the staff in a community mental health team, who have worked with people living in the home. We received one response.

Requires Improvement

Is the service safe?

Our findings

People were administered their medicines safely; however some aspects of medicine administration did not follow national guidance. This included completing annual checks to ensure staff were competent to administer medicines. Records showed that staff who were responsible for medicine administration undertook training before they started to do this task and refreshed the training every three years. The registered manager said they did annual observations of staff administering medicines but these were not formally recorded. They also said they checked that medicine administration record sheets (MARS) were completed correctly. They said from now on they would ensure they kept a record of checks they had undertaken.

Some people required medicines where the dosage varied from week to week based upon a blood test. A senior care worker described how staff at the home were told on the phone what dosage they should administer each day of the following week. We discussed how this could mean there was a risk to people as the dosage could be incorrectly transcribed. The senior care worker said they would talk to the staff at the GP surgery to ensure they received written confirmation of the dosage. By the second day of inspection this had been put in place as the surgery had agreed to send an email with the dosage for the week ahead, which was then placed on the person's file.

Medicines were stored safely and securely in a large locked cupboard. Where medicines required refrigeration, these were kept in a dedicated refrigerator inside the locked cupboard. Checks on temperature of the room and the refrigerator had been recorded each day to ensure they were within the recommended limits. However during a recent heatwave, there had been one day when the temperature of the room had been higher than the recommended limit. No action had been taken when this had happened, for example contacting the pharmacist for guidance on whether there was any impact on the medicines stored. The refrigerator temperature had remained within the recommended limits throughout the heatwave.

Medicine administration rounds were completed by a designated staff member trained to administer medicines. They administered medicines from a lockable trolley which they kept secure when supporting each person.

Staff took time to ensure people were given the correct medicine. Some people were prescribed medicines to be taken 'when needed' (often referred to as PRN). Staff checked with the person whether they wished to have the medicine and only administered them where the person said they did. A health professional commented that "PRN [drug name] when prescribed are used very judiciously."

Staff recorded the medicines that had been administered accurately on a MARS. Where a person refused a medicine this was recorded on the MARS. Staff understood the importance of helping people to take their medicines at a time which suited them. For example, where one person refused their medicine, staff offered to return at a later time. When the staff returned and offered the medicine again, the person then accepted it.

Medicines were audited regularly and action taken to follow up any discrepancies or gaps in documentation. Stock levels tallied with written records.

We checked the stock of medicines requiring additional security and found records and quantities tallied exactly; demonstrating good controls were in place. Homely remedies, such as mild pain relief, were stored safely and records kept of their use. Where people were given medicines covertly, records showed that this had been discussed as part of a best interest assessment with the person's GP, who had confirmed this in writing. These were reviewed by the GP each year.

There were enough staff on duty to meet people's needs. However there were times when staff were not deployed in such a way to ensure people received the care they needed. For example during staff hand-over, we observed there were no staff in the lounge for over 40 minutes. Although there was a call bell in the lounge, most people in this room would not have been able to use it. During our observation we noted one person in need of support with no means of being able to let staff know. We discussed this with the registered manager, who said that a member of staff was on duty but may have been supporting someone in their room. The registered manager said they would review staff rotas to ensure that there was sufficient staff at these times to meet people's needs. After the inspection, the registered manager informed us that they had altered the working arrangements so there were always staff available in communal areas at shift hand-over times.

Emergency plans were not in place to ensure that staff knew what actions to take if there was a catastrophic event, such as fire or flood affecting the home. Individual personal evacuation plans had been written so staff knew what they needed to do to support people in the event of a fire. There were no plans of what would happen if the home became uninhabitable for an extended period. However, between the first day and second day of inspection, the home had experienced a prolonged period without electricity. The registered manager and staff had taken appropriate actions to ensure people were kept safe. For example they had recognised that the power outage meant that air mattresses would not be functioning and had changed these mattresses. They had also taken action to ensure people were supported safely until the electricity was restored, which was within a few hours.

After the inspection, the registered manager said they put in place emergency plans for catastrophic events including an arrangement for a place of safety for people to go to in the event of a fire or flood. They had also agreed contingency plans in the event of another electrical failure.

People said they felt safe living at the home. People appeared relaxed and content. Comments included, "it's lovely" and "We are looked after well." Another person gave the thumbs up sign when asked if they liked the home and felt safe. Relatives commented that the home was "very good" and "I am very happy and want to come in myself when the time comes."

Risks to people had been assessed and plans put in place to manage these risks. For example, people's falls risk had been assessed. Other risks including risks to skin integrity and the risks of choking had also been assessed. Where people were at risk, plans had been put in place to reduce the risks. However some risks associated with long term conditions such as epilepsy and diabetes had not been fully assessed. There was insufficient information to ensure that staff knew what they should do in particular circumstances relating to these conditions.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff had completed safeguarding adult training and had refreshed the training when required.

Where safeguarding concerns had been identified, the staff and the registered manager had taken action to ensure that the appropriate authorities were informed. The registered manager had worked with the local authority to ensure that people were protected from the risk of abuse.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends.

The home was well maintained and kept clean to ensure people were protected against the risks of infection. There were supplies of gloves and aprons available for staff and staff were observed using them appropriately. Risk assessments of the environment were undertaken and measures put in place to reduce risks to people. For example, extra precautions had been put in place to keep people safe whilst scaffolding had been erected to enable repairs to the home.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, records of interview and appropriate references. Checks had been made with the Disclosure and Barring Service (DBS) to make sure people were suitable to work with vulnerable adults. The DBS is a criminal records check which helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Good

Is the service effective?

Our findings

Staff said they had the training and skills they needed to meet people's needs. Comments included: "[The registered manager] makes sure we are up to date with training" and "we have to stay on top of our training". Training records confirmed that this was the case.

New staff were supported to complete an induction programme before working on their own. They said that this included shadowing other staff, completing an induction handbook and receiving supervision with the registered manager to check on their progress.

The induction was aligned to the nationally recognised Care Certificate. The Care Certificate was developed by Skills for Care. It is a set of 15 standards that all new staff in care settings are expected to complete during their induction.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Records showed that supervisions were carried out regularly and enabled staff to discuss any training needs or concerns they had. One member of staff said, "[The registered manager] supervises us every month". Staff described how they were supported by the registered manager and other members of the team. One staff member said, "It's really good, we have a good team".

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were respectful of people and ensured they gained the person's consent before undertaking support and care. For example staff knocked on bedroom doors and waited for permission before entering the room. Where one person did not want care given at a particular time, staff said they would come back later to see if they had changed their mind.

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met

At this inspection, we found staff had an understanding of the MCA. People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005.

The registered manager ensured where someone lacked capacity to make a specific decision, a mental

capacity assessment was carried out. Best interest meetings had been held to discuss how to support one person who wanted to spend some time in their own home. Relatives, health and social care professionals, care staff as well as the person had been involved to support the decision making. Minutes of the meetings and the decisions made were held in the person's care record. Staff were able to describe what these were and how they affected the person's care.

The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. Where DoLS had been authorised, the registered manager ensured that they submitted applications for renewal at the appropriate time. A visiting professional commented "They support people to remain as independent as possible."

Staff supported people who could become anxious and exhibit behaviours which may challenge others. For example, where one person became agitated, staff supported them by talking in a friendly and quiet manner to them. They were able to distract the person so that they became calmer and happier.

People's dietary needs and preferences were documented and known by the kitchen staff and care staff. Staff were all aware of people's dietary needs and preferences. People's needs and preferences were also clearly recorded in their care plans. One person was a coeliac and could therefore not tolerate gluten or wheat. Kitchen staff ensured that all the meals prepared were suitable for them to eat. Where some cakes for afternoon tea contained gluten, these were clearly labelled and gluten free cakes were also provided.

People were involved in selecting menus which they liked. Where people did not like a dish, they were offered alternatives that might suit them instead. Fresh flowers were on every table and drinks including a choice of water or squash were offered. Comments included that the food was "really nice" and "home cooked, good food." A relative commented ""Good food, and if it's something [person] doesn't like, they always offer something else."

People were supported to have a meal of their choice by organised and attentive staff. Where people needed support to eat their meals, staff sat with them and helped them. We observed staff supporting one person with their lunch. Throughout the meal, the member of staff focussed on the person and encouraged them to eat their meal. The member of staff took their time and ensured that the person had the opportunity to eat at their own preferred speed. People said they enjoyed the meals and our observations confirmed that this was the case. A relative said "They give their time, they won't just leave food in front of mum, they always encourage and help her if she's having a bad day."

Volunteers and relatives were invited to eat lunch with people, as the staff recognised the importance of mealtimes as social occasions. Throughout the lunchtime, we observed people chatting sociably and enjoying their food.

People were referred appropriately to the dietician and speech and language therapists if there were concerns about a person's weight or ability to swallow. Where necessary, guidance provided by these health professionals was recorded and followed to reduce the risks.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and were supported to attend appointments when required.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Some adaptations to the environment of the home had been made to meet the needs of people who lived there. Corridor areas were kept clear so people could move around the home more easily. A lift and stair lifts had been fitted which enable people with limited mobility to go up and downstairs easily. The home was light and well-maintained. There were spaces for people to use, both indoor and outdoor. Improvements had been made to the home to make it more dementia friendly. For example bathroom and toilet doors were painted a different colour to help differentiate them from bedroom doors. Hand rails had been repainted so that they were more clearly visible.

Good

Is the service caring?

Our findings

People said they were happy with the care they received. Comments included "They are very kind" and "They look after me well." Relatives commented "[The registered manager] really cares and that shows with all the staff."

Staff knew people well and spoke knowledgeably about them. Staff engaged with people in conversations about their day and what they preferred to do. For example, staff discussed what activities people wanted to do, such as joining in an art class in the home, attending a coffee morning run locally or going out for a walk.

People were treated with kindness and compassion in their day-to-day care. For example staff were supportive of one person who decided at the last minute they wanted to go to the coffee morning. Staff ensured the person was wearing the right clothing and footwear as the weather was inclement. Staff then went to the person's room to collect specific items they wanted to take with them.

People were encouraged to raise concerns they might have. For example, the registered manager described how one person had believed that their room would be given away. The registered manager had spent time with the person, making sure that they were reassured and that they would not be moved unless they wanted to be. The person had been offered, when they first came to the home, a key to their room in case they wished to lock it. Although the person had chosen not to have a key at that point, because of their anxiety, the registered manager had offered a key again. The person said they would consider this.

People's bedrooms were personalised and people had their own belongings and furniture with them if they chose to.

The home was spacious and allowed people to spend time on their own if they wished Some people chose to remain in their rooms while others chose to go communal areas including the lounge, a conservatory and the dining room. There was an attractive garden which staff said people used during clement weather.

People's relatives and friends were welcomed to the home and encouraged to visit at times that suited them. Relatives said staff were always polite and chatted to them when they came. During the inspection, we observed relatives and friends having refreshments and meals with people.

The relationships between staff and people receiving support demonstrated dignity and respect at all times. Staff knocked on people's doors and waited for permission before entering. Staff were discreet when talking to people about personal care, such as whether they wished to go to the toilet.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. Some people did not have verbal communication skills, so staff communicated with them in other ways. For example one person wrote down a question and staff responded by writing down an answer as well as

talking to them.

People's views were sought through care reviews and annual surveys. Paper copies of care plans were signed by the person or, where appropriate, their relative to show they consented to the care.

Requires Improvement

Is the service responsive?

Our findings

Care, treatment and support plans were personalised. However there were examples where these did not fully address how to support people's risks and needs. Although risk assessments of people had been undertaken, there were not always plans in place to ensure people were kept safe. For example, one person had diabetes which meant they were at risk if their blood sugars got too high or too low. The care record did not contain information about what the safe upper and lower limits for the person's blood sugars should be. Although there was some information about what staff should do if the person had a low blood sugar reading. There was no protocol about what actions staff should take if the person's blood sugars were above safe levels. Another care record had information about a person having epilepsy. There was no protocol advising staff on what they should do if the person had a seizure.

Another person had a long term condition which meant they were at risk at particular times. However there was no risk assessment in relation to this this condition and no guidance for staff on how the person might present at these times or what actions they should take at these times. This meant that staff might not take appropriate actions to reduce the risk to the person.

After the inspection, the registered manager confirmed that they had contacted health professionals and had taken action to ensure that staff had protocols to follow to support these people.

People or their relatives were involved in developing their care, support and treatment plans. A relative described how they had been involved in developing the care plan for their family member. Care plans were personalised and detailed daily routines likes and dislikes specific to each person.

People's needs were reviewed regularly and as required. Where necessary, health and social care professionals were involved. For example, records showed where one person had lost weight, a dietician had been contacted for advice and guidance.

Where people required support with their personal care they were able to make choices and be as independent as possible. One person said they had always enjoyed doing housework and staff encouraged them to help around the home. During the inspection, one person helped to hand out refreshments to others, which they clearly enjoyed doing.

Staff knew people's history and background and were able to describe the activities they enjoyed. Several people chose to attend a weekly coffee morning. Over lunch, they described how much they enjoyed these events as it provided an opportunity to go out and meet other people. One person described how much they had enjoyed a recent music session which had taken place in the home. We also observed an art and craft session being run, which people enthusiastically joined in.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. However, there were no notes of the hand over. This meant staff finishing shift were reliant on memory to ensure they handed over

important issues about people. Similarly staff starting a shift had to rely on memory to know what had occurred to people on previous shifts. The registered manager said that staff usually did make notes and she would raise this with senior staff to ensure that hand-over meetings were documented at the end of each shift.

A staff member was responsible for coordinating activities in and outside the home which people wanted to do. These activities included attending coffee mornings at a local centre, doing arts and crafts in the home, beauty therapy sessions, armchair games, bingo, going on trips to local places of interest, singing groups, music sessions as well as a discussion group. People who were not able to leave their rooms were also supported by staff with activities, including having one to one sessions.

There was a complaints process and people said they knew how to complain. Complaints were managed in line with the provider's complaints policy. Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been one complaint in the last 12 months and this had been investigated thoroughly and resolved.

Requires Improvement

Is the service well-led?

Our findings

There was a governance system which monitored the quality of service being delivered and the running of the home However these quality assurance systems were not fully effective as checks and audits had not identified the concerns found during the inspection..

Some medicine administration audits were not recorded, for example there were no records of the annual observation of staff administering medicines Audits of care records had not identified that protocols to support people with long term conditions were not adequate to ensure their safety. The lack of staff in communal areas during hand over periods had also not been identified.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Other quality assurance checks were undertaken by designated staff and included audits on the home, fixtures and fittings and the equipment used. For example regular checks were undertaken of water temperature and quality, building maintenance and fire systems. A weekly audit report which included the maintenance of the home was completed by the registered manager and sent to the provider's head office.

Records showed that residents meetings were held, for example the last meeting had been held in April 2017. However, the minutes did not record whether actions identified in the previous meeting had been addressed.

A senior manager visited the home on a bi-monthly basis and completed an audit which included a review of care records, both on the online system and in paper records in the home. The audit also looked at staff training, staff behaviour, the home's presentation and views of people living at Kent House. These audits had identified some areas where improvement was required.

The provider had implemented a 'secret shopper' system to monitor the quality of the home. This involved a visitor calling at the home unannounced acting as someone who was interested in finding a home for a relative. They provided a written report which described what they had thought of the experience, including positives and negatives. The registered manager and senior staff in the provider organisation received a copy of this report and produced an improvement plan on areas where issues were identified.

The registered manager had been in post for a number of years and understood their role. This included ensuring that the quality and safety of the home was managed as well as notifying the CQC about significant events. Where issues had arisen, the registered manager had responded appropriately to requests for information.

The registered manager regularly worked alongside staff which gave them an insight into the values and behaviours towards people. Staff meetings were regularly held; minutes of these showed that not only was information communicated to staff, but also staff were able to make suggestions of how the service could

be improved. Staff received regular supervision and were also supported by the registered manager and other senior staff to improve the care given.

People and staff had confidence that the registered manager would listen to their concerns and these would be received openly and dealt with appropriately. Comments from people and their relatives included "Excellent manager."; "The manager employs an open door policy, so we talk about any concerns and she deals with them quickly." A member of staff said the registered manager was "really supportive" while another commented that the registered manager "was very understanding and really cares."

The service has a positive culture that was person-centred, open, inclusive and empowering. People and their relatives were encouraged to get involved in providing feedback and ideas of how they found the care at Kent House. For example, the home had received 14 comments on the Carehomes.co.uk website in the last 12 months, all of which rated the home as either good or excellent overall. Where there were comments which reflected that people were less than satisfied about a particular aspect, the registered manager or a director of the provider organisation had responded with actions they would take to address the issue.

The registered manager had made links with the local community including local organisations such as a charity, a college and local church. The home held a weekly coffee morning which was open to visitors. People had been supported to maintain links with the local community through attending a local coffee morning run by an outside organisation.

People benefited from staff who understood and were confident about using the whistleblowing procedure.

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 17 HSCA RA Regulations 2014 Good governance Some audits and checks had not identified issues that were picked up during the inspection.