

# Shaw Healthcare (Group) Limited

## Kent Lodge

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service caring?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

The inspection took place on 3 April 2018 and was unannounced.

The last inspection of the service took place on 13 April 2017 when we rated the service Good in all key questions and overall.

At this inspection we have rated the service Requires Improvement in all the key questions of Safe, Effective, Caring, Responsive and Well-led. The overall rating for the service is Requires Improvement.

Kent Lodge is a 'care home' without nursing. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide care for up to 38 older people in a single building. Accommodation is provided on two floors.

The service is provided by Shaw Healthcare, a national organisation providing health and social care. At the time of our inspection there were 31 people living at the service.

The registered manager had left the service since the last inspection although they were managing a similar service within the company and were still involved in managing Kent Lodge. An interim manager had also recently left. The provider's representatives told us that they had recruited a manager who was due to start work at the service the day after the inspection and this person would apply to be registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

Staff did not always follow the procedures to manage medicines which meant that people were at risk of not receiving their medicines safely.

People were not always protected by the provider's arrangements in relation to the prevention and control of infection. Some areas of the home had a malodour and we found some health and safety issues.

On the day of our inspection, we saw that people's needs were not always met in a timely manner and people's concerns about their welfare were not always taken seriously.

People had access to healthcare professionals and the outcomes of their visits were recorded in people's care plans, however, care plans did not always include guidelines where people had specific healthcare needs.

Some staff practices were not always person-centred and did not take into account people's choices.

The provider had a number of systems in place to monitor the quality of the service and put action plans in place where concerns were identified. However, these had failed to identify the issues we found at this inspection.

The provider was not always acting in accordance with the Mental Capacity Act 2005 (MCA). There was no evidence that any attempts had been made to appropriately assess a person's mental capacity in line with the MCA principles.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe care and treatment, Person-centred care, Dignity and respect, Need for consent and Good governance. You can see what action we told the provider to take at the back of the full version of the report.

The provider had not employed a full time or permanent manager for the service. The registered manager had moved to another service but was still involved in managing Kent Lodge and was therefore working part time at both services. This meant that improvements to the service were not as fast or embedded as they could be.

Most staff had received training in end of life care and some people had advanced care plans. However, the provider acknowledged that this area needed to be developed further to ensure they could meet people's needs when they reached the end of their lives.

Processes had been followed to ensure that, when necessary, people were deprived of their liberty lawfully.

The provider had processes for the recording and investigation of incidents and accidents. These were investigated and where necessary measures put in place to prevent reoccurrence.

Care plans and risk assessments were reviewed and updated whenever people's needs changed. People and relatives told us they were involved in the planning and reviewing of their care and support.

Recruitment checks were carried out before staff started working for the service and s included checks to ensure staff had the relevant previous experience and qualifications.

The provider had taken steps to develop the design and decoration of the premises to meet the needs of people who used the service, in particular people living with the experience of dementia.

People's health and nutritional needs had been assessed, recorded and were being monitored.

People were supported by staff who were sufficiently trained, supervised and appraised. The service liaised with other services to share ideas and good practice.

People's care plans were comprehensive and detailed how their individual needs were to be met. They were personalised to reflect people's wishes and what was important to them.

A range of activities were arranged that met people's individual interests and people were consulted about what they wanted to do.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Staff did not always follow the procedure for the management of medicines. This meant that people were at risk of not receiving their medicines safely.

People were not always protected by the provider's arrangements in relation to the prevention and control of infection. We identified a number of health and safety concerns.

People's needs were not always met in a timely manner and people's concerns about their welfare were not always taken seriously.

Incidents and accidents were recorded and appropriate action was taken to reduce the risk of reoccurrence.

Recruitment checks were undertaken before staff started working at the service.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

People's healthcare needs were not always met in a timely manner.

Mental capacity assessments did not always take into account people's individual needs.

People's individual needs had been assessed and recorded in their care plans prior to receiving a service, and these were regularly reviewed.

People were supported by staff who were well trained, supervised and appraised.

**Requires Improvement** ●

### Is the service caring?

The service was not always caring.

**Requires Improvement** ●

Some staff practices were not always person-centred and did not take into account people's choices.

Feedback from people and relatives was positive about both the staff and the management team.

People and relatives said the care workers were kind, caring and respectful.

### **Is the service responsive?**

The service was not always responsive.

People's requests for care and support were not always addressed appropriately.

Most staff had received training in end of life care and some people had advanced care plans. However, the provider acknowledged that this area needed to be developed further to ensure they could meet people's needs when they reached the end of their lives.

Care plans were comprehensive and staff told us they knew how to meet people's needs.

There was a range of activities available that met people's needs and preferences and people were encouraged to join in.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

There were systems and processes to assess and monitor the quality of the service. However these were not effective because they had failed to identify the areas for improvement we found.

Staff did not always feel supported because of the inconsistency of the management team.

The provider encouraged good communication with staff and people who used the service, and there were regular meetings.

**Requires Improvement** ●

# Kent Lodge

## Detailed findings

### Background to this inspection

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The service is provided by Shaw Healthcare, a national organisation providing health and social care. At the time of our inspection there were 31 people living at the service.

Since the last inspection, the registered manager was also managing a similar service within the company as well as still being involved in managing Kent Lodge. An additional interim manager had recently left. The provider's representatives told us on 12 March 2018 that they had recruited a new manager who was due to start at the service the day after the inspection, and this person would be applying to be registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

Staff did not always follow the procedures to manage medicines which meant that people were at risk of not receiving their medicines safely.

People were not always protected by the provider's arrangements in relation to the prevention and control of infection. Some areas of the home had a malodour and we found some health and safety issues.

On the day of our inspection, we saw that people's needs were not always met in a timely manner and people's concerns about their welfare were not always taken seriously.

People had access to healthcare professionals and the outcomes of their visits were recorded in people's care plans, however, care plans did not always include guidelines where people had specific healthcare needs.

The provider had a number of systems in place to monitor the quality of the service and put action plans in place where concerns were identified. However, these had failed to identify the issues we found at this inspection.

The provider was not always acting in accordance with the Mental Capacity Act 2005 (MCA). There was no evidence that any attempts had been made to appropriately assess a person's mental capacity in line with the MCA principles.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Safe care and treatment, Person-centred care, Need for consent and Good governance. You can see what action we told the provider to take at the back of the full version of the report.

Some staff practices were not always person-centred and did not take into account people's choices.

We made a recommendation in relation to person-centred care.

The registered manager was managing another service but was still involved in managing Kent Lodge and was therefore working part time at both services. This meant that improvements to the service were not as fast or embedded as they could be. A new manager had been recruited and was due to take up their post the day after the inspection.

Most staff had received training in end of life care and some people had advanced care plans. However, the provider acknowledged that this area needed to be developed further to ensure they could meet people's needs when they reached the end of their lives.

Processes had been followed to ensure that, when necessary, people were deprived of their liberty lawfully.

The provider had processes for the recording and investigation of incidents and accidents. These were investigated and where necessary measures put in place to prevent reoccurrence.

Care plans and risk assessments were reviewed and updated whenever people's needs changed. People and relatives told us they were involved in the planning and reviewing of their care and support.

Recruitment checks were carried out before staff started working for the service and s included checks to ensure staff had the relevant previous experience and qualifications.

The provider had taken steps to develop the design and decoration of the premises to meet the needs of people who used the service, in particular people living with the experience of dementia.

People's health and nutritional needs had been assessed, recorded and were being monitored.

People were supported by staff who were sufficiently trained, supervised and appraised. The service liaised

with other services to share ideas and good practice.

People's care plans were comprehensive and detailed how their individual needs were to be met. They were personalised to reflect people's wishes and what was important to them.

A range of activities were arranged that met people's individual interests and people were consulted about what they wanted to do.



# Is the service safe?

## Our findings

All the people we spoke with indicated they felt safe in their environment and trusted the staff who supported them. Their comments included, "Yes I do [feel safe]. They are smashing. They are so good. The girls are so polite. They always see that you're alright. They are top price. There is never an attitude. They are like a nice niece to me", "Yes I feel safe. It's quite nice. People are friendly and care for you. If you need anything, you let them know and they try and solve the problem" and "They look out for you here." Relatives agreed and stated, "Oh yes absolutely. I can only sing the [manager's] praises. They are [family member's] family. They are perfect. She is safe and secure here" and "[Family member] is safe here. As safe as she would be anywhere else."

Notwithstanding the above, we found that medicines were not always managed safely. We looked at storage, stock, record keeping and systems for the management of medicines at the home. Team leaders were responsible for administering people's medicines. We saw that they were caring and gained permission before giving people their medicines. The staff recorded each medicine that was given to people on their Medicine Administration records (MARs), which was an electronic record keeping system. However, during the medicine round we saw that staff left the medicines trolley and computer system open when it was unsupervised. This meant visitors, people at the home and unauthorised staff members could access people's medicines records and medicines stored in the trolley. We raised this with the staff member who told us that internet coverage in the home was poor and only good in some areas which was needed for the electronic MARs.

Staff checked and recorded room and fridge temperatures daily and these were within in the recommended range. Controlled Drugs (CDs) were stored securely (CDs are medicines which are liable to misuse and therefore need close monitoring). However, we found that staff were not carrying out regular checks for CDs as outlined in the provider's own policy. We also found evidence that staff had not appropriately recorded disposal of unwanted CDs. For example, a person using the service had died in April 2017 and their CDs had been sent to the pharmacy for disposal in November 2017 but this was not recorded in the CD register. In addition there were no witness signature on the medicines waste disposal form sent to the pharmacy.

We found that the stock levels on the home's inventory record were not reflective of the stock held on site. This was because discontinued/destroyed medicines were not updated on the electronic inventory system. Also, medicines received were not always recorded. For example, for one person, a medicine had been discontinued and we saw there was none in stock. However the electronic system recorded 30 tablets in stock. For the same person, the electronic system recorded 65ml in stock of a liquid medicine but we saw that 230ml of this medicine remained. This meant that people had not received their prescribed medicines because of poor record keeping.

We looked at MARs for four people. We found staff members were not always giving people their medicines as prescribed. For example, one person was not given their eye drops for seven days out of 14 days of the current cycle. The reason recorded on the MARs was that there was no stock of this medicine at the home although we found that there was adequate stock. This resulted in staff not administering this medicine. We

also saw that the eye drops administered were past their shelf life as these had been in use over 28 days.

Some people who had been prescribed topical medicines (creams) were not always having these applied. We found care records were inconsistently completed. Some people were prescribed medicines on a 'when required' basis (PRN). Guidance was not in place for everyone to advise staff when and how to give these medicines consistently. This meant people may not have been receiving their medicines when necessary.

We found there was a process in place to manage conditions of people who were prescribed higher risk medicines such as anticoagulants. Anticoagulants are medicines prescribed to prevent blood clots. For example, these medicines were given according to the person's blood results and dosage prescribed. However, there was no guidance in people's care plans for staff to identify likely side effects of these medicines and information on how to manage them.

People were not always protected from the risk of infection. During our inspection we checked the environment including communal areas, bathrooms and toilets. We found that some areas of the home had a malodour. We also found a number of safety concerns. For example, in one of the toilets, we saw a hoist with a soiled sling. We raised this with the registered manager who told us that hoists were hardly ever used, but they were unable to explain why the sling had been left soiled in a communal bathroom. In another bathroom we saw that the sink was loose. Some of the bathroom bins were unclean and chairs with unclean cloth seats were being used in two of the bathrooms. We saw a cleaning schedule in one of the bathrooms which had already been signed by staff at 10.20am for the 11am check, although there was evidence that the room had not yet been cleaned. In the lounge leading to the smoking room, we saw that the door was dirty and there was a broken telephone socket hanging off the wall. We also saw that there were some cracked tiles in one of the bathrooms and one of the toilets was unstable and missing a bolt to make it secure.

The provider did not have proper arrangements to protect people from the risks that can arise if health and safety checks are not carried out appropriately. We found two disposable razors left in a bathroom which we handed to the partnership manager and found that staff had left the laundry room open which meant that people could access it and there was a risk they could come to harm. We discussed our findings with the registered manager and a senior manager who told us action would be taken without delay. We were informed after our inspection that action had been taken to address all areas of concern.

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

Despite our findings, people told us they were happy with the way their medicines were managed. Their comments included, "I get them given to me on time give or take", "If I need extra medication, I just have to go down and ask", "I get my tablets ok. If I need anything I just ask", "Yes if I need anything extra I just ask the nurse" and "Yes every day. Yeah no problem."

The home had a medicines management policy in place. The provider had carried out regular medicines audits. We saw records to show staff received regular medicines management training. The home had a process to receive medicines alerts and acted upon them if required. There was a system in place to report and investigate medicines errors and incidents.

Staff had received training in infection control and there was a policy and procedures in place. Staff were provided with personal protective equipment such as gloves, aprons, hand washing facilities and sanitisation gels to help ensure infection was prevented and controlled.

Most people told us they were happy with the staffing levels. One person stated, "Yes I think so. There is always someone about" and another said, "Yes they have enough." A staff member told us that mornings were always very busy but thought there was a safe number of staff on each shift. They added that there was always time in the afternoon to spend time with people chatting and undertaking activities.

The registered manager told us they employed the services of agency staff to cover staff shortage, but ensured they used a reputable agency and a regular core group of staff. Agency staff were inducted into the service to ensure they were familiar with the layout of the building and the provider's policies and procedures. Each agency staff had a staff profile which included recruitment checks and training records.

Some staff worked a 12 hour shift and took a 30 minute break at 3pm. One staff member told us, "It makes for a very long day. We do not even get a drink during this time, 7.45am to 3pm. It can make you feel really tired and unwell. Don't know why it changed. I came on shift one day in February and was told by a colleague that 'you don't get a 15 minute break anymore'. There was no consultation or explanation given." We discussed this with the registered manager who told us they would never deny staff a drink or a quick break, but they would discuss this with senior management in their next meeting.

Incidents and accidents were recorded and analysed by the management to identify any issues or trends. The registered manager told us they ensured that lessons were learned when things went wrong, or when accidents and incidents occurred. We saw evidence that incidents and accidents were responded to appropriately. There had been a serious incident at the home which had been investigated by the police and the local authority's safeguarding team and involved a person falling/jumping from a height. We checked and saw that appropriate measures had been put in place to help prevent this type of incident from happening again. These included new window restrictors which were checked regularly and all balcony doors locked securely.

The provider had taken steps to protect people from the risk of abuse. Staff received training in safeguarding adults and training records confirmed this. Staff were able to tell us what they would do if they suspected someone was being abused. A healthcare professional stated that people were safe at the service and said, "I have been visiting this service for a long time. There have been some instability because of the changes of managers, but I do believe they keep people safe here. People always look well looked after." The service had a safeguarding policy and procedure in place and staff had access to these. Staff told us they were familiar with and had access to the whistleblowing policy.

Where there were risks to people's safety and wellbeing, these had been assessed. Person-specific risk assessments and plans were available and based on individual risks that had been identified either at the point of initial assessment or during a review. These were reviewed yearly or more often if necessary and included risks to general health, mental health and the person's ability to complete tasks related to everyday living such as nutrition, personal care and mobility. There were appropriate control measures to mitigate risks. For example, where a person was at risk of falls, there was an up to date risk assessment in place and measures in place to prevent falls included, 'To ensure [Person] has the right footwear' and 'To ensure [Person] uses their tripod when mobilising'. There was a 'falls prevention' support plan and this was regularly reviewed and updated. We also saw that there were appropriate risk assessments where people were at risk of absconding.

Staff were clear about how to respond in an emergency. Senior staff were available to help and support the staff and people using the service as required. There were staff on duty 24 hours a day and they knew who to call in case of emergency. Managers were available at the weekend via an on call system.

The provider had a health and safety policy and procedures, and staff told us they were aware of these. This helped to ensure the safety of people, staff and visitors. Safety checks were undertaken regularly by external professionals. These checks included electrical and gas safety, water, manual handling equipment, fire safety and laundry equipment. Any concerns were recorded and records we viewed showed that where an issue was identified, prompt action was carried out to rectify this.

The provider had taken steps to protect people in the event of a fire, and an up to date fire risk assessment was in place. We saw that where issues had been identified, action had been taken to rectify these. People's records contained individual fire risk assessments and personal emergency evacuation plans (PEEPS). These included a summary of people's circumstances and needs, and appropriate action to be taken in the event of fire. Senior staff carried out weekly alarm testing and monthly fire checks which included means of escape, emergency lighting and fire extinguishers. There were regular fire drills which included night time unannounced drills. Where concerns were identified, a post drill discussion took place and appropriate action was taken. For example staff were provided with fire warden training when their response during a drill had not been in line with the provider's fire safety policy and procedures.

The staff files we viewed demonstrated that the provider operated robust recruitment processes. All files viewed were organised and accessible. Contents of files were consistent and included photographic ID, reference checks, a Disclosure and Barring Service check and evidence of the right to work in the UK.

## Is the service effective?

### Our findings

People told us their healthcare needs were met. Their comments included, "I saw a chiropodist last week. And if I need they will book me an appointment with the GP", "Yes they are calling my doctor about my blood" and "Yes they are good." Relatives agreed and said, "As far as I can see [They meet their needs]" and "[Family member] sees the chiropodist and dentist."

According to people's records, appointments with healthcare professionals were booked, recorded and followed up by staff to ensure people attended these. Staff also supported people with effective care and followed the advice and guidance of these professionals. However, on the day of our inspection, we saw one person crying and complaining of a sore foot. Staff dismissed this as 'behaviour' and did not investigate and offer appropriate support to the person. Members of the inspection team needed to intervene to ensure the person was supported appropriately. This included staff offering support and pain relieving medicines. We discussed this with the partnership manager who was able to provide evidence that the person had been seen by a podiatrist on 20 February and was due to see them again on 4 April. However there were no records to show that this issue has been identified as a need for the person and there was no care plan in place to support the person with foot care between professionals' visits. As a result, we could not be sure the person was receiving appropriate care and support with their condition.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found they were not always doing so.

The senior staff undertook mental capacity assessments where they thought people lacked capacity in certain areas. We viewed an assessment for a person whose first language was not English and saw that under the section 'Demonstrating capacity', staff had recorded the person's responses as 'No response' and 'Said something in [Person's language]'. Another assessment for the same person in relation to medicines stated under communication, 'Difficult as speaks [Person's language]'. Under the section 'How can information be presented to enable maximum comprehension', staff had recorded, 'Provide in [Person's language]'.

We found no evidence that staff had engaged with the person in any language other than English. Records

also showed that other professionals had not been involved in the assessment or decision making process. We saw a document addressed to the GP to get their views in a best interests decision about the same person to be given their medicines covertly. There was no record of a response from the GP and therefore this did not demonstrate the GP's involvement in this decision.

We discussed this with the partnership manager who agreed that the assessment did not demonstrate either capacity or lack of it, as it was not clear if the person's mental capacity had been assessed by providing the necessary information in a language the person could understand. The registered manager stated that the person had lived in England for many years and spoke English and the reason they could not communicate was because of their dementia. However, there was no evidence that any attempts had been made to appropriately assess the person's mental capacity in line with the MCA principles.

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

In other cases we saw that consent was obtained before staff provided care and support and we saw evidence of this in the care plans we looked at. People told us staff consulted them. One person said, "They do [consult me]. They will say, "Let's go to the dining room" asking and explaining what they are doing."

Some of the staff we spoke with demonstrated a basic knowledge of the MCA and DoLS and had received training in this. Their comments included, "Everyone has capacity unless proved otherwise. Managers undertake assessments and tell us if someone does not have capacity", "Best interests decisions would be made if someone did not have capacity. This would be reflected in their care plan" and "If someone lacks capacity, social services make the decisions as to what is in a person's best interests. Some people have a DoLS in place but not everyone." Some staff could not, however, offer any examples of who might have a DoLS and why. We discussed this with the registered manager who confirmed that they would address this in team meetings and would ensure all staff received training refreshers.

People's needs and choices were assessed in line with legislation and good practice guidance. The staff completed pre admission assessments with each person, asking them about their needs and specific likes. People who used the service had been referred by the local authority. Assessments we viewed were comprehensive and we saw evidence that people had been involved in discussions about their care, support and any associated risks in supporting them to meet their needs. People and relatives told us that they were consulted before they moved in and they had felt listened to. The healthcare professionals reported that the staff team provided a service which met people's individual needs and they had no concerns.

People were supported by staff who had the appropriate skills and experience. All staff we spoke with had a four day induction that included shadowing more experienced staff members and a probation period after which they were assessed before becoming permanent. New staff were supported to complete the Care Certificate qualification. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. A member of staff told us, "I had a good induction. We shadow other colleagues first. We are never on our own."

Staff received training the provider had identified as mandatory. This included moving and handling, health and safety, infection control, food hygiene, safeguarding and food hygiene. They also undertook training specific to the needs of the people who used the service which included dementia awareness, catheter care, pressure ulcer prevention and reducing the risk of falls. Records showed that staff training was up to date and refreshed yearly. Staff told us they received regular training and refreshers and felt they were well trained. The provider's training matrix we looked at confirmed this. This meant that staff employed by the

service were sufficiently trained and qualified to support people appropriately.

People were supported by staff who were regularly supervised and appraised. Staff we spoke with told us they felt supported and were provided with an opportunity to address any issues and discuss any areas for improvement. We saw evidence that issues about staff's conduct and ability to carry out their duties were addressed during supervision sessions and additional sessions took place where necessary. For example, we saw that a concern had been raised about the staff member by a visiting professional and these concerns had been addressed appropriately by their line manager.

The provider recognised the importance of food, nutrition and a healthy diet for people's wellbeing, as an important aspect of their daily life. People told us they enjoyed the food. Their comments included, "The food is very good. You have two choices at lunchtime", "Food is edible. It's ok", "Food is perfect. Especially the cooked dinners", "I can have egg and bacon for breakfast if I want" and "The food is great."

Lunch was calm and unrushed and there was music playing in the background. Dining tables were set with linen cloths, placemats, condiments and drinks were available on tables. Staff who handled food were seen to wash their hands and wear a disposable apron and gloves. Food was served directly from the kitchen by the chef. Although staff were heard asking people what they wanted to eat, there were no other ways that were used to help people who could not always make decisions, make choices about their meals for example with the use of pictorial menus or samples of plated meals. We raised this with the registered manager who told us they would address this.

One person required support with eating. We saw that a member of staff sat and engaged with the person throughout their meal, checking they were ready and encouraging them to eat. We saw other people who were independent with eating being given encouragement to finish their meals and being asked if they had enjoyed the food. We noted that people were given time to eat and were not served their dessert until they had finished their main meal. Staff were heard asking people if they would like tea or coffee after they had eaten their meal. We heard one person say, "That's a nice surprise, we don't normally get coffee. I used to enjoy coffee and a fag after my meals." Drinks were made available during the day and snacks such as fruit and biscuits were provided between meals.

People's individual nutritional needs, likes and dislikes were assessed and recorded in their care plans. Each person using the service had a dietary assessment which included a nutrition and hydration support plan and these were reviewed regularly. We spoke with the chef who was knowledgeable about people's dietary needs and choices and ensured that people's diverse and cultural dietary needs were met. However, one relative told us, "The food is not really suitable for people without teeth. Myself and another relative will bring it up at the next residents' meeting." We discussed this with the registered manager who confirmed that all people who used the service had their own teeth or wore dentures. They added that nobody required pureed food at present but they would refer people to the speech and language therapy (SALT) team if they thought people were having difficulties with eating their food. All food was correctly stored and fridge temperatures checked twice every day.

The provider had taken steps to improve the environment to meet the needs of the people living at the service, in particular those living with the experience of dementia. This included rooms and communal areas painted in contrasting colours and the provision of areas of interest such as tactile objects, art work and photographs of events that took place at the home, books and objects of reminiscence throughout the communal areas and corridors. Although the bathrooms were dated and plain, attempts were made to make these more attractive and inviting by adding flowers and pictures.

There were notice boards throughout the service which included information for people and their visitors, information about making complaints, whistleblowing policy, information about befriending and advocacy services, mealtime procedure, activity plan and information about health and safety.



## Is the service caring?

### Our findings

All the people we spoke with were complimentary about the care and support they received and said that staff treated them with kindness and respected their human rights. Their comments included, "Yeah they are quite polite. They don't ignore you", "They asked me if it was ok to call me [Person's name]", "Very fair. They are quite good. [Person waved at a member of staff]. She is very good and kind. She went to Tesco's for me to buy me some fruit juice. She does it from the heart." Relatives agreed and stated, "Absolutely fantastic. They're fabulous here. Lovely people. I would not have [Family member] anywhere else", "Oh yes, always [treat them with respect]", "Staff are very aware of dignity and respect. They change [family member] regularly. She has a bath or shower. She is always clean."

Notwithstanding the above comments, on the day of our inspection, we saw that some staff practices were not person-centred and did not always demonstrate respect for people's dignity and privacy. During the morning, we observed a member of staff placing two biscuits on a plate using bare hands before handing these to a person, without offering them a choice. Although the staff member approached people in a friendly manner, the only interaction was to ask people if they wanted tea or coffee. Whilst waiting for people to finish their drinks, the staff member just stood watching TV then left the room without a word. We spent one hour in a lounge where three people were sitting. Apart from when the drinks trolley came round, we did not see any staff visiting people or checking if they were alright. One person was too far from the TV to be able to watch and had nothing to occupy them. They fidgeted with their cardigan and looked around blankly. These observations were fed back to the registered manager at the end of our inspection.

We recommend that the provider seeks relevant guidance with regards to improving person-centred care for people using the service.

Despite our observations, staff told us they respected people's dignity and privacy. One staff member stated, "When doing personal care, I close the door, and ask them first. You have to talk to them." One relative agreed and said, "I think they turn their back to give her privacy. The toilet door is always shut."

People's cultural and spiritual needs were respected and they were supported to practice their religion if they wished. Information about people's cultural background and religion was recorded in care plans.

People were consulted about which activities they preferred and each person had their own activity plans based on their likes and dislikes. We saw that these were reviewed and updated regularly.

## Is the service responsive?

### Our findings

People and relatives told us staff were responsive to their needs and they felt valued and listened to. However, from our observations of staff interactions and support throughout the inspection, we found that not all staff were responsive to people's needs and some failed to show a caring and enabling approach.

On the day of our inspection, we saw that staff were rushed and could not always meet people's needs in a timely manner. For example, one person requested painkillers for a headache and we noted that these had still not been administered one hour later. Another person was heard asking everyone for a lighter, including the inspection team and registered manager, but was told to wait until after lunch. We noted that the person had been asking various people for at least 30 minutes and still had not been assisted with their request. Although there was a care plan about how to meet the person's needs in relation to their smoking, staff were not following this. We fed this back to the registered manager at the end of our inspection.

People and their representatives were involved in the development and review of their care plans and records we viewed confirmed this. All the care plans we looked at were comprehensive, detailed and personalised. They were designed in a way to support people whilst maintaining their independence. Care plans also provided staff with clear guidance on how to meet each person's specific care needs. Each person's care plan included details of their preferences in relation to how their care and support should be provided. They were developed from information provided by people and family members, as well as healthcare and social care professionals involved in people's care. This information was combined with details of people's specific needs identified during initial assessments.

Care plans were regularly reviewed and updated to help ensure they provided staff with sufficient detailed information to enable them to meet people's individual needs. Each care plan included details of the people's background, past occupation and family, likes and interests as well as information about their medical history so staff had all the necessary information about the person to understand the person's needs and how they liked to be cared for.

People told us they enjoyed the activities on offer at the service. Their comments included, "Activities go on after breakfast. I would like keep fit classes. I have not been out for a considerable length of time", "Yes, in the dining room after breakfast we do activities." A relative stated, "The activity coordinator does the activities here. They do bingo, quizzes, sometimes in the afternoon they have someone who comes in and plays the saxophone, another person comes in and sings. They always celebrate birthdays."

The provider employed an activities coordinator who provided and facilitated a range of activities at the service. People had their own activity record in their care plan. This enabled staff to see what people enjoyed taking part in. A four week activity plan was created following discussions with people and this was displayed in communal areas. However this was printed on a small sheet and was not pictorial. This meant that people who used the service may find it difficult to see what activities were on offer if they were visually impaired or were living with dementia. Activities on offer included sing along, group exercises, quiz, art and craft, ball games, bingo, film afternoons, reminiscence sessions, cooking and church service.

The provider had a policy and procedures for dealing with any concerns or complaints. Details of the complaints processes were available to people who used the service and were displayed in communal areas. People told us they understood how to report any concerns or complaints about the service. Their comments included, "No I have no complaints", "No, if there was [a complaint], I would tell them. I would tell the girls." A relative added, "No. I think they are pretty amazing here." No complaints had been received recently, however, we saw evidence that the provider had taken past complaints seriously and had helped to resolve issues in a timely manner.

The provider had a policy for end of life care and staff had received training in this during their induction. The registered manager told us that nobody was in receipt of end of life care at the time of the inspection. However they told us that there had been occasions when people had been cared for at the end of their life. Some people had an advanced care plan recording their end of life wishes. However the registered manager acknowledged that there was room for improvement, and most people did not yet have an advanced care plan in place. Where people had an advanced care plan, we saw that this was comprehensive, included the person's personal choice of funeral, including what music they wanted played and this was reviewed regularly.

## Is the service well-led?

### Our findings

The provider had put in place a number of different types of audits to review the quality of the care provided. These included medicines audits, environmental checks and health and safety checks. However these audits had not always been effective in monitoring and assessing the quality of services provided and in addressing any areas that needed to improve. This was because they had failed to identify the issues we found in relation to medicines, health and safety, failure to meet the principles of the Mental Capacity Act 2005 and people not always receiving personalised care which reflected their needs.

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

People and relatives were complimentary about the management team although they were sometimes confused about who was the current manager. One person told us, "A new manager has just started." One relative stated, "Yes [Registered manager] is lovely. There is a replacement coming soon" and another said, "[Registered manager] knows them all well. He was a wonderful manager."

Staff told us working at the service had been difficult without a permanent manager and a deputy manager but they had felt supported by the team leaders. One staff member told us the home was like 'A boat without a captain'. The current registered manager previously worked full time at Kent Lodge but recently has been dividing their time between Kent Lodge and one of the provider's other care home. There was another manager who also provided support during the week. This arrangement provided some stability and support for the staff, however there were many occasions when there was no manager on site to support staff.

We discussed this with the senior management team and they told us they had recruited a new full time permanent manager and deputy manager for the service who were due to start working the day after our inspection.

The management team recognised the importance to keep themselves abreast of changes within the social care sector by attending regular managers' meetings, conferences and workshops. From these meetings, relevant information was cascaded to the staff team during meetings to improve knowledge and to share information. They also attended managers' forums organised by the local authority, where they discussed social care changes and updates and liaised with other managers. They also consulted the Care Quality Commission (CQC) website and provider's handbook to keep abreast of developments within the regulatory framework of care services.

There were systems in place to monitor the standards of care provided and identify any areas in which the service could improve. These included regular meetings with people who used the service and relatives. The provider carried out satisfaction surveys of people and relatives. The results of these were analysed and any areas for improvements were discussed in meetings and used to improve the service.

Records showed there were regular staff meetings and team leaders meetings. Issues discussed included communication, report writing, incident reports and training. These meetings gave staff an opportunity to raise issues and to be involved in the development of the service. There were also monthly managers' meetings where any relevant operational matters were discussed.

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 not always ensure that care and treatment was provided to meet service users' needs.  Regulation 9(1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent  Care and treatment was not always provided with the consent of the relevant person and the provider did not always demonstrate they acted in accordance with the Mental Capacity Act 2005 where a person could not give consent.  Regulation 11(1) (2) (3)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider did not ensure that care and treatment was always provided in a safe way for people using the service.  Regulation 12 (2) (a) (b) (d) (e) (g) (h)
Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

The provider did not ensure that systems and processes were established and operated effectively to assess, monitor and improve the quality of the service and to mitigate the risks relating to the health, safety and welfare of service users.

Regulation 17(1), (2) (a) (b) and (c)