

# Shaw Healthcare (Group) Limited

## Kent Lodge

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This comprehensive inspection took place on 24 October 2018 and was unannounced.

The last inspection of the service took place on 3 April 2018 when we rated the service requires improvement in all key questions and overall. At this inspection, although we found that some aspects of the service had improved, there were still concerns about the safety of people who used the service so we have rated the question, 'is the service safe?' as inadequate in and the question, 'is the question well-led?' as requires improvement. The overall rating of the service is requires improvement.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all the key questions to at least good. We received the provider's action plan on 15 June 2018, telling us they would complete all actions by 20 June 2018.

Kent Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 people in a single building. Accommodation is provided on two floors.

The service is provided by Shaw Healthcare (Group) Limited, a national organisation providing health and social care. At the time of our inspection, there were 32 people living at the service, one of whom was in hospital.

There was a manager at the service. They had been the manager for six months. They were in the process of registering with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We received confirmation on 1 November 2018 that the manager had successfully registered with the CQC.

Although improvements had been made, staff did not always follow the procedures to manage medicines. This meant that people were still at risk of not receiving their medicines safely and as prescribed.

Risk assessments were in place for each person, however, the level of risk was sometimes wrongly calculated which meant that risk management plans might not have been adequate to mitigate the risks. Guidelines and support plans were also not always reviewed and updated when the risk had increased.

A recent Food Standards Agency inspection had highlighted some concerns about the standards of hygiene in the kitchen. We saw that the provider had taken immediate action to meet requirements and make the necessary improvements.

The provider had processes for the recording and investigation of incidents and accidents, however, where a person using the service had a fall, staff were unable to show us a record of the accident report and actions in place to reduce future risks.

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

We found the continuing breaches of two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment and good governance. We are taking further action against the provider. Full information about CQC's regulatory response to these concerns will be added to the report after any representations and appeals have been concluded.

The provider did not always act in accordance with the Mental Capacity Act 2005 (MCA). Processes had not been followed where a person using the service was receiving their medicines covertly. We have made a recommendation regarding this.

Care plans were comprehensive and regularly reviewed. However, these included out of date documents. Staff told us they found them difficult to read.

People were protected by the provider's arrangements in relation to the prevention and control of infection. The home was clean.

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

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

People's health and nutritional needs had been assessed, recorded and being monitored. People had access to healthcare professionals and the outcome of their visits were recorded.

People's needs were met by caring and compassionate staff. On the day of our inspection, we saw that people were attended to promptly and staff were kind and caring.

People were given choice and were consulted in different aspects of their care and support. Their individual needs and wishes were respected, including their religious and cultural needs.

An introduction to end of life care training was provided during staff induction, and we saw that some people's care plans included an advanced care plan. However, the registered manager acknowledged that this area needed to be developed further to ensure staff could meet the needs of people when they reached the end of their life.

A range of activities were organised and the activities coordinator told us they consulted people about what they wanted to do.

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

Complaints were recorded and responded to appropriately and in a timely manner.

Staff reported that the manager was effective and making improvements at the service. They found them approachable and visible, and felt valued and supported.

The manager told us they felt supported by senior managers and were working hard to continue making the necessary improvements.

## 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.

Although some improvements had been made, staff did not always follow the procedures to manage medicines. This meant that there was a risk that people would not receive their medicines safely and as prescribed.

Risk assessments were in place for each person, however, the level of risk was sometimes wrongly calculated, and guidelines and support plans were not always reviewed and updated when the risk had increased.

The provider had processes for the recording and investigation of incidents and accidents, however, an accident form was not completed where a person using the service had a fall, with actions in place to reduce future risks.

People were protected by the provider's arrangements in relation to the prevention and control of infection. The home was clean.

Recruitment checks were undertaken before staff started working for the service and included checks to ensure they had the relevant previous experience and qualifications. □

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

The provider did not always act in accordance with the Mental Capacity Act 2005 (MCA). Processes had not been followed where a person using the service was receiving their medicines covertly.

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

People's health and nutritional needs had been assessed, recorded and were being monitored. People had access to healthcare professionals and the outcome of their visits were recorded.

**Requires Improvement** ●

The provider had taken further steps since our last inspection to develop the design and decoration of the premises to meet the needs of people who used the service, in particular those living with the experience of dementia.□

### Is the service caring?

Good ●

The service was caring.

People's needs were met by caring and compassionate staff. On the day of our inspection, we saw that people were attended to promptly and staff were kind and caring.

People were given choice and were consulted in different aspects of their care and support. Their individual needs and wishes were respected, including their religious and cultural needs.

### Is the service responsive?

Good ●

The service was responsive.

Care plans were detailed and addressed people's needs although relevant information might be hard to find, because of the way the care files were organised.

Basic end of life training was provided during staff induction, and we saw that some people's care plans included an advanced care plan. However, the registered manager acknowledged that this area needed to be developed further to ensure staff could meet the needs of people when they reached the end of their life.

A range of activities were organised and the activities coordinator told us they consulted people about what they wanted to do.

Complaints were recorded and responded to appropriately and in a timely manner.

### Is the service well-led?

Requires Improvement ●

The service was not always well-led.

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

Staff reported that the new manager was effective and making

improvements. They found them approachable and visible, and felt valued and supported.

The manager told us they felt supported by senior managers and were working hard to continue making the necessary improvements.

# Kent Lodge

## Detailed findings

### Background to this inspection

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

The inspection was prompted in part by notification of incidents regarding unsafe medicines management at the service which indicated potential concerns about the management of risks.

This inspection took place on 24 October 2018 and was unannounced.

The inspection was carried out by one inspector, a pharmacist and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This included support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019. This inspection report does not include the findings of the dental inspector.

We reviewed the information we held about the service, including notifications we had received from the provider and the findings of previous inspections. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The registered manager had sent us 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.

During the inspection, we observed support being delivered to people to help us understand people's experiences of using the service. We looked at records, including the care plans for seven people, four staff records, medicines administration records and records relating to the management of the service. We spoke with seven people who used the service, two relatives, a friend of a person who used the service, the



manager, the administrator, deputy manager, two senior care staff, the activity coordinator and four care workers. We received feedback by email from two social care professionals who had regular involvement with the service.

# Is the service safe?

## Our findings

At our last inspection of 3 April 2018, we found that staff did not always follow the procedure for the management of medicines and people were at risk of not receiving their medicines safely and as prescribed. At this inspection, we found that, whilst some improvements had been made, medicines management remained unsafe.

The provider had notified us of a number of medicines errors prior to our inspection, where people had not received their medicines as prescribed. We saw that they had taken appropriate action following these incidents, such as seeking medical advice to ensure people had not suffered any ill effects, suspending the member of staff responsible from administering medicines, providing them with additional training and assessing their competencies. In addition, they had increased the frequency of medicines audits with the aim to identify any shortfalls.

However, we found that there were still a number of areas of concerns. For example, we saw that one person did not receive a medicine prescribed to relieve constipation from 25 August until 8 September. Care records indicated that this medicine may not have been needed, however, staff had not recorded a reason why this medicine had not been administered. We also saw that the stock reconciliation showed six different medicines which were not properly accounted for between actual stock and what the electronic medicines administration records (eMAR) system had on record.

Senior staff in charge of administering medicines had not received training about high risk medicines and did not understand why these were prescribed to people. For example, for a person who was on Lithium therapy, there was no risk assessment and no purple book in place (this is a book produced by the National Patient Safety Agency designed to contain information and reminds the person when their next blood test is), and staff were not aware that this was a high-risk medicine. There was also no risk assessment for a person on a blood thinning medicine and for another person who had diabetes about the signs and symptoms to observe if the person was having a high or low blood sugar, so appropriate remedial action could be taken.

There was a medicines policy and procedures. The policy was due for review in March 2018, but this had not taken place at the time of our visit on 24 October 2018. The policy stated that practical competency of staff should be reviewed annually. We saw that most staff had been assessed in March and April 2017, but there was no evidence of any refresher training for 2018. The policy also stated that a written assessment should take place and staff must achieve a pass. We discussed this with the manager who told us that this was not part of the practice and the policy needed to be amended.

The process for ordering medicines was not consistent. Staff told us they received an alert on the electronic system telling them when a medicine was running low, and this prompted them to call the GP and request a prescription. However, we saw evidence that there was poor communication between the home and the pharmacy who supplied the medicines. For example, they did not have a robust agreement between them on how to ensure people would get their medicines in a timely manner when important medicines had been

prescribed. This had sometimes resulted in delays getting prescribed medicines to people who used the service.

We saw some medicines on the worktop in the medicines room. Upon questioning, it was determined that these were due to be returned to the pharmacy as they were no longer needed. Entries were made into the returns book. Whilst the medicines room was kept locked, the medicines policy stated that medicines to be returned should be stored in a separate, labelled container. When asked what the process was for returning unwanted medicines, a senior staff member told us, "When there is a lot." We did not see and we were not shown a labelled container for medicines to be returned to the pharmacist.

The provider did not always ensure the safety of people, visitors and staff. There had been a recent Food Standards Agency inspection on 8 October 2018 and the provider had received a rating of two stars out of five stars, with five stars being the best score. This was because the assessor had found that out of date food were being used, there was an ongoing mice infestation, large cracks in the ceiling and evidence that staff had not received appropriate training in food hygiene. The provider was required to complete all actions by 8 November 2018. At the time of our inspection, we saw that staff had received appropriate training and actions were being taken regarding the other concerns identified.

Risk assessments did not always reflect people's individual risks and were not always regularly reviewed. We viewed the care and support plans for seven people who used the service. Each person had an initial assessment in place. This highlighted specific areas of risk. These included risks to general health, mobility and personal safety, mental health and the person's ability to complete tasks related to everyday living such as washing, dressing and nutrition. Each risk assessment described the possible consequences and measures in place to manage the risk.

Each risk was calculated in terms of likelihood and consequence, and rated either low, moderate, high or extreme. This was measured before and after measures were in place to reduce the risk. However, some risk assessments had not been rated correctly, therefore these were misleading. For example, a person's moving and handling risk assessment rated the risk as moderate when the scoring showed the risk was in the high risk category. Some risk assessments only showed the final risk score, but no initial rating of the risk identified.

One person's falls risk assessment was rated 18 (very high risk), but their falls prevention support plan stated a rating of 12 (high risk). On closer examination, we saw that this support plan was at the back of a 2016 assessment. We discussed this with the manager and deputy manager who told us that this had not been reviewed and admitted there should have been an updated version of the support plan. This meant that the provider had failed to identify the increased risk of falls for this person and therefore the plan to mitigate the risk might not have been adequate to support the person safely.

In addition, although we saw that most accidents and incidents were recorded and included an action plan to prevent reoccurrence, the same person had sustained a fall on 3 April 2018, but there was no incident report available for us to view. The manager told us that the person had been referred to the physiotherapist and had been provided with equipment to prevent them falling. However, they were unable to show us a record of this in the person's file.

The above is a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Notwithstanding the above, some risk assessments were appropriately completed and included a support

plan with guidelines about how to reduce the risk and meet the person's needs. For example, where someone was at risk of skin deterioration, we saw that the provider had made suitable arrangements for the person to be seen by the district nurse, and staff knew what to do to meet the person's needs. Another person had been identified at risk of falls. We saw that their support plan stated a number of instructions to minimise risk, such as, "Staff to make sure the environment is clean and safe at all times" and "Staff to observe [Person] when mobilising around the home and to be aware of their whereabouts at all times." We saw the person had not had a fall in the past year.

The fire safety documents we viewed stated that there were weekly tests of the fire alarm system and weekly inspections of fire doors and fire guards. However, we saw that the last recorded fire alarm test, emergency lighting and green box emergency system were carried out on 9 October 2018.

The provider carried out checks on the safety of the environment and equipment used. For example, we saw up to date checks on fire safety equipment, water temperatures and electrical safety. Any concerns were identified and recorded and we saw that prompt action was taken to rectify these.

On the day of our inspection, we saw that appropriate measures were in place to prevent cross infection. The home was clean and hygienic and there were appropriate hand washing facilities. Staff wore protective equipment such as gloves and aprons and these were disposed of appropriately.

A fire risk assessment was in place and due for review this month. People's records contained individual fire risk assessments and personal emergency evacuation plans (PEEPS). These included a summary of people's needs and how to support them to evacuate in the event of a fire. The provider undertook regular fire drills at the service, including unannounced drills. Following these, there was a discussion and reflection with staff about what went well and what could be improved.

Staff had completed training in safeguarding adults and were able to demonstrate knowledge in this subject when we spoke with them. The service had a safeguarding procedure and all staff were aware of this. We saw evidence that the provider worked with the local authority's safeguarding team where concerns had been identified and appropriate measures were put in place to address these.

The manager told us they ensured lessons were learned when things went wrong. They said, "I speak to my team and we think about how we can learn and improve from mistakes. We have meetings, we do audits. I support the team leaders in their supervisions and we highlight what should be done, what is missing and how to improve, like the care plans."

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

We saw there were enough staff on duty on the day of our inspection to support people. We viewed the staffing rotas for four weeks and saw that there was adequate cover at all times. The manager told us they sometimes used an agency to cover staff absence and ensured continuity by using the same group of staff whenever possible. A care worker told us, "Each day is different. Sometimes we need more staff, other days is fine. Sometimes we want to spend more time with people. We can't always." A relative stated, "There aren't enough staff but that's everywhere. I think it is good. I am impressed by the fact that the staff understand my [family member]'s needs. They all do their best."

## Is the service effective?

### Our findings

At our last inspection on 3 April 2018, we found that people's healthcare needs were not always met in a timely manner. At this inspection, we saw that improvements had been made.

People and relatives told us they were supported to maintain good health and had access to the healthcare services they needed. The care plans we looked at contained details about people's health needs and included information about their medical conditions, mental health, dental, medicines and general information. Records of healthcare appointments included the outcome of the appointment and any action needed. These included routine appointments and specialist appointments. Staff we spoke with were aware of people's individual healthcare needs and knew how to meet these.

At our last inspection on 3 April 2018, we found that mental capacity assessments did not always take into account people's individual needs. At this inspection, we found that improvements had been made.

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 whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider understood the principles of the MCA and had followed its requirements. Since our last inspection, staff had been provided with mental capacity training and the management team included this in meetings and supervisions so they could test the staff's knowledge and understanding.

Covert medicines were reviewed by the GP in January 2018 but there was no evidence of regular reviews. We found that two people received their medicines covertly. We saw that risk assessments were in place for both people, but only one of them had their mental capacity assessed. Although staff told us the person lacked capacity, they were unable to show us evidence of this, so we could not be sure if the person was given their medicines covertly in line with the principles of the MCA.

The provider's action plan stated that they would ensure that future mental capacity assessments would be undertaken with an interpreter if the person's first language was not English. Staff told us they ensured that information was available to people in an accessible format, such as using pictures. Consent was obtained before care and support were delivered. We saw consent forms in people's files which included consent for photographs and record sharing. These were signed by people or their representatives.

The provider had made appropriate applications for DoLS where necessary and we saw that these had been approved by the local authority. We saw that best interests assessments had taken place and that the relevant people had been involved. This meant that people were being lawfully deprived of their liberty.

Staff told us that they encouraged people to be as independent as they could be. People confirmed that staff gave them the chance to make daily choices. Their comments included, "I have got what I need. I got a new bed as I have asked to change it", "I get myself up whenever I want and go for my breakfast", "I can smoke in the garden" and "I can choose meals." Our observations throughout the day confirmed this.

People's needs and choices were assessed in line with legislation and good practice guidance. Pre-admission assessments included all details about the person, their likes and dislikes and how they wanted their care and support. Assessments we viewed were comprehensive and we saw evidence that people or their representatives had been involved in discussions about their care, support and any associated risks in supporting them to meet their needs. Most people were referred by the local authority but three were privately funded. Where they were referred, there were detailed assessments undertaken by the local authority. This informed the service of the person's requirements before they assessed them to see if they could meet their needs at the service.

People and their relatives confirmed that staff had the knowledge and skills they needed. One person said, "They are definitely well trained and know what they have to do." When asked if they received enough training, staff told us, "It's ok. It's good. I have done dementia training so it's good. And Safeguarding. It makes you aware of certain things We also get MCA training and refreshers" and "Training is consistent. We are frequently reminded of it so we are well trained." We saw that people were being cared for by staff who had received the necessary training to deliver care safely and to a high standard. The manager had identified training courses as mandatory. They included first aid, infection control, administration of medicines, health and safety and safeguarding adults. They also undertook training specific to the needs of the people who used the service which included MCA, dementia awareness and catheter care. The training records we looked at confirmed that the provider had taken the necessary steps to ensure training was up to date. All staff had been supported to complete a recognised qualification in health and social care. This meant that staff had received a range of training to support them in providing appropriate and safe care.

Staff we spoke with told us the training they received provided them with the skills they needed to support people who used the service. However, one stated, "We could have a bit more training about dementia really. We have had e-learning but we would like an in-depth understanding of it so we could meet their needs better, and know why they do certain things." The provider sent us evidence that training in dementia care had been provided for staff, and that 27 staff out of 31 had received this. However, only six staff had been trained between 2017 and 2018, and three staff in 2016. Sixteen staff had received the training between 2010 and 2015. However, they had not received refresher training to include new approaches and updates in the way people with dementia are cared for. The provider confirmed they would provide this training to all staff in the near future. All new staff were subject to a thorough induction which included training in the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

The manager told us they ensured that staff received regular supervision and said that they were currently undertaking staff appraisals. The records we looked at confirmed that supervision was regular and included an action plan where issues were identified. Staff told us they received support from their line manager. In addition, there were group supervisions, which included areas for discussions such as breaks and the use of mobile phones whilst on duty.

The staff recognised the importance of food, nutrition and a healthy diet for people's wellbeing generally and as an important aspect of their daily lives. People's individual nutritional and cultural needs, likes and dislikes were assessed and recorded in their care plans. People told us the food was good and they were offered choice. Their comments included, "I've no complaint about the food", "I like the food. There's mostly a choice I like" and "I am a Muslim and eat halal. I have a little fridge so I can keep my food." A relative stated, "The food is really good. [Family member] enjoys her meals."

People's weight was monitored and we saw evidence of this in their care records. Where a person was at risk of weight loss, we saw that a Malnutrition Universal Screening Tool (MUST) was used and reviewed monthly. MUST is a screening tool to identify adults who are malnourished, at risk of malnutrition or obese. Each person who used the service had a dietary assessment. These included the person's likes and dislikes, allergy status and particular dietary requirements. Nutrition and hydration support plans included all aspects of the person's needs and choices with regards to food and drinks. For example, one person's dietary assessments stated they liked roast dinners and fish and chips but disliked spicy food.

We observed breakfast and lunch on both floors. We saw that tables were laid with table cloths, cutlery, napkins, a small vase of flowers, condiments and a pictorial menu. People were offered a choice of drinks and meals at the point of service. When one person was unable to decide what to have, we saw staff showing pictures of meals to help them make their choice. The food served looked appetising and people appeared to enjoy their meals. People were offered dessert once they finished their main course. However, we saw that staff left bowls of dessert on the table for some people who had not finished their main course.

The manager had continued to improve the environment to meet the needs of people who used the service, in particular those living with the experience of dementia. This included themed photographs in different parts of the home, bright artwork and paintings, tactile objects and more attractive bathrooms.

# Is the service caring?

## Our findings

At our last inspection on 3 April 2018, we found that some staff practices were not always person-centred and did not take into account people's choices. At this inspection, we saw improvements had been made.

People and a relative we spoke with were complimentary about the care and support they received. One person told us, "I don't have any complaint. The manager and staff are excellent." A social care professional stated that staff were, "friendly and professional."

On the day of our inspection, we saw that staff spoke to people in a kind and respectful way and were attentive to their needs. For example, we heard comments such as, "Let me close the curtains, the sun is in your eyes", "Which drink would you like, do you want me to help you?", "Have you finished? No? that's ok, take your time", "which hand to you want to hold your fork? This hand? Ok, that's fine" and "Do you want fresh orange? That's fine, I will go and get you some right now." Where a person who used the service needed support with intimate personal care, we saw a member of staff approaching them gently, saying, "Let's go to your room, I will come and help you change. Don't worry". We saw staff lowering themselves to be at eye level when they spoke with people. People appeared to have a trusting relationship with staff. Staff constantly checked if people were well. At lunch time, they were asked if they had enough, if they enjoyed their food and if they needed something else. People who needed support with their meals were assisted in a calm and unrushed manner.

We saw staff treated people with respect and in a caring, professional manner throughout our inspection. Staff spoke respectfully about the people they cared for. Their comments included, "I want to make residents happy and I feel happy when they respond to me positively", "Our care is good. We are caring. The staff chosen to work here are kind and patient" and "I am a caring person and I love to care for elderly people. I love my job." They talked of valuing people and respecting their rights and their diverse needs. Every member of staff we spoke with demonstrated a good knowledge of people's individual needs and wishes and we saw that the culture of the service was based on providing care that met each person's unique needs.

People told us that their views and choices were respected and that they were consulted about their care. People's cultural and spiritual needs were respected and they were supported to practice their religion if they wished. One person told us, "I offer my prayer in my room and go to west Ealing mosque for prayer" and "I go to church and they can help me whenever I ask them." Information about people's cultural background and religion was recorded in their care plans. A care worker told us, "We have a person who is [Nationality] but does speak English but we use a translating book so we can communicate."

We viewed the care notes for some of the people who used the service and saw that these were written in a respectful way and detailed how people had spent their days, including any concerns and information about health or emotional needs.

People told us that staff respected their privacy and dignity and we saw evidence of this throughout the day



of our inspection. For example, we saw people knocking on people's door and waiting to enter. Staff told us they ensured they closed curtains and closed doors when supporting people with personal care.

## Is the service responsive?

### Our findings

At our last inspection of 3 April 2018, we found that people's requests for care and support were not always addressed appropriately. At this inspection, we found that improvements had been made.

Although staff were busy throughout the day, nobody had to wait long for support, and we saw that staff attended to people's needs promptly and appropriately. Where people needed support to mobilise, staff did this calmly and explained what they were doing. We saw that where people were able to mobilise by themselves, they were supported to do so in their own time, and were encouraged and praised.

Care plans were developed from the initial assessments of people's needs. Some included a snapshot of the person so staff could get a visual reminder about them and their particular needs and wishes. For example, their place of birth, where they lived, their marital status and any special family members or friends involved in their care. These also listed any particular hobbies or interests so that staff could use this to guide how they provided activities to the person.

We noted that the care folders contained out of date documents which were no longer relevant and in some cases, we could not locate up to date information. A care worker told us, "Care plans are overwhelming. The information could be more concise. Like important information on the first page instead of spending half an hour looking for information. Look how thick they are." We discussed this with the manager who told us they had identified this as an area for improvement, and were planning to undertake this task in the near future.

Staff told us they encouraged and supported people to undertake activities of interest to them. There was a large pictorial activity plan displayed in communal areas, so people could see what was happening each day. The provider employed a full-time activity coordinator who organised activities on a daily basis. They told us, "When a new resident comes, I assess them and find out what they want to do. We use memory exercises. About 14 people always attend this. Morning activities are better because after lunch they want to relax and watch TV. I bring puzzles and word searches and ask if they want to do that. Otherwise I put a film on for them. I took several residents to the zoo, they did enjoy that. We do take them shopping and to the pub."

On the day of our inspection, we saw staff interacting with people and offering pampering sessions such as painting nails. One person was supported to go out shopping with a member of staff and returned later showing us their purchase. Other activities on offer included chair-based exercises, memory cards, bingo, skittles and puzzles. One staff member, however thought the activities could be improved and said, "I think things are improving. I think the activities are terrible. We now have a minivan to take some people out. We should do that more often. I think there could be more variety."

The provider had a complaints policy and procedures for dealing with any concerns or complaints. People knew who to complain to if they had any issues but told us they had not needed to make a formal complaint. One person told us, "I don't have any complaints" and another said, "I've not really had to say anything. If I had a problem I could talk to a carer first." We saw evidence that complaints were taken

seriously and dealt with appropriately and in a timely manner. The provider kept a record of compliments they received. We viewed a sample of these and saw comments such as, "I would like you to know how grateful we are for the care and kindness shown to [family member] since he came to Kent Lodge" and "Bless you for all your hard work."

At our last inspection, we discussed the importance for people to have advanced care plans, and for staff to know how people wanted their care and support to be delivered when they reached the end of their lives. At this inspection, we saw that, where appropriate, people were consulted about their end of life wishes. We saw that some people had end of life support plans in place. These contained details about where they wished to end their life and any particular requirements, such as burial or cremation. However, the manager acknowledged that this area still needed to be improved so they could be sure that each person's end of life wishes were respected and met. They told us they would discuss this at the next managers' meetings and seek appropriate training for staff.

## Is the service well-led?

### Our findings

At our last inspection of 3 April 2018, we found that, although the provider had systems and processes to assess and monitor the quality of the service, these were not effective because they had failed to identify the areas for improvement we found.

During this inspection we found that the provider's audits and quality assurance systems were not always effective because these had not identified and addressed the concerns we found in relation to the safe management of medicines. This was despite the provider identifying a number of other concerns associated with the management of medicines prior to our inspection. This meant that people were still at risk of not receiving their medicines safely and as prescribed. In addition, we found that the provider's arrangements for the management of risks had not picked up that risk assessments were not being appropriately carried out in that the level of risk was sometimes wrongly calculated, and guidelines and support plans were not always reviewed and updated when the risk had increased. Where a person using the service had a fall, staff were unable to show us a record of the accident report and the actions they were taking to minimise the risk to the person.

The provider had arrangements to monitor and ensure food was appropriately and prepared and served to people, but these were found to be lacking and not very effective. A recent Food Standards Agency inspection had highlighted some concerns about health and safety and the standard of hygiene in the kitchen.

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

At this inspection, we found that some improvements had been made to address some of the concerns we found at our last inspection. For example, the environment was clean and fresh, people's needs were met in a timely manner, care plans included guidelines where people had specific healthcare needs and staff practices were person-centred and took into account people's choices.

People and their relatives we spoke with were complimentary about the staff and the manager. They said that they were approachable and friendly. One relative told us, "I know that [family member] is happy here. The staff are terrific. They all like her and she likes them. [Manager] is terrific. She and [family member] get on. Communication is good" and "I am confident as I turn up at all sorts of time, they never know when I turn up and I have never seen anything of concern. Staff really make my [family member's] life happy."

Staff told us they enjoyed the stability of having a permanent manager and felt supported by them. Their comments included, "This manager is very supportive. She is a smart lady and keeps professional" and "I feel supported here. I feel that you can approach the team leader or the manager. They listen. We work as a team."

The provider had appointed a permanent manager and deputy manager in April 2018. We received

confirmation shortly after the inspection that the manager had successfully registered with the Care Quality Commission. The manager told us they had worked hard to make improvements and it had been challenging. They said they felt supported by the senior management. They told us, "I feel supported by my manager. She is at the end of the phone when I need her. The other senior managers also support me. I only have to send an email and they respond."

The manager was well qualified and experienced in managing care services. They kept themselves abreast of developments in the social care sector by liaising with healthcare and social care professionals, seeking advice from other managers and reading social care publications. They told us they intended to start attending provider forums organised by the local authority.

Staff told us they had regular team meetings and records confirmed this. The items discussed included the needs of people who used the service, communication, time keeping, activities, health and safety and training. There were also regular team leader meetings, where subjects such as medicines, safeguarding, teamwork and care plans were discussed. There were also monthly managers' meetings where relevant operational matters were discussed.

There were systems to seek feedback about the standards of care provided and to identify any areas in which the service could improve. These included regular meetings with people who used the service and relatives. The provider undertook satisfaction surveys of people and relatives. The outcome of these were analysed and any areas for improvement were discussed in meetings and used to improve the service. We saw a recent survey sent in October 2018 which showed that people were happy with the service. Comments included, "I would like to say how much I appreciate the care and support I have been given", "I cannot speak too highly of the staff of Kent Lodge, who care for my [family member] with kindness and good humour at all times" and "Staff are kind and always cheerful."

This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered person had not made suitable arrangements to ensure that medicines were managed safely.</p> <p>The registered person did not always assess the risks to the health and safety of service users of receiving care and treatment and did not do all that was reasonably practicable to mitigate any such risks.</p> <p>Regulation 12 (1)(2) (a)(b)(g)</p>

### The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered person did not have effective systems to assess, monitor and improve the quality of the service</p> <p>The registered person did not always assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.</p> <p>The registered person did not always maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.</p> <p>Regulation 17 (1)(2) (a)(b)(c)</p>

### The enforcement action we took:

We issued a warning notice.