Abbeyfield Society (The)

Kenton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Kenton House is a residential care home providing accommodation and personal care to up to 11 people. The service provides care and support to older people some of whom live with dementia. At the time of our inspection there were 10 people using the service.

People's experience of using this service and what we found
The provider did not ensure that the systems they had in place to assess, monitor and improve the quality and safety of the service for people were always effective. The provider had not identified the issues we found on this inspection.

The service management and leadership, and the culture they created did not always support the delivery of high-quality, person-centred care. There was no registered manager at Kenton House. The home was being managed and run by a senior care team leader with support from a regional manager. However, due to staffing issues the senior care team leader was often working long shifts carrying out care and other tasks ,including management administration and medicines tasks. Therefore, it was not clear how they had the time to complete the many managerial responsibilities despite receiving some support from the regional manager.

Due to staff shortages some staff had worked a significant number of hours above their contracted weekly hours. Staff were at risk of extreme tiredness, which could affect their capability to effectively and safely carry out their duties, which could put people at risk of harm.

Care plans were not always personalised and in place for people's specific health conditions. So, we could not be assured that peoples' needs were fully understood and met by the service.

Suitable infection control practices helped to prevent and control the spread of infections including COVID-19.

Arrangements were in place to protect people from abuse. Staff had received training on how to safeguard people from abuse and were aware of the procedure to follow if they suspected that people were subject to abuse.

People were supported to access the health services they needed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 10 January 2018).

Why we inspected
We received concerns in relation to the management of medicines, staffing, quality monitoring and people's care. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We have found evidence that the provider needs to make improvements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staffing, person centred care and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

We have made two recommendations, one about equality and diversity and the other about the Mental Capacity Act.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Kenton House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and one 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.

Service and service type
Kenton House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Kenton House is a care home without nursing care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback about the service from the host local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection visit we spoke with five people using the service, two relatives, one senior team leader, one senior care worker, one care worker, one domestic member of staff, the activities co-ordinator and a cook. We briefly spoke via telephone with the regional operations manager. We reviewed a variety of records which related to people's individual care and the running of the home. These records included; care files of four people living in the home, four staff records, audits and policies and procedures that related to the management and running of the service. Following the inspection visit we spoke with five relatives and four staff by telephone.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- It was not evident that the provider had ensured there were always enough staff on duty to ensure that people were safe and their needs were met.
- Considering people's range of needs, including where people needed more staff time because of their overall needs/specific nature of their individual needs, we were not assured that the staffing needs and skill mix had been determined to be suitable and safe. During the inspection we observed that some people using the service were needing and requesting considerable support and assistance from staff. One person was observed to be wandering around making anxious sounds and needing frequent reassurance from staff.
- There were only two staff on duty (a senior care worker and a care worker) until an agency care worker joined them later. One person frequently requested staff to engage with them. This meant at times these staff needed to attend to the person whilst in the process of carrying out tasks such as medicines administration and breakfast preparation (there was no cook during breakfast). This could impact on people's care and safety. Staff were also having to answer people's call bells which rang several times during the inspection.
- From observation and information in people's care plans it showed that some people had significant dependency needs. One person had recently been discharged from hospital and at the time of the inspection, required two staff to assist them with personal care.
- The staff rota during July and part of August 2022 showed there had been several shifts where only two staff had been on duty and no registered manager. Some staff told us that during some shifts they felt there were not enough care staff to ensure people were safe and received the care they needed. They informed us that the numbers of staff on duty had recently been cut from three staff to two, which meant that when one staff was administering medicines there was only one member of staff available to provide care for people.
- There had been a recent incident where one person at risk had left the home in the late evening without staff being aware they were missing. Staff told us that at the time the person went missing there were only two staff on duty, who at the time were supporting one person on the first floor, so the ground floor had been left unattended. One person commented about that recent incident, telling us that they had found the incident "unsettling."
- One person using the service told us, "Some residents need three staff for help, it's hard but staff do manage to finish all in the end. I am not sure if more staff would help, probably yes."
- Staff rota records showed that some staff had worked a significant number of hours during some weeks in July and August 2022. For example, one staff had worked 81 hours in one week. They had only one rest day within 10 days (8 of those days they had worked a long day shift/13.5 hours). Another staff had worked 73.5 hours in one week. Records showed that some staff had worked back to back shifts such as an afternoon shift (7 hours) and then a wake night shift (11.5 hours). One staff had worked an afternoon shift, then a night

shift, then 4 hours on a day shift, with a wake night shift following that. Another staff worked a 13.5 hour day shift then straight on to a night shift (11.5 hours), then an afternoon shift and then a wake night shift before having a rest day. There was no indication that people were harmed but staff were at risk of being excessively tired which could have an impact on people's care and safety.
● We observed at one point during the morning that five people were in the lounge, two of them took part in the exercise and one person sang, no staff were present to encourage everyone to take part and ensure people remained safe. It was not clear how the current staffing arrangements enabled people to be supported by staff to go out in the local area when only two staff were on duty and the activities coordinator was working.
● Following the inspection in September 2022 we were informed by a member of staff that there were still two care staff on duty during the morning, afternoon and night, and an interim manager had commenced working in the home.

The above demonstrates a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us that teamwork could be better. They told us about two incidents where staff had shouted at each other in front of people. Records of recent staff meetings indicated that there was some disharmony within the staff team.
● The provider had proper recruitment and selection systems in place to help ensure that only suitable staff were recruited to assist people with their personal care and support needs. These included obtaining and verifying references, checking gaps in employment history and carrying out Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management
● The provider had policies and systems in place to monitor, assess and minimise the risk of people being harmed and to keep them and staff safe.
● People and/or their representatives were involved in all decisions to minimise potential risk. Risks associated with people's care, self-neglect, medicines, eating and drinking and other needs had been identified, assessed and documented within their care records. Guidance was in place for staff to follow to manage identified risks, reduce the risk of people being harmed and to support their independence.
● People's care records showed that some risks had been reviewed and updated when people's needs changed to help ensure that staff have up to date information about meeting people's individual needs safely.
● People told us they felt safe. Comments included, "I feel completely safe because staff are around and they help. I call them or they come to check if everything ok" and "I feel safe."
● Regular health safety and maintenance checks were completed to ensure equipment and the premises were safe to use. The service had assessed fire risks and equipment was available to support people to evacuate in the event of an emergency. One person told us, "Staff are very good at doing mock fire drills regularly, to keep everybody very safe." Relatives told us they felt people were safe.
● We noted that according to records a fire drill had not been carried out since March 2022. Following the inspection, a member of staff informed us that in September 2022 staff had received fire training, which had included a fire drill.

Systems and processes to safeguard people from the risk of abuse
● The provider had processes and systems in place to protect people from the risk of abuse and keep them safe.

● Staff had received training about safeguarding people and knew how to recognise potential signs of abuse and that they needed to report all allegations and suspicions of abuse without delay.

Using medicines safely
● There were policies and systems in place to make sure medicines were managed and administered safely and to ensure improvements were made and lessons learnt when shortfalls were found. We found two medicines issues that needed to be addressed. Following the inspection visit we were provided with information that showed appropriate action had been taken to deal with the issues. This included minimising the risk of similar issues happening again by reminding staff of medicines best practice.
● Medicine administration records (MAR) were completed appropriately and regularly audited.
● Before administering people's medicines, staff received medicines training and had their competency to manage and administer people's medicines safely assessed.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using personal protective equipment (PPE) effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Visiting was carried out in line with current government guidance. Relatives visited people without restrictions.

Learning lessons when things go wrong
● It was not always clear whether lessons were learnt when things go wrong.
● Accident and incident records included details of each incident; however, the paper incident forms were not always fully completed. We found examples where the section of the form for recording details of 'lessons learnt and subsequent action planned to mitigate future risk' were blank. It was not clear from those records whether any action had been taken to minimise similar events reoccurring. We were informed by a senior manager that this information had been recorded electronically. However, the electronic incident/accident records we were provided with indicated that only one out of nine incidents had been investigated and lessons had been learnt.
● Following the inspection, we were provided with 'analysis' of incidents that had occurred during the last twelve months. This indicated that 85% had full, accurate information, logged within 24 hours. However,

there was no indication from that or the electronic records that action had been taken to make improvements or to determine whether there were any patterns or trends, which could help to lessen the risk of similar incidents happening again.

The above demonstrates a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had received an initial assessment of their care needs and preferences before they were admitted to the home. However, people's care plans and risk staff did not always show that staff had the guidance they needed to provide people with high quality personalised care.
- There were some people living in the home who exhibited distressed behaviour that at times challenged the service. Some people and staff spoke of the impact on them of these behaviours. One person told us that there were, "Issues with residents who because of their condition shout or kick off swearing. Staff do let them swear but make sure others are safe. Staff keep watching, generally all goes well in the end."
- Staff told us there were three people whose actions were challenging at times. These included; swearing, saying racist words to staff, kicking, shouting and punching. Staff told us there was a lack of consistency about the way staff had responded and managed people's actions and that some people living in the home were afraid of these behaviours.
- Records showed that one person during the last few months had exhibited distressed behaviour on ten occasions and at times had shouted and hit out at staff. There was no care plan with written guidance to help support the person and help staff understand and manage this behaviour safely. This could mean that people had been admitted to the home when possibly another more suitable environment would be more appropriate.
- One person did not have care plans for; glaucoma (eye condition, blurred vision is a symptom), Alzheimer's Disease (type of dementia that affects memory, thinking and behaviour and for their distressed behaviour. Another person had a mental health condition. The lack of assessment information and guidance, meant people could be at risk of not receiving personalised, consistent safe care. We were provided with a glaucoma care plan that had been completed following the inspection.
- Some people had diabetes (this causes too much sugar in their blood) and can cause serious health problems if not treated. However, at the time of the inspection care plans and risk assessments were not available to provide staff with guidance in how to manage and minimise the risk of this condition. For example, there was no information how staff should support a person when experiencing high or low glucose (sugar) levels and the risk this may have on the person's health. Following the inspection we were provided with one person's reviewed care plan, this recorded that the person had diabetes that was diet controlled but there was no detail about what kind of diet this was or guidance about responding to symptoms that included high and low blood sugar levels.
- One person's care records showed they had a personality disorder and in another record, schizophrenia. Therefore, it was not clear what mental health condition the person had. There was no care plan about the condition or guidance that showed the service understood and supported the person's mental health

needs. Detailing the personalised symptoms of the person's condition and impact it had on their life and providing guidance for staff to support the person with managing it, could help ensure the person's mental health needs were fully met.
● We were informed by the quality and compliance manager that care plans for these needs would be developed.

The above findings demonstrate a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People's cultural, religious and dietary needs were recorded, but there was little detail about how they impacted on their lives and well-being. For example, one persons' care records stated the person was 'passionate about [their] religion and beliefs'. However, the only information in the person's records was that they did not eat pork, there was nothing written about any other aspects of the religion including festive days and how they were supported to practise their faith. After the inspection a senior manager told us that the person 'is no longer practising [their] religion. We will amend his care notes to reflect this.' There was no information provided about the reason for this change or whether the religion's festive days would still be acknowledged by the service.
● Another person's European country of birth was detailed in their care records, however, there was nothing written that showed that this had been discussed with the person and whether there were ways that staff could support the person in celebrating their culture.

We recommend that the provider considers appropriate guidance to ensure people are protected from discrimination and their differences are recognised, respected and valued.

● The home employed an activities coordinator for three hours a day during weekdays. During that time people had opportunities to participate in a range of activities. The activities coordinator spoke passionately about supporting people to take part in activities that were meaningful to them and enjoyable. Group and one to one activities took place. These included, exercises, arts and crafts, crosswords and board games. However, outside those hours and particularly during weekends it was not clear how people were supported to take part in activities of their choice, including going out when there were only two staff on duty. During the inspection, one person went out with a friend.

Staff support: induction, training, skills and experience
● Staff received the provider's mandatory training. We were supplied with the staff training matrix following the inspection. This showed that most staff were up to date with their training, which included, pressure ulcer prevention, food safety, equality and diversity, First Aid at work, oral health awareness and medicines awareness. A member of staff told us they had also received some training about dementia, mental health and diabetes.
● Staff told us they had received an induction when they started working in the home. Their views about the quality of the induction were mixed. One staff told us they felt their induction had prepared them for carrying out their roles and responsibilities. Two staff were less positive about their induction, one provided an example of having been asked to do a task they had not been fully prepared for.
● Staff had been supported to complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and care sectors. It is made up of 15 minimum standards that should form part of a robust induction programme.
● Staff had mixed views about the support they received. Two staff told us they hadn't had a supervision meeting with a senior member of staff for some time. One staff told us, "I can't remember when I last had

one." This meant staff did not always receive appropriate ongoing or periodic supervision in their role to make sure they were supported and their competence was maintained.

This further demonstrates a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff spoke of there being a lack of teamwork and the working environment being not always pleasant.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support from staff to eat and drink enough. They had nutrition and hydration care plans that detailed their dietary needs and preferences. However, staff informed us that the evening meal was at approximately 17.30 and the next meal was not until breakfast from 8.00 am. One staff told us there was a "limited amount of food to make snacks and they weren't encouraged to offer them. People are just offered biscuits and a cup of tea". If someone asked for a sandwich, they told us they would make it but that generally people due to their needs did not request anything.
● The home employs a cook, who was knowledgeable about people's dietary needs and preferences. Most people were satisfied with the meals. However, one person told us, "Regarding food in Kenton House, its adequate. They do provide meals and that's about it. I cannot recall when we had freshly made cake, we are supposed to have at 4pm cake and tea, [but] it's usually tea and biscuits as it is at 11 in the morning."
● There was a four week rolling menu. The meals during the inspection reflected those on the menu. Each day meat and vegetarian option. People were offered a choice of meals during the inspection. The details of the day's meals were displayed on a white board. This information was unlikely to have been accessible to every person using the service. Following our feedback, we were informed that accessible menus had been provided.
● People's weight was monitored. Staff knew they needed to report changes in people's appetite and food preferences. One person's relatives spoke of the support and encouragement their family member had received from staff when the person's appetite had lessened. They told us staff had "tried with boosting [person's] appetite with special milkshakes."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with other agencies to make sure people received the care they needed and wanted. People were supported to access health services, when required. These included hospital appointments and chiropody and eye care and treatment.
● When we asked if people received dental care, we were informed by senior management that the home was 'trying to negotiate a service for residents.' People had oral (mouth) care assessments, which were personalised and detailed their mouth care needs and routines. However, according to records, one person's oral assessment had not been reviewed since 03 June 2021, so any changes may not have been identified.
● Records showed that people saw a doctor when required. Staff informed us that a GP reviewed people's needs regularly.

Adapting service, design, decoration to meet people's needs
● Some parts of the environment due to chipped paint needed redecoration. Flooring in some bathroom floors was stained. Senior management told us that there were plans to carry out refurbishment. One person told us they had moved into another bedroom whilst theirs was being redecorated.
● There were unsightly items including an old mattress that should be removed from the back garden.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Staff received training in understanding the MCA legislation and its implications for people. However, some staff we spoke with were unclear about the principles of MCA and DoLS.
● Some mental capacity assessments detailed when people did or did not have the capacity to make decisions such as about going out, doing their own personal care and managing their own medicines. However, it was not always clear in some people's mental capacity assessments what the particular decision was being assessed. One person's mental capacity assessment stated '[Person] has a diagnosis of Alzheimer's and unable to make decisions.' There was no record provided that showed whether the person could make some decisions such as what to wear and eat.
● The staff we spoke with understood the importance of gaining people's consent before providing care and support and promoting people's rights and choices.
● Some people had DoLS authorisations. During the inspection the senior team leader, following advice from the host local authority had started to complete applications for further DoLS.

We recommend the provider considers current guidance on the Mental Capacity Act and then updates people's mental capacity assessments and shares that information and learning with staff.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At the time of the inspection the care home did not have a registered manager. A senior care team leader was managing the service with oversight and support from a regional manager.
- People spoke about the lack of registered manager, comments included, "It would be nice for staff to have an official manager we could call for any issues, but its only acting manager". One person spoke about the provider, "I do know that Abbeyfield is huge national organisation with many services around the country and I am not surprised that nobody from head office ever come for visits."
- Relatives told us, "Right now we know that there is no manager and its like that for like several months, they do need to do something about it" and "They will have to appoint somebody sooner or later!"
- Some people's relatives told us they had not been asked for their feedback about the service.
- Although the provider had systems in place to monitor the quality of the service and to make improvements when needed, these were not always effective. We identified areas of the service where improvements were needed or could be developed, to ensure people were safe and received effective personalised care. These included the need to ensure that people's care plans met each person's specific needs and there was always sufficient staff on duty to provide people with personalised, safe and effective care.
- A range of checks were carried out of areas of the service including medicines audits. However, the records of these did not always show who had carried them out, and the exact date of the checks. We were provided with one person's care plan that had been reviewed after the inspection. There was no record of who had reviewed the care plan and whether the person and where applicable the person's representative had been involved in that review. According to records, some of these checks had not been completed in line with the provider's timescales.
- The provider's 'Monthly Quality assurance Monitoring' check of the service at Kenton House had not been completed since April 2022. Therefore, shortfalls in the service may not have been identified and improvement actions implemented within reasonable timescales.
- A care plan audit noted the person's risk assessments had not been reviewed since 2020 but did not include an action plan with time scales for addressing this. The other audit showed that there were a significant number of areas where the person's care plan lacked significant information and needed improving. It was not clear from both audits who had completed them.
- The provider did not assure us that action was always taken to minimise the risk of similar incidents reoccurring. Electronic incident/accident records we were provided with indicated that only one out of nine incidents had been investigated and lessons had been learnt. In June 2022 one person who needed support

when going out had managed to open a side gate, they were assisted back inside by a member of staff. In August 2022 the person left the premises unseen by staff and was later found by police. This indicates that quality assurance systems had not been effective as action had not been taken after the first incident to minimise the risk of a similar incident happening again and that lessons had been learnt, so the person was at risk of being harmed.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We observed positive engagement between staff and people. Staff knew people well and endeavoured to ensure people received effective personalised care. However, they told us that the staffing numbers did not always support this.

● Feedback from people using the service was positive, comments included, "I feel very much as at home" and "It's a nice atmosphere, we have space if we want to be alone, or if we want to spend in company".

● Relatives also told us they were satisfied with the care people received. Comments included, "[Person] is very comfortable here and we could not be happier that people in Kenton House are looking after [them]. They told us that when issues had been raised by them, they had been addressed and they were kept informed about their relatives living in the home.

● The residents' meetings were chaired by a person living in the home. Records showed that people had participated in resident meetings and raised issues about the service. However, there were no written action plans, so it was not evident that those issues had been addressed. One person told us, "We have meetings with other residents, everybody is welcomed, last one was two weeks ago, we were planning to go to the local cricket green to watch a game. Then long term planning was about going to seaside, I am not sure how far organising it has gone."

● One staff told us about the importance of talking with people to get to know them. They told us about people's interests and that talking about interests helps to "understand them better and build a better relationship with them."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider was aware of the duty of candour and their legal responsibility to be open and honest.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Records showed that staff had engaged with people about their views of the service during resident's meetings. A feedback survey had been carried out earlier in the year, this showed people who took part in the survey were satisfied with the service.

● People told us they made choices and they spoke in a positive way about the care they received. Comments included, "I shower twice a week and it's my choice; I presume I can have more if I like but I don't. Nobody rushes me and they do try to keep me independent so I try a lot for myself" and "I feel well looked after."

● A range of topics to do with the service were discussed during staff meetings. These included health and safety, safeguarding people and learning and development. Some staff told us that they felt they had not been listened to and that "nothing" was done when they raised issues to do with the service. A recent staff feedback survey showed that staff were dissatisfied about a number of issues including teamwork.

● A person's relative told us, "What Kenton House should improve is communication between us, relatives

and head office. We had and email sometime in March 2022 from new area manager who said they will be looking to improve things and nothing from that list has come to be realised."

● Staff knew the importance of respecting people's differences. One staff told us, "Everyone is given the same treatment regardless of nationality race sex and other characteristics." However, people's care plans could include more detail about people's equality needs and show more consideration of people's protective characteristics as identified in The Equality Act 2010. This could help to ensure that people's individual needs were understood and reflected in the delivery of their care.

Working in partnership with others

● Records showed that the service had worked with healthcare professionals, such as GPs and chiropodists and in supporting people to attend clinical appointments. However, with regard to some people's health and other specific needs, people's well-being and care could possibly benefit from additional engagement with healthcare specialists to assist staff and people in managing those needs.

● Records showed that the previous manager had attended the host local authority provider forums where a range of topics to do with health and social care had been discussed and best practice guidance shared. A senior member of staff told us that when a manager had been recruited, they would attend these sessions.

● During staff meetings, a range of issues about the service and improvements and learning were discussed. During a recent meeting, staff had been reminded to ensure they maintained the cleanliness in the home.

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 was failing to ensure people received care and support in line with their all their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not ensure that it always operated effective systems to assess, monitor and improve the quality of service provided to people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not demonstrated that they had deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that people were safe and their needs were met.