ADR Care Homes Limited

Keneydon House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Keneydon House is a 'care home'. People in care homes receive accommodation and nursing or 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. Keneydon House is located in the town of Whittlesey. The service can accommodate and support up to 21 people with their personal care.

This unannounced inspection took place on 12 and 19 November 2018. On the first day,17 people were receiving the service. On the second day of our inspection, 18 people received the service.

The service did not have a registered manager. The last registered manager left the service in August 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection a senior care worker was managing the day-to-day running of the service.

The provider lacked oversight of the service and there was a lack of robust systems and controls in place to protect people and keep them safe. Governance systems, audits and checks were ineffective and failed to identify shortfalls in the service and bring about improvement.

There were significant risks associated with fire safety, assisting people to move, people choking, people's food and fluid intake, and the use of equipment that had not been managed adequately and mitigated. People's prescribed medicines were not always managed safely. The internal environment of the building did not help people to find their way around or engage in everyday life.

There were not enough staff with the right skills to meet people's assessed needs at all times. The provider did not have robust checks in place to ensure they recruited suitable staff. Staff had not received effective training to enable them to meet the needs of the people using the service. Staff lacked understanding on how and when to report incidents that occurred.

People with short term memory loss were not supported adequately to make choices about the meals they would like to eat. People were not always provided with appropriate equipment to help them eat independently. Staff were not all aware of people's dietary needs.

Staff lacked understanding in relation to gaining people's valid consent. Staff did not involve people in decisions about their care. Staff did not always respect people's personal preferences about the way they wanted to be supported. Staff did not always support people to maintain their dignity and respect their privacy. People had access to healthcare professionals when needed.

People did not receive personalised care that was responsive to their needs. Staff did not always support

people in a consistent and planned way. Care plans lacked detail to inform staff on the type and level of care people needed to meet their individual and diverse needs. Staff did not have enough information on how to meet people's end of life care needs. Staff did not encouraged people to take part in meaningful activities and they were left unsupervised, unoccupied and unstimulated.

The provider did not demonstrate that complaints received were investigated and resolved to the complainants' satisfaction. Records were not always up to date and accurate.

The provider did not have systems in place to ensure they were up to date with best practice. The provider had not notified the CQC of all incidents that it was legally obliged to let us know about.

Following this inspection, we sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We requested an urgent action plan from them telling us what they were going to do at once to address them. An action plan was returned the next day. We also shared our concerns with the local authority and their safeguarding team.

The overall rating for the service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If no improvement is made within this timeframe so that there will still be a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate in any of the five key questions it will no longer be in special measures. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff lacked understanding on how and when to report safeguarding incidents that occurred.

Fire safety was not managed adequately and risks to people's health and welfare were not identified and mitigated.

Staffing levels and skill mix were not sufficient to meet people's individual needs at all times. Robust checks were not in place to recruit staff safely.

People's care records and risk assessments were not always updated as guidance for staff to meet their current needs.

People's prescribed medicines were not always managed safely.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had received sufficient training and induction to ensure they had the knowledge and skills to carry out their roles and responsibilities and meet people's needs. Staff competency was not assessed.

People with short term memory loss were not supported adequately to make choices about the meals they would like to eat. People were not always provided with appropriate equipment to help them eat independently. Staff were not all aware of people's dietary needs.

Staff lacked understanding in relation to gaining people's valid consent.

The internal environment of the building did not help people to find their way around or engage in everyday life.

People had access to healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always support people to maintain their dignity.

Staff did not always respect and maintain people's private information.

Staff did not always consider people's comfort and involve them in their care. Staff did not always respect people's personal preferences about the way they wanted to be supported.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive personalised care that was responsive to their needs. Staff did not always support people in a consistent and planned way.

Care plans lacked detail to inform staff on the type and level of care people needed to meet their individual and diverse needs. Records were not always up to date and accurate.

Staff did not encouraged people to take part in meaningful activities and they were left unsupervised, unoccupied and unstimulated.

The provider could not demonstrate that complaints received were resolved to the complainants' satisfaction.

Staff lacked guidance on how to meet people's end of life care needs.

Is the service well-led?

Inadequate

The service was not well-led.

Support and resources needed to run the service were not available and the provider was not operating the service in line with their own mission statement and philosophy of care.

There were widespread and significant shortfalls in the way the provider was leading the service. The provider failed to ensure there were robust systems in place for effective oversight and governance.

There were no systems in place to ensure staff had the right knowledge, skills and confidence to support people in a safe manner.

Links had not been established with other organisations to keep up to date and take part in initiatives to improve practice.

Notifications of incidents, that the provider was legally obliged to report, were not always notified to the CQC.

Keneydon House

Detailed findings

Background to this inspection

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

This inspection site visit took place on 12 and 19 November 2018. This inspection was partly prompted by an incident which had a serious impact on a person using the service when they were scalded by a hot drink. This indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks. The inspection was also partly prompted by concerns raised about the service prior to our visit. These concerns related to the management of the service, staffing levels, staff competence, attitude, and ability to meet people's needs.

The inspection visits were unannounced. Two inspectors carried out the inspection on 12 and 19 November 2018. An inspection manager joined the inspection on the first day. We started our visit on the second day at 6.45am to enable us to speak with night staff.

Prior to our inspection we reviewed information sent to us about the service from representatives from the local authority contracts and safeguarding teams. We looked at the notifications received from the provider, and at other information we hold about the service. A notification is information about important events which the service is required to send us by law.

During this inspection we spoke with three people living at the service. We observed how staff interacted with people who lived at the service to help us understand the experience of people who could not talk with us due to complex health needs.

We spoke with a senior care worker who was managing the day to day running of the service (referred to in this report as the 'acting manager)'. We also spoke with three other senior care staff, seven care workers, an activities co-ordinator, a cook/senior care worker and a maintenance person. We also spoke with the registered manager of another of the provider's services who was present for part of the inspection. We looked at care records for eight people living at the service, medicines records, two staff files, staff training

records and other records relating to the management overview and running of the service. These included policies and procedures, accident and incident records and audits.

Inadequate

Is the service safe?

Our findings

Fire safety arrangements were insufficient. The provider had not reviewed the home's fire risk assessment to ensure it was still relevant and valid, and they had not carried out a fire drill in over a year.

On the first day of our inspection the emergency escape plan was incorrect. Senior staff had not revised the document to reflect the current number of people accommodated in the home following one person's admission to hospital. When we pointed this out, the acting manager from another of the provider's services updated the document.

Personal emergency evacuation plans (PEEPs) identify the level and type of assistance each person requires during an emergency evacuation. These were not centralised to enable quick and easy access for staff, or others, in an emergency. They were limited in detail and did not consider essential information for a safe evacuation such as a person's level of awareness and co-operation, vision or hearing impairment or any medication prescribed that may cause drowsiness. Some PEEPs were inaccurate and had not been updated as people's needs changed. For example, one person's PEEP stated they could walk with a Zimmer frame. However, staff told us this person had not been able to walk for several months. This meant accurate information was not available to those assisting people in an emergency.

Staff had not received adequate training in fire safety. Records showed that eight of the 26 staff had not received any fire safety training. This included a staff member who was due to work that night. The remaining staff had completed fire safety awareness through e-learning. However, they had not received training in the practical aspects of evacuation procedures for all people using the service and how to move people quickly including the use of the evacuation sledge.

The acting manager told us they had recently attended Fire Marshall training. They believed this training was also meant to enable them to train other people. The provider had informed them that they were to cascade the training to the rest of the staff at Keneydon House. They told us that they did not feel confident to deliver the training effectively.

We wrote to the provider asking what action they would take to address these issues as a matter of urgency.

On the second day of our inspection the acting manager told us they would be delivering the training supported by another of the provider's employees. They had also briefed staff in the fire procedures and the use evacuation equipment. However, some staff said they were still unclear about what fire extinguishers to use and did not feel confident in using the evacuation sledge.

We found a fire door propped open with an armchair, stopping the self-closure device from working. This meant the person in the room would not be protected by the fire door in the event of a fire. Another person liked to lock their door overnight. Staff were to have access to a key for emergencies, such as a fire. However, a night staff member did not know where the key was kept and therefore was unable to access the person's room in an emergency. We reported our concerns to the fire safety and rescue service.

Staff did not receive adequate training on how to help people to move safely, putting both staff and people at risk of harm. Five care staff had not received practical training in how to move and transfer people safely with the right equipment. Staff raised concerns about the quality of the training they had received and some said their training had not included how to use key pieces of equipment such as hoists and slide sheets. The provider did not assess staff competency in moving and transferring people safely.

Staff demonstrated little understanding of safe moving and handling techniques and used only stand-aids to move and transfer people. Staff should only use this equipment for people who can support their own body weight using their legs, have good body and head control and are able to hold on. This equipment enables a person to pull themselves up into a standing position. On our second visit we saw two staff members trying to move a person using the stand aid. The person was sleepy, uncooperative and unable to hold on. The use of this equipment was therefore unsafe and put the person at risk of harm. A senior staff member intervened and stopped staff, instructing them to use a hoist with a full body sling instead. The staff did not know how to use the hoist and needed detailed instruction from the senior staff member. However, they had not checked the equipment to ensure it was fit for use and found the battery was flat and had to wait for it to be charged. This failure to maintain equipment significantly delayed the person receiving the care they needed.

Staff also told us when they used the stand-aid for another person who did not always co-operate with them, a staff member stood on the equipment to prevent it from toppling over. This put the person and the staff at risk of harm.

Moving and handling risk assessments and associated care plans did not cover people's individual moving and handling needs for both day, night and in case of emergency. They lacked detail to include the extent of the person's ability to support their own weight, co-operate and other relevant factors such as pain or spasm. They also lacked relevant and current information about the type and size of moving equipment people needed; one care plan had conflicting information about the size of sling and attachment loops to use. Incorrect choice of loops for an individual could put them at risk of harm from falling out of the sling.

People with dementia and/or Parkinson's Disease are more susceptible to having swallowing difficulties (dysphagia). Arrangements for improving the safety of individuals with swallowing difficulties from the potential risk of choking risk, were insufficient. The acting manager had recognised seven people had swallowing difficulties and were at risk of choking and had referred them to the speech and language therapist (SALT), for assessment. Five people were still waiting for SALT assessment and the senior carer had not chased up the referrals. Interim arrangements were not in place to help minimise their risk from choking while waiting for assessment.

Throughout the first day of our inspection we heard a person cough and splutter during and after a drink. They were continually trying to clear their throat; a symptom of dysphagia with a potential risk of choking. The person had a risk assessment in place for the risk of choking. However, it was insufficient and did not guide staff on what to be aware of and how to minimise the risk, for example positioning, small sips, specific food stuffs, what to avoid etc. The assessment stated to give 'pureed food' but this was not observed at lunchtime when they were given mashed potato, baked beans and fish cake.

The tool used for assessing risk for people in relation to eating and drinking and choking did not consider all associated signs and symptoms that show a person may have swallowing difficulties. Therefore, staff were not informed and guided to recognise if people were developing changes that could directly affect their eating, drinking and swallowing function. Such as coughing during and after a meal or drink, taking a long time to swallow, drooling of saliva or clear discomfort in swallowing - particularly tablets. Some staff had

undertaken basic e-learning in dementia awareness but this did not cover the wider risks related to dementia, such as dysphagia.

Some people were prescribed thickeners for their fluids to reduce the risk of choking. However, there was a lack of information to guide staff on how thick the fluid for each person should be. Having fluids too thick is as dangerous as too thin. If the fluid is too thick it may stick in the throat, if the fluid is too thin it can go into the windpipe. Both can increase the risk of coughing and choking.

The provider had failed to ensure people's care was co-ordinated or managed effectively and their specific needs met safely. Staff did not have enough guidance within care planning documentation on the type and level of support people needed to meet their needs and keep them safe in a consistent way. Risk assessments did not have clear individualised care planning strategies in place in relation to people's dementia related needs, moving and handling, nutritional needs and falls.

There was insufficient oversight of people's fluid intake. One person had a long-term catheter in place and records showed they had needed medical intervention three times in the last nine months. Their risk assessment informed staff of the need to record fluid input and output to ensure they drank adequate amount of fluids. However, staff did not always record in the person's fluid charts and daily measurements were not totalled. The measuring, recording and monitoring of fluid intake and output are particularly important for people requiring a catheter to manage their continence. An imbalance can identify emerging health risks such as a blockage, a urinary tract infection (UTI) and dehydration. Oversight arrangements failed to ensure fluid charts were properly managed and monitored. By not monitoring fluid output effectively emerging risk relating to a potential blockage of a catheter, UTI or dehydration would not be identified to enable prompt action.

The provider had not trained staff and ensured they understood how to use the new stair-lift. One staff member said, "We tried using it but couldn't get it going." This resulted in two staff having to support a person up a flight of stairs because they could not get the stair-lift to work, placing them all at risk of potential harm. Stair-lifts have a 'winder' to be used to move the chair if the stair-lift gets stuck. A staff member told us the 'winder' on a second stair-lift had been lost for some time and they did not know how to move the stair lift if it got stuck to get people to the top or bottom safely.

Two of the service's three bathrooms were being used to store equipment and or furniture. In one bathroom the bath had been removed leaving exposed pipework and brickwork. Neither room had been locked and could be accessed by people exposing them to risk of harm.

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

Safeguarding concerns and incidents had not been effectively recorded or investigated. The provider had not developed and trained their staff effectively to fully understand safeguarding and to properly apply policies and procedures when circumstances needed it. During our second visit to the service staff told us of three incidents that should have reported to the local authority for investigation, but were not. Two incidents were of a person who received the service hitting another, the third incident was of a person swearing at another. Staff had recorded only one of these incidents, on a poorly completed incident form. Senior staff took no further action. The reluctance to report issues and concerns which may constitute abuse, potential mistreatment, neglect or risk of serious harm to the local authority and to the Commission is of serious concern. Following our inspection, we immediately referred these incidents to the local

authority safeguarding team for investigation.

People were at risk of repeated safeguarding incidents as there were no care planning arrangements recorded to guide staff on how to support individuals and help to prevent further incidents triggered by features of their mental state and dementia related needs.

Records showed that nine of the 26 staff employed had not received safeguarding training. All staff told us they would refer any concerns to senior staff. However, they were not all aware of the external agencies they could report their concerns to. In addition, senior staff did not recognise that physical assaults between people using the service should be reported to the local authority.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The providers systems for deciding staffing levels and shift planning were ineffective and did not ensure there were enough numbers of staff to meet people's needs. Following a revision of people's dependency levels staff told us more staff were needed to meet people's needs effectively. The provider was recruiting new staff to increase staffing numbers. However, for the interim period staffing rotas showed the provider had not taken steps, for example employing temporary agency staff, to ensure there were enough staff working always, to meet people's needs safely and effectively.

Records showed, and staff told us, that the numbers of staff were not consistent and on some nights, there were only two staff for the whole service. This meant that while staff were assisting the seven people who required two staff to assist them to move or with personal care, other people were unsupervised. Records showed the majority of falls had occurred during the night. The acting manager told us they had noticed a reduction in people falling when there were three staff on duty overnight.

People living at Keneydon House were all, except for two people, living with varying levels and types of dementia. They needed continued support and supervision throughout the day and night to meet their needs and keep them safe. There were not enough staff to ensure appropriate supervision, occupation and monitoring to keep people safe.

On four occasions members of the inspection team had to find staff to assist people who had removed their clothes in communal areas. This clearly distressed both the people who had removed their clothes, and others in the lounges who started to shout at the person. On one occasion, two staff were helping one person in their bedroom, and the remaining two staff assisted another person, who had started to remove their wet clothes, to change in the bathroom. This left the remaining people unsupervised.

There were not always enough staff to stay in the lounge and give people the support they needed. For example, on the first afternoon of our inspection staff placed a drink on the right side of a person who had a right-side weakness. This meant they could not reach the drink. Another person using the service placed the drink into the person's left hand, enabling them to drink. On another occasion a person requested their drink hotter than served. The acting manager told staff, that for safety reasons, they could have this only if a staff member sat with them. The staff member told the person they would, "Have to wait" as there were insufficient staff to facilitate this.

The service did not have a contingency plan in place to address unforeseen staff absences and ensure there were enough staff at all times to meet people's needs, including ensuring staffing levels were sufficient and

available at all times, and to facilitate the movement of people to safety in the event of an emergency, such as a fire.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recruitment practices were insufficient to protect people from the risk of unsuitable staff. There was no evidence to show the provider had explored and recorded staff members employment history and previous employment where they had worked with vulnerable adults. The acting manager, who was responsible for staff recruitment, was unaware of the requirement to do so. The acting manager did not check the content of the Disclosure and Barring Service (DBS) check was satisfactory and was uncertain as to whether the provider did this.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's prescribed medicines were not always managed safely. One person's GP had prescribed a new medicine to help calm their anxiety. This had run out three days before our inspection without it being reviewed as to whether the medicine was beneficial to them. The senior contacted the person's GP to review this during our inspection.

Some people were prescribed medicines to be taken 'as and when required' (PRN). Where people had PRN protocols in place they were not sufficiently detailed to guide staff on the purpose of the medicine and when it should be given to ensure it was taken appropriately and safely. Staff had not considered that people's dementia related needs could affect their ability to request pain relief. Pain assessment tools to gauge a person's level of pain from non-verbal indicators such as change in behaviour were not in use. There was no guidance for some medicines, such as laxatives, on when to administer the medicines.

Staff told us they had received training to administer medicines and a senior staff member had assessed their competency in this area. One staff member said they had received training via e-learning and, "I also had to watch the seniors [give medicines] and then they watched me." The quality of the training raised concern when we saw a staff member drop a medicine on the floor and then give it the person to take. The staff member told us that the training informed them if a medicine tablet was dropped on the floor, if it had not been in the person's mouth and was not wet, it could be picked up off the floor and given to the person. This is not in line with good practice guidance which recommends the tablet is disposed of and a new one is given to the person.

At other times during our inspection we saw staff administered medicines appropriately and explained to each person about the medicines they were giving them. One person told us, "[A senior staff member] does my medicines. They know I don't want my pills until I've had my breakfast."

Overall, we found the service was clean but a hoist used to move and transfer people was very dirty. Day staff told us the night staff cleaned this equipment but night staff we spoke with were not aware of this.

Although over a third of the staff team had not received training in how to prevent and control the spread of infection, staff had a basic understanding in this subject. They wore aprons and gloves when providing personal care and washed their hands between tasks.

Inadequate

Is the service effective?

Our findings

The provider stated on their website that Keneydon House is a 'residential dementia care home'. People living at Keneydon House were at various stages of their dementia. The provider had no plan about how the service kept up to date with developments in this area to ensure the care provided was right for each person, in keeping with best practice and met people's assessed needs.

Some staff had undertaken a basic e-learning in dementia awareness. Not all staff demonstrated a good knowledge of the various difficulties people experienced in day to day living with dementia, and they were unable to tell us how they could support people to reduce their anxieties.

The provider's website claimed, 'Staff are trained to the highest standards.' We found that this was not the case and a more substantial training programme was needed to enable staff to develop the skills and expertise required to carry out their roles and responsibilities. This included being able to meet people's diverse needs and understand and recognise people's physical and mental health conditions. Moving and handling practice was poor, staff did not recognise poor practice or understand the impact this had for the people they cared for.

Staff told us most of the training the provider delivered was via e-learning. This gave staff basic information on the topics covered. One staff member described the training was "not very good." They said they preferred face to face training to help their understanding. The acting manager confirmed that the provider did not support staff with additional training in relation to people's specific needs, for example, Parkinson's Disease, dysphagia, or end of life care, to enable them to deliver safe and effective care.

The provider did not manage staff training effectively. There were shortfalls in mandatory training and not all staff had received training and/or update training in subject areas relevant to their role. For example, fire safety, health and safety, infection control, emergency first aid, risk assessment and care planning.

There was no structured induction process that ensured new employees understood their role and responsibilities. One staff member had worked three shifts at the service. They, and the acting manager, told us they were 'shadowing' an experienced staff member. However, we saw the new staff member alone in the dining room, without supervision or support, assisting people with swallowing difficulties to eat. The new staff member confirmed they had not received any training since working at the service.

Another staff member had worked at the service for six weeks. They had completed medicines training and senior staff had assessed their competency in this area. However, they had received no other training or competency assessment. Their induction record was not completed. They told us on the second day of our inspection they had only recently seen this induction record. A third staff member told us they had no earlier experience working in care. They had worked seven shifts at the service, but senior staff had only shown them how to access the e-learning four days before we spoke with them.

The induction process in use at the service had not incorporated the Care Certificate, and the senior was

unaware this was available. The Care Certificate is a recognised competency based assessment of a set of standards and introductory skills that health, and social care workers should consistently adhere to.

The provider did not have systems in place to follow up on new staff progress and there was a lack of overview to ensure that the quality expected from them was being delivered or if any further training and support was needed. This did not give new staff the opportunity or support to ensure their learning was effective and they were competent to meet the needs of people safely.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people told us the food was satisfactory. One person said, "I enjoy some of the meals. Today's was alright." They said the food was usually hot enough but that occasionally it was served before they got to the table and the food was cold by the time they got there. They told us there was, "Lots of veg."

People told us they were offered a choice of meals. We saw the cook asking people what they would like, patiently repeating the options offered. Some people struggled to understand the choices on offer and were unaware of their choice when given their meal. Despite Healthwatch, following their visit in November 2017, recommending the use of a pictorial menu to help people to make choices, the provider had not supplied this. Healthwatch is the independent national champion for people who use health and social care services.

The level of support given to people to eat and drink varied. Staff did not sufficiently support people with advanced dementia and mental health needs to ensure they ate enough. Where people were left to eat independently they had very little interaction or practical help to encourage them to eat more. One person said they were hungry, and eagerly started to eat their meal using a spoon; they were unable to scoop the food onto the spoon and it left the plate and went over the table. Despite having assisted crockery, cutlery and plate guards in the kitchen these were not brought out until we requested it. The person then managed to eat all their food. We commented to the person that they really were hungry. They replied, "I am always hungry."

Some people ate very little of what they were served and staff did not explore this further. People's weights were checked regularly and staff had identified a number of people who had lost weight. They had referred these people to the GP for onward referral to the dietician or SALT. In the interim staff were fortifying people's diets with high calorie foods such as cream and butter to help them gain weight.

Where people needed full support to eat, staff were patient and engaging, encouraging them to eat. However, a staff member was not following the care plan for one person which informed staff to approach the person from the left because they had lost the vision in their right eye. During their meal we saw the staff member seated on their right. The staff member was not aware and did not tell the person when they were approaching them with each spoonful of food.

Not all staff were aware of people's health and dietary needs. For example, that a person had diet controlled diabetes. This placed them at potential risk of harm from receiving food containing high levels of sugar.

People had access to healthcare professionals when needed. Staff referred people to their GP and community nurse appropriately and requested onward referral as needed.

People had a hospital passport in place which is a document used to inform hospital staff of the person's communication, mobility and support needs. They were not all dated, reviewed or revised to ensure they were relevant and current. For example, one person's hospital passport stated they were able to walk, but

staff told us this was no longer the case. Another person's hospital passport had not been updated to reflect the deterioration in their person's speech and that they were at a very high risk of falls because they forgot to use their Zimmer frame. Providing the hospital with inaccurate information means there is a risk people would receive inappropriate care.

Keneydon House is an older style building. The provider advertises the service on their website as a care home for people living with dementia. However, very little had been done to consider dementia related or sensory needs and the building did not provide an enabling environment to assist people with recognition and orientation. There was a lack of proper use of colouring, signage, visual clues and stimulation to assist people with recognition, orientation and stimulation. There were no relevant settings around the home such as reminiscence areas and other areas of interest; communal areas and corridors lacked stimuli to attract people's interest.

The dining room, upstairs corridors and bedrooms were dimly lit. Older people often have some form of vision-reducing eye disease and benefit from areas being well lit, reducing falls and confusion. The décor in some areas of the home was very tired with scuffed paint and cracks in the walls.

The provider had not adequately maintained the bathrooms so that people had a choice of bathing facility. The service had three bathrooms. Only one of these, which was on the ground floor and contained only a shower, was safe to use. The other bathroom on the ground floor had a notice on the bath recommending it was not to be used. The bath from the third bathroom, which was on the first floor, had been removed completely.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called 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 the service was not always working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles and the principles of DoLS had not been fully considered for people living in the service.

The provider had not properly trained and prepared staff in understanding the requirements of the MCA in general, and the specific requirements of the DoLS. Staff had limited knowledge of MCA. This lack of understanding meant issues of consent were overlooked. People's care plans had not been updated to reflect DoLS applications and inform staff on the support individuals needed to keep them safe without unnecessarily restricting them.

Risk assessments for bed rails did not take into consideration whether people could consent to their use or whether the person's mental capacity had been assessed in relation to their use. A staff member told us that they did not believe a person was able to consent to bedrails being used. However, there was no evidence that their mental capacity had been assessed in relation to this or whether the use of bedrails was in their best interest and safe.

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

Requires Improvement

Is the service caring?

Our findings

The provider states on their website that it is their 'aspiration to provide homes where people matter.' this did not concur with our findings. The provider did not run Keneydon House in a manner that promoted a caring and respectful culture. Although staff were very attentive and caring in their interactions with people, there was not enough staff to enable them to have the time to support people in a consistent, safe and planned way.

Staff did not always support people to maintain their dignity. We saw several examples during the inspection of where people's dignity was compromised. On each occasion we intervened and summoned staff to assist these people. For example, on two occasions we saw a person with their pants and trousers around their ankles in communal areas. Shortly after we arrived at the home on the second day we saw a person in the lounge exposed to other people, wearing only their pants and clutching a nightdress to their chest. Staff told us they explain to the person to keep nightdress on "because it is night time and if anyone came in they don't want to see her exposed." This demonstrated a complete lack of understanding and awareness of dementia and associated needs and behaviours, which meant people's dignity needs were not understood and met with compassionate care.

Staff did not always respect and maintain people's private information. We saw staff handover between shifts take place in a lounge in front of three people who received the service. As part of the handover staff shared private and confidential information about people using the service in front of others, breaching confidentiality.

Staff did not always consider people's comfort. For example, a person preferred to sleep in an armchair in a lounge. We asked staff if the person had a blanket or cover to help keep them warm and settled. The staff member told us they didn't have a blanket because they hadn't brought one in with them.

Staff did not always involve people in their care. We saw staff did not always speak with people when they were assisting them and other staff commented on this to us. One staff member said, "You should tell people what you're doing. I've just seen staff just do it [for example] lower the bed without saying anything. I can't just let it happen."

Staff did not respect people's private space. During the inspection we asked staff if there was somewhere we could speak with them privately. On two occasions staff suggested using people's private bedrooms. On one occasion the person was in hospital, on the second occasion the person was in lounge. Staff told us the person "won't mind." On the first day of the inspection we asked senior staff if there was a room the inspection team could use. Senior staff directed us to a room on the first floor. On the second day of the inspection staff told us this room belonged to a person living at the home and had done so during our previous visit.

Staff did not always respect people's personal preferences about the way they wanted to be supported. For example, we saw a notice in the office advising staff of the location of three people's electric razors and

reminding staff to use them. One of these people's care plan stated that they preferred a wet shave, but did have an electric razor. It was not evident that staff had supported this person to shave.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People made positive comments about some of the staff. For example, one person described the staff as, "Friendly" and said they, "Have a laugh" with them. We saw some caring interactions. For example, a staff member noticed the sun was shining in a person's eyes and asked if they would like to curtain pulled to shield them from the glare. Another staff member was very caring with a person they were assisting to move, speaking with them throughout the procedure even though the person didn't respond. A third staff member engaged people in conversation while they assisted them to eat and excusing themselves when they had to attend to another person.

Requires Improvement

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs and there was no consistent and planned approach to supporting people. People's care plans did not give staff sufficiently detailed information and guidance to give personalised care and consistent support that was responsive to their individual and specific needs, and reduce the risks to their health and wellbeing. They did not include enough detail about people's strengths and aspirations, past lives, hobbies, pastimes or social histories, which would help staff, understand the person and enable them to communicate and interact more effectively.

Some staff told us they did not refer to people's care plans. Staff said that when care plans were being reviewed these were locked in the office overnight and they could not access them. One staff member told us they were a person's key worker. A keyworker is a staff member who has a key role in co-ordinating the person's care. However, they told us they had never read the person's care plan and asked a member of the inspection team if they should read this.

There was a lack of clear guidance and key information for staff to enable them to support people with their basic care needs and specific health conditions such as diabetes, catheter care or dysphasia. For example, a person's care plan stated the person had their own teeth and needed to be supported with 'all aspects of oral hygiene' twice daily. However, it gave staff no further direction as to the level of support the person needed. A person who had swallowing difficulties, known as dysphagia, did not have a personalised care plan that explained the specific symptoms they experienced in relation to how dysphagia affected them. Care staff, therefore, did not have enough information to guide them on how to monitor and review this person, recognise when symptoms were worsening and identify any emerging increase to their risk of choking.

Another person had very red, swollen legs. Two weeks before our inspection, a doctor had advised that the person should elevate their legs. We did not see staff encourage this person to elevate their legs at all during our inspection and staff confirmed the person was reluctant to do this. The person was at high risk of falls. They had taken to sleeping downstairs in an armchair all night, had confused day and night and was prone to wandering. Care plans lacked guidance for staff on how to enable them to effectively support this person to sleep, reduce their risk of falls or keep their legs elevated. Therefore, staff did not know the signs and symptoms to be aware of, or their relevance to indicate a risk to people's health, safety and wellbeing. This meant staff may not recognise the need to act to prevent people from becoming seriously unwell.

Other care plans were vague in relation to the triggers, understanding and personalised support people, who at times presented distressed behaviour or behaviour that was challenging to others, needed. They lacked detail for staff on how to communicate effectively. Evaluations did not demonstrate what worked well or include revised and effective strategies to meet people's changing needs. We heard a person become very distressed when staff moved them and when they received personal care. The person's care plan told staff to 'reassure' the person and 'explain what you are doing.' However, it gave no advice to staff on how to effectively manage the person's anxieties.

Staff signed and dated a document to show they evaluated care plans each month. This process did not include a re-assessment of a person's needs or risk, or a revision of their care plan where needed. For example, one person's care plan it stated they were able to transfer with staff support. However, staff told us this was not the case and staff cared for the person in bed. Staff had not revised another person's care records to reflect a change in their mobility needs from walking with the aid of a frame to no longer being able to walk. Without up to date information people were at risk of not receiving the right level of assistance.

When reviewing or updating people's care plan, staff had not taken into consideration where people were experiencing an increased number of falls. Staff had not re-assessed the risk or updated their care plan to include any further actions that staff could take to help prevent any reoccurrence of the event.

Staff completed a daily communal chart that showed if people had been helped to the toilet, had their continence pad changed, passed urine, had their bowels opened or their catheter emptied. This did not demonstrate personalised care delivered in a planned and responsive way to meet each person's individual needs.

People's care records included a document called 'My life history' which had names of family and personal, memorable dates. The document lacked relevant important information about the person and how they have lived their life to enable staff to have a good understanding of the person and enable them to engage in a meaningful way that might trigger memories and pleasurable thoughts.

Where technology was used to help staff support people it was not used consistently and was not always the safest or most appropriate option. For example, one person sometimes left their bedroom and became disorientated. Staff told us of occasions when the person had been into other people's rooms without their permission. Staff placed a sensor mat outside the person's door, that alerted them when the person had left their room. We found the sensor mat was not always placed properly and posed a trip hazard and staff did not always remember to switch it on. Staff were not aware if a more appropriate sensor, such as door sensor to alert staff when the door was opened, had been considered.

An activity co-ordinator worked for 20 hours and had very good relationships with people. On the first day of our inspection, people's wellbeing improved when they engaged with the activity co-ordinator. We saw people take part in dancing, music and armchair exercises and people told us they enjoyed these and visiting the local town. We saw people became more alert, interactive and smiling when they received this stimulation. However, on the second day of our inspection the acting manager told us the activities co-ordinator had left. No staff member fulfilled this role and we saw no-one take part in any meaningful activities all day. This meant that people were left unsupervised, unoccupied and unstimulated.

There were limited resources available around the home to interest and occupy people who were living with dementia. For example, reminiscence activities or the use of familiar daily tasks to encourage physical and mental stimulation. Staff did not have time to interact in a meaningful way or meet people's emotional and social needs. We saw some people being left largely to their own devices which resulted in heightened anxiety levels and distress in the afternoon of the first day and intermittently throughout the second day of our inspection. Senior staff confirmed this was usually the case.

One person received all their care in their bedroom. They had limited contact with staff and were socially isolated. We asked staff how the person occupied their time. One staff member told us, "The person has a TV in [their] room and if I take [them] a milkshake I will try and chat to [the person]. The only time staff go to [the person] is when [the person] needs to be fed."

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

People told us that they knew how to raise concerns and were confident that the staff addressed any issues they had. The acting manager told us they had received no complaints. However, the complaints log showed the provider had received a complaint. This was undated and did not show if an investigation or action was taken as a result. This meant that the provider was unable to demonstrate to us that concerns or complaints received about the service were dealt with in line with their complaints policy and resolved, wherever possible, to the complainant's satisfaction.

Staff told us that they had not had end of life care training. Senior staff said that they worked closely with external healthcare professionals as people became in need of end of life care. However, we found staff had not always made essential preparations in relation to people's end of life care. For example, staff told us that about a person whose health condition was slowly deteriorating and that a doctor had prescribed them 'just in case' pain relief. The person's care plan did not hold this information, or any other information to indicate the person's wishes in relation to their end of life care, or whether staff had attempted to discuss this with the person, or if relevant, their relatives. The staff therefore lacked guidance on how to meet people's end of life care needs.

Several people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions in place. These documents set out the person's wishes or a decision made on their behalf by a medical doctor, in discussion with relevant family members that, in the event of a cardiac arrest, they were not to be resuscitated.

Inadequate

Is the service well-led?

Our findings

Support and resources needed to run the service were not available and the provider was not running the service in line with their own mission statement and philosophy of care. The provider's website stated this was, 'To provide exceptional care and comfort to residents during their stay at our homes regardless of their nationality, social standing or state of mind. Whilst at all times acknowledging the rights of individuals, encouraging independence and providing a safe friendly, caring support service from appropriately trained staff.' However, there were widespread and significant shortfalls in the way the provider was leading the service and the governance arrangements did not assure delivery of high quality and safe care.

The provider did not promote a clear vision in delivering high quality care and did not support staff in promoting a positive culture. The provider had a poor staff retention record and staff morale was very low and they felt unsupported by the provider.

There was not a registered manager in post and managerial arrangements and leadership in the service were unstable. The last registered manager had left in August 2018. A senior care worker was managing the service and although they were doing this to the best of their ability, they were inexperienced and had not undertaken any relevant management training. They had minimal support and direction from the provider.

Staff told us that morale was low. They did not feel valued or supported by the provider and were reluctant to report bad practice due to fear of recrimination. The staff were under pressure with not enough staff to meet people's needs effectively. The acting manager told us despite trying to manage the home they often helped staff to deliver personal care. Other staff told us the acting manager had "been doing that a lot lately, as we don't have enough staff to see to the higher needs residents."

The provider failed to ensure there were robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively. The provider was compromising people's safety and welfare because they were not operating effective quality monitoring and assurance processes to identify issues that presented a potential risk to people. The service lacked drivers for improvement.

Governance systems had not ensured previously identified fire safety deficiencies were addressed promptly or that staff had received effective fire safety training to ensure people's safety. Audits and checks were ineffective. They were not followed up with robust analysis and action to address identified shortfalls and improve outcomes for people. There was a lack of focus on proactive prevention and on the monitoring of safety incidences. Despite there being a high incidence of unwitnessed falls a root cause analysis was not undertaken which may help to identify other issues, for example demonstrate when and where staffing levels were insufficient or if there were any other physical health or safety issues to be considered.

There was a lack of provider oversight to ensure the service delivered was of good quality and safe, and continued to improve. The last provider audit carried out on behalf of the provider in September 2018

identified that staff supervision and meetings had lapsed, the training matrix had not been updated since June 2018, there were trip hazards in courtyard, bathrooms were not in working order, the utility room tap leaked, there was a lack of natural light upstairs, and pen portraits were needed for people. Actions had not been taken to address this audit.

Without this oversight the provider had failed to ensure that improvements were being embedded, were capable of being sustained, that future shortfalls would be identified, and that appropriate action would be taken and lessons learnt.

The service did not have a pro-active approach to staff member's learning and development to enable them to carry out their role effectively and ensure their practice was relevant and up to date. There were no systems in place to ensure staff had the right knowledge, skills and confidence to support people in a safe manner.

Observation and discussion with staff showed that they had not had the training and support they needed to give them the skills to support people living in the service. They lacked guidance and understanding on how to respond to concerns about people's safety and manage people's behaviours. This did not ensure that people, staff and others were protecting people from the risk of unsafe care or treatment.

Staff made positive comments about the support they received from the acting manager. One staff member told us, "[The acting manager] is a big support. If I'm not sure about anything she'll explain to me clearly." Another staff member said, "[The acting manager] is very approachable and you feel that you can always talk to her."

Links had not been established with other organisations to keep up to date and take part in initiatives to improve practice.

There was no evidence of learning, reflective practice and service improvement. Incidents, accidents, falls, concerns and safeguarding were not effectively investigated or sufficiently analysed to determine root causes and to use this information to drive improvement.

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

Records we held about the service and looked at during the inspection, confirmed that the provider had not sent notifications to the CQC to notify us of safeguarding incidents, which is required by law.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the CQC of all the incidents they were legally obliged to notify us about. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always support people to maintain their dignity and respect their privacy. Regulation 10.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Not all people using the service and those lawfully acting on their behalf had given lawful consent before any care and support was provided. Regulation 11

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 have adequate arrangements in place to identify, assess and manage risks appropriately and support people to stay safe and protect them from harm. Regulation 12 (1) (2) (a) (b) (c) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have effective systems and procedures in place to protect people from harm. Staff were unaware of what constituted a safeguarding incident, known risks to people were not documented to help mitigate and reduce further incidents and staff did not report safeguarding concerns to the appropriate external agencies. Regulation 13 (1) (2) (3) (6)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a robust governance system in place to find, monitor and improve any areas requiring improvement, in a timely manner to ensure that a safe, effective and good service is provided. 17 (1) (2) (a) (b) (c) (d) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not demonstrate that robust recruitment checks had been made on all new staff to ensure that they were of good character and suitable to work with vulnerable people. Regulation 19 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were always enough staff deployed who had received suitable induction, training and supervision to ensure they had the knowledge and skills meet people's care and support needs. Regulation 18 (1) (2) (a) (b)