Trees Park (Kenyon) Limited

Kenyon Lodge

Inspection report

99 Manchester Road West
Little Hulton
Salford
Greater Manchester
M38 9DX
Tel: 0161 790 4448
Website: www.abbeyhealthcare.org.uk

Date of inspection visit: 6, 7 and 13 October 2015
Date of publication: 12/01/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of this service on 6 October 2015, with a further two announced inspection visits on 7 and 13 October 2015.

Kenyon Lodge is owned by Trees Park (Kenyon) Limited, trading as Abbey Healthcare. The service is registered with the Care Quality Commission to provide nursing and personal care for up to 60 people. The single room accommodation is arranged over two floors and has lift access. On-site car parking is available and the service is situated on a local bus route and is close to the motorway network.

At our last inspection of Kenyon Lodge on 19 and 20 May 2015, we found two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 with regard to safe care and treatment and staffing. As a consequence of this, we gave an overall performance rating of 'Requires Improvement'.

Summary of findings

At the time of this inspection there was no registered manager in post at Kenyon Lodge. However, a new manager had been appointed and they were applying to the Care Quality Commission (CQC) to register as the registered manager for the service. A registered manager is a person who has registered with the CQC. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection, we found eight breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in regard to person-centred care, dignity and respect, need for consent, safe care and treatment, meeting nutritional and hydration needs, good governance, staffing and requirement as to display of a performance rating. We are currently considering our enforcement options in relation to these regulatory breaches.

We found there to be insufficient numbers of suitably qualified and experienced staff to meet the needs of people who used the service. In particular, we found insufficient numbers of qualified registered nurses. The nursing unit at Kenyon Lodge can accommodate up to 30 people, yet we found for the vast majority of time only one registered nurse would be on duty. At the time of our inspection the service had three registered nurse vacancies and was reliant on the use of agency nurses.

The service did not always complete regular nurse-led assessments and reviews of people who used the service. This meant the service did not always recognise and respond to people who presented with clinical features of a condition that was likely to deteriorate. For example, during our inspection we found the service had failed to recognise and respond appropriately to a person who used the service who was clinically dehydrated.

During our last inspection of Kenyon Lodge we found the service was in breach of Regulation 12 of Health and Social Care Act 2008 because people who used the service were not protected against the risks associated with the safe management of medicines. However, during this inspection, we found significant improvements had been made. We found that medicines were now stored, administered, recorded and disposed of safely and correctly. Additionally, staff were adequately trained and kept relevant records.

We looked at how people who used the service with a high risk of malnutrition were being supported. This group of people each had a nutritional action plan prescribed for them by a community dietitian. However, the service was unable to demonstrate how peoples' meals had been fortified and whether additional nutritional supplements were being provided. Furthermore, we found regular weights were not always obtained, recorded and acted upon.

Care and support plans of people who used the service at Kenyon Lodge were not of a consistently acceptable standard. We found gaps and omissions in recording and information was disorganised and not easy to understand. We found care plans were not sufficiently person-centred and did not effectively demonstrate peoples' likes, dislikes, personal preferences and their life history. Care plans also failed to demonstrate how people who used the service, and/or their lawful representatives, had been involved in planning and agreeing the care and support being provided.

We found the service did not always fully complete individual risk assessments for people who used the service. We found gaps in recording and some individual risk assessments in peoples' care plans were blank. Recording of accidents and incidents was inconsistent, particularly around falls. In a number of care plans we were unable to establish how people who fell on multiple occasions had been kept safe and what preventative strategies had been considered or implemented.

Personal emergency evacuation plans (PEEP) were not always completed and the evacuation status of each person who used the service was not readily available as the service did not maintain a PEEP 'grab file' in case of emergencies.

We looked at how staff were supported to raise concerns. The service had a whistle-blowing policy and associated procedures which contained the contact details of relevant agencies and internal contacts within Abbey Healthcare. However, despite the service having such policies and procedures in place, we found documentary evidence which demonstrated that not all staff had been supported appropriately when attempting to raise concerns about care and staffing.

We looked at a sample of recruitment files to make sure safer recruitment practices were being followed. We

Summary of findings

found the identity of people applying to work at the service had been checked, references had been sought and checks had been completed with the Disclosure and Barring Service (DBS). A DBS check helps to ensure that potential employees are suitable to work with vulnerable people.

We looked at how well people were protected by the prevention and control of infection. We found the service had previously been working with the local authority infection prevention and control team and had achieved an overall IPC audit score of 91%. However, we found over recent months attention to IPC issues had deteriorated. This was reflected in the services last audit which demonstrated an overall deterioration in IPC standards and an audit score 73%.

At our last inspection of Kenyon Lodge, we found the service was in breach of Regulation 18 of the Health and Social Care Act 2008 because professional development and supervision of staff was not effective. During this inspection, we found some improvements had been made to the frequency of one to one supervision. However, insufficient improvements had been made to professional development of staff.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the service had a policy in place concerning DoLS and information was included about best interests, lasting power of attorney and access to an Independent Mental Capacity Advocate (IMCA). DoLS literature was also clearly displayed in the reception area.

We looked at DoLS documentation concerning six people who used the service on the nursing unit and found that due processes had been followed by the service for each DoLS application and that decisions were made in those peoples' best interests. However, on the residential unit we found only two people who used the service to be the subject of a DoLS, this was despite the residential unit caring for significant numbers of people who lacked capacity and were not free to leave of their own accord.

We looked at the meal time experience for people who used the service on both the residential and nursing unit at Kenyon Lodge. We found dining tables were presented appropriately with table cloths, crockery and condiments. People who used the service told us the food was generally good and appetising. However, on the nursing unit, we found lunch time meal service was chaotic and noise levels were very high. On the residential unit we found the atmosphere to be less chaotic.

Kenyon Lodge employed two activity coordinators. We found information was displayed on a number of notice boards around the service which gave details of various activities. These included a knitting club, visit by a live singer and other activities such as board games and arts and craft. Holy communion was also available to people of faith.

During our last inspection of Kenyon Lodge in May 2015, the provision of end of life care was under review following a safeguarding incident. As part of this review, additional clinical support was provided to Kenyon Lodge by the local NHS district nursing service. At the time of this inspection, the review into end of life care was still on-going. However, we found one example of a person who used the service who was nearing the end of life had not been referred by Kenyon Lodge to appropriate palliative care professionals. The early intervention of such professionals is crucial to ensure those people nearing the end of life, are able to do so in a dignified and comfortable manner.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve

Summary of findings

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

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

Not all aspects of the service were safe.

There were insufficient numbers of staff to consistently keep people who used the service safe.

Individual risks to people who used the service were not always adequately assessed and acted upon.

The service failed to recognise and respond to people who used the service suffering from a condition that was likely to deteriorate.

Since our last inspection, the service had made significant improvements in the safe management of medicines.

Is the service effective?

Inadequate

The service was not effective.

Since our last inspection, insufficient improvements had been made to professional development and one to one supervision of staff.

The service was inconsistent in the way it assessed the mental capacity of people who used the service and in its application of the Deprivation of Liberty Safeguards.

Consent to care and treatment was not always sought in line with legislation

The service was unable to demonstrate how it was meeting the nutritional and hydration needs of people at high risk of malnutrition.

Is the service caring?

Inadequate

The service was not consistently caring.

End of life care was not consistently delivered to an acceptable standard and people's needs at the end of their life were not always met.

Some staff did not always interact with people who used the service in a caring manner and did not always protect their privacy and dignity.

A number of people who used the service and their visiting relatives told us they thought the service was caring.

Is the service responsive?

Inadequate

The service was not responsive.

The delivery of day to day care and support was too task based and did not sufficiently take into account peoples likes, dislikes and personal preferences.

People who used the service and/or their legal representatives were not always involved in planning and agreeing their own care and support.

Summary of findings

People who used the service were not always dressed in clothes which belonged to them.

Management of complaints was inconsistent.

Is the service well-led?

Inadequate

The service was not well-led.

At the time of our inspection there was no registered manager at the service.

Systems for audit and quality assurance were not effective, including audit of accidents, incidents and care plans.

The service did not effectively demonstrate how the views of people who used the service and/or their representatives were sought.

The service failed to notify CQC of serious incidents involving people who used the service and failed to notify us when the previous manager had left

Kenyon Lodge

Detailed findings

Background to this inspection

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

Since CQC last inspected Kenyon Lodge on 19 and 20 May 2015, several relatives and a health care professional shared information of concern with us via the 'share your experiences' page of our website. Concerns were raised in relation to staffing levels and quality of care. In response to this, we brought forward the date of an already planned follow-up inspection.

This unannounced inspection was carried out on 6 October 2015. Three members of the inspection team arrived at Kenyon Lodge at 6.30am. The inspection team consisted of two adult social care inspectors, a specialist nurse advisor, a specialist pharmacist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A further two visits were also completed on 7 and 13 October 2015 by one adult social care inspector.

Before the inspection we reviewed all the information we held about the service. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local authority and various NHS community services.

During our inspection of Kenyon Lodge we spoke with the following people:

- Eight people who used the service.
- Six visiting relatives.
- 11 members of staff directly involved in providing care.
- Four managers.
- Two visiting NHS health care professionals.

We looked in detail at:

- 10 care plans and associated documentation.
- Supervision and training records.
- Six staff records including recruitment and selection records.
- Audits and quality assurance.
- Variety of policies of procedures.
- Safety and maintenance certificates.

We observed how care and support was being delivered in communal areas of the service and inspected the kitchen area, laundry, communal bathrooms and peoples' bedrooms. We also completed a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

On the first day of our inspection we arrived at Kenyon Lodge at 6.30am. We found one registered nurse and two care assistants on night duty on the ground floor nursing unit. They were caring for 24 people. Two people who used the service were in hospital and the unit had four vacancies.

On the residential unit, located on the first floor, we found one senior carer and one care assistant on night duty. They were responsible for 26 people who used the service. Two people on the residential unit were in hospital and the unit had two vacancies.

One person who used the service told us "I'm safe here because there's no trouble." Another person said "I feel safe here because nobody can get in." And a third person commented "I don't feel safe because I'm a worrier."

Staff told us that the 24 people being cared for on the nursing unit had varying levels of dependency, ranging from high to medium needs. We were told those people with 'high needs' required regular input from a registered nurse. Additionally, a number of people who used the service on the nursing unit were also living with dementia, in addition to their physical health issues.

On the residential unit, staff told us over half of the people who used the service required the help and support of two care assistants in order for their personal care needs to be met. This meant that during the night, when both care assistants were occupied providing care to one person, no one else was available on the residential unit to provide support to all the other people.

One member of staff told us "You simply cannot be in two places at once. Its common sense. If I'm busy providing nursing care to one resident, how can I possibly tend to the needs of others?" Another member of staff commented "Too much is expected of the staff at night. As well caring duties we are expected to do housekeeping, such as cleaning. It's just impossible." A third member of staff told us "There's only one nurse on at night. We have lots of poorly people living here so the nurse can't be in two places at once. Things get difficult if there's an emergency because the nurse's time is taken up dealing with that and then other people don't get the care they need."

Two members of the inspection team witnessed at first hand the challenges the staff had described. Unfortunately, a person being cared for on the nursing unit had died during the night and we saw how the vast majority of the registered nurse's time was occupied dealing with the bereavement and other associated activities. This meant they had no capacity to provide nursing care to those other people with a nursing need.

We looked at the staffing rota covering three months from July to September 2015 and found fluctuating staffing levels, particularly for registered nurses. We found across all shift patterns, days and nights, only one registered nurse had been on duty to care for up to 30 people on the nursing unit. We found the service had three registered nurse vacancies and there was a reliance on the use of agency nurses.

We looked at the dependency tool utilised by the service which calculated the dependency levels of people being cared for on both the nursing and residential unit. We found the dependency tool did not accurately reflect the actual dependency levels of people who used the service and did not translate into sufficient numbers of staff, particularly registered nurses. For example, at the time of our inspection, five people being cared for on the nursing unit were supported through continuing healthcare funding, and four people were receiving end of life care. This meant these people were dependant on the care of a registered nurse.

Furthermore, the services own dependency tool calculations indicated that seven people who used the service were 'high dependency' and that 21 people who used the service were 'medium dependency.' As a consequence of this, the service had failed to deploy sufficient numbers of suitably qualified and experienced staff to meet the needs of people who used the service at Kenyon Lodge.

We shared our concerns with the regional manager and acting manager, both of whom acknowledged staffing levels had been a significant challenge over recent months, particularly retention of existing staff, and recruitment of new staff. We were also told the service aimed to use the same agency nurses who were familiar with Kenyon Lodge, but this was not always possible.

Inadequate

Is the service safe?

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

During our inspection, we identified one person who used the service who was being treated for the symptoms of dehydration. We case tracked this person by looking at their care and treatment records and found written entries had been made which clearly demonstrated poor fluid intake over the proceeding 12 days. We also looked at fluid balance charts which demonstrated this person had only taken 300mls of fluid during the previous seven days. A written entry made by a registered nurse after the seven day period suggested a diagnosis of 'dehydration' and a referral to a GP was made.

Following the GP assessment, records indicated they were then commenced on a course of treatment which included a regime of subcutaneous fluid. However, prior to the GP being contacted, we found no evidence to support how the service had effectively managed the deteriorating health. We raised our immediate concerns with a registered nurse on duty to request an urgent review. As a GP was already on-site, a full medical review was completed and a further course of treatment was initiated.

This demonstrated the service had failed to recognise and respond to clinical features that would indicate a condition likely to deteriorate. Furthermore, the service failed to carry out a proper nurse-led assessment in order to determine the most appropriate level of care and failed to make an early referral for treatment.

We looked at a sample of eight care plans to understand how the service managed individual risk. We found a variety of risk assessments for topics such as falls, nutrition, manual handling and continence. However, in five care records we found not all risk assessments had been fully completed. Gaps in recording were evident and insufficient information was provided in order for the service to effectively monitor and assess risk.

We looked at accident and incident records and identified four people who used the service had suffered an unwitnessed fall, two of whom had fallen multiple times. We case tracked these people in order to compare information detailed in the accident report against information in their respective care plans. In all four cases, we found no evidence to demonstrate how the service had carried out an individual assessment of risk. Additionally, we found no evidence to support what preventative strategies had been considered or implemented.

This demonstrated Kenyon Lodge had failed to ensure care and treatment was provided in a safe and effective way and that it had failed to assess the risks to the health and safety of people who used the service.

We found personal emergency evacuation plans (PEEP) were not always completed and the evacuation status of each person who used the service was not readily available as the service did not maintain a PEEP 'grab file' in case of emergencies.

A store room located on the first floor residential unit had an A4 sign taped to it advising 'Oxygen Store Room.' This contravened health and safety requirements as the service was not displaying appropriate signage to warn 'No smoking' and 'No Naked Flames.' We informed the acting manager and regional manager about this and asked for the signage to be changed.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Safe care and treatment.

During our last inspection of Kenyon Lodge in May 2015, we found the service had failed to protect people against the risks associated with the safe management of medicines. As a consequence of this we issued the service with a requirement notice. During this inspection, we checked to see if the required improvements had been made.

On the nursing unit we looked at a sample of nine medication administration records (MAR) and found recording to be accurate. Each record contained a photo of the person who used the service and clear documentation of their allergy status. There was an additional sheet highlighting which individuals' required medication to be administered early in the morning.

People who used the service requiring topical medication had a body map located in their room and a duplicated administration record for recording when products had been applied.

Medication was safely and securely stored with appropriate policies and procedures. Medicines that required refrigeration were stored in a medicines fridge located in

Is the service safe?

the treatment rooms'. Daily temperature checks were also recorded in line with guidance. Controlled drugs (CD's) were stored appropriately and in line with legislation. The CD cabinet was not overstocked and the keys were in the possession of a registered nurse.

On the residential unit, medication was securely stored and MAR charts were accurately completed. A copy of the medication policy was kept in the looked treatment room and staff responsible for medicines told us training was adequate and they felt well supported by management in this.

However, during a medication round on the residential unit, we observed the senior member of staff responsible for administering medicines was frequently interrupted. This was because some people who used the service on the residential unit had behaviours that might challenge and the other care assistants on duty required support to deal with the situation. This meant the risk of medication errors was increased during this time. We spoke with the acting manager and regional manager about this and were assured protected medication rounds would be implemented.

We looked at medication audits covering the previous two months and found these had been completed on a weekly basis for both the nursing and residential unit. Additionally, the external provider pharmacist had also completed an independent audit. However, we found the service had not yet implemented a method of communicating the outcome of medication audits both to individual members of staff and across the service as a whole in order to demonstrate wider learning. We spoke with the acting manager about this and reassurance was provided that service wide learning from medication audits would be implemented.

Overall, we were satisfied the service had made sufficient improvements to demonstrate its safe management of medicines.

We looked at how the service protected people against abuse. We found the service had an appropriate safeguarding policy and information relating to how to raise a safeguarding concern was clearly displayed. Safeguarding training was completed via online e-learning.

We looked at how staff were supported to raise concerns and the effectiveness of the service's own whistle-blowing policy. We found contact details of all relevant agencies including social services, the local CCG and CQC were detailed in the policy and associated procedures; internal contact details were also provided for the manager and regional manager. However, we found documentary evidence that a member of staff who had previously raised concerns with a visiting healthcare professional about care and staffing, had not been supported by the service in line with its own whistle-blowing policy. We found this member of staff had been required by management at Kenyon Lodge to sign a written statement to indicate they would not give out 'confidential' information to professionals about 'situations in the home'.

We looked at the recruitment files of six members of staff. We found recruitment checks had been completed with regard to the Disclosure and Barring Service (DBS). A DBS check helps to ensure that potential employees are suitable to work with vulnerable people. We found employment references had been sought and identification checks had been completed.

We looked at how well people were protected by the prevention and control of infection. We found the service had been working with the local authority infection prevention and control (IPC) team and following the most recent IPC audit, the service had scored 73%. This was a deterioration from their previous audit score of 91%. We spoke with the acting manager and regional manager about this and assurance was provided the service would continue to work with the local authority IPC team to improve standards of cleanliness and hygiene.

Inadequate

Is the service effective?

Our findings

At our last inspection of Kenyon Lodge, we found the service was in breach of Regulation 18(2) of the Health and Social Care Act 2008 as it had failed to ensure all staff received appropriate professional development and supervision. We found training and development of staff was not effective. Training was mostly delivered via short online e-learning courses and staff were expected to complete this training in their own time. We also found significant gaps in staff knowledge around safeguarding vulnerable adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

As a consequence of this, we issued the service with a requirement notice. During this inspection, we checked to see if the required improvements had been made.

We spoke with eight members of staff with regard to training, professional development and supervision. We also looked at training records and a training matrix maintained by the service. Staff confirmed they had completed some additional learning since our last inspection, but again, this was completed through online e-learning. Staff reported they were still expected to complete e-learning in their own time. Two members of staff told us they did not have access to a home computer, therefore they hadn't completed any up-to-date e-learning.

One person who used the service told us "Some staff are good at their job but there are others who don't have a clue. It might be because of training but I think sometimes it's because of their attitude. They have a 'couldn't care less' attitude to their work but the good ones are really good and think of things I might need." Another person who used the service told us "I'm not sure about their [the staff] training. I need help with getting about and some staff seem to help me OK but others don't seem to know what to do."

A significant number of people who used the service at Kenyon Lodge had multiple complex needs including those people living with advanced levels of dementia, people living with a disability and/or sensory impairment, and people who required additional support with nutrition and hydration.

At the time of our inspection, Kenyon Lodge employed 38 members of staff who were directly involved in providing care and support. However, by looking at training records and the most recent training matrix, we found only 26% of staff had completed diet and nutrition training; 3% of staff had completed dementia training; and 45% of staff had completed equality and diversity training.

We also found that two members of staff who were employed by the service as 'senior care assistants' did not have any care related qualifications such as NVQ level two or three. This was despite both senior carers being expected to provide support, and leadership and guidance to more junior members of staff. Furthermore, we established that one member of staff who had been employed by the service for three months as a care assistant, had not received any moving and handling training throughout this period of time.

We looked at professional development and clinical competency records in respect of registered nurses employed at Kenyon Lodge. We found the service was not keeping consistent records to demonstrate how clinical competencies were assessed. In one record, we found a registered nurse had an identified training need around catheter care but we found no evidence to support how this training need had been met. We also found inconsistencies in how the service 'signed off' registered nurses to deem them fit to practice a particular clinical skill.

At our last inspection we found not all staff were in receipt of regular supervision and annual appraisal. By looking at the most up-to-date supervision matrix, we were able to see the vast majority of staff had now completed a supervision session in July. We compared the supervision matrix to the actual documentation used by the service to record such sessions and found inconsistencies in the way supervision had been recorded. There was insufficient evidence to demonstrate the effectiveness of supervision and how this was used to inform and improve practice across the service.

We then spoke with eight members of staff who all told us they did not consider access to professional development, training and supervision had improved since our last inspection. One member of staff commented "My last supervision lasted less than 15 minutes. I was just basically asked to sign the form then return back to work." Another told us "Training and development isn't good. Some people can do NVQ's but not everyone." A third member of staff commented "I'm expected to do these supervision sessions because I'm a senior but I've not had any training

in how to carry them out and we're never given enough time to do them properly anyway." A fourth member of staff told us "It's a tick box exercise because CQC told them to do it. Simple as that."

We found the service had continued to fail to ensure staff were suitably qualified, competent, skilled and experienced; and that staff receive appropriate professional development and supervision.

This is a continued breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Staffing.

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

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

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

We found the service had a policy in place concerning DoLS and information was included about best interests, lasting power of attorney and access to an Independent Mental Capacity Advocate (IMCA). DoLS literature was also clearly displayed in the reception area.

The service maintained a DoLS matrix which detailed those people who used the service that were the subject of a DoLS. We looked at DoLS documentation concerning six people who used the service on the nursing unit and found that due processes had been followed by the service for each DoLS application and that decisions were made in people's best interests.

However, on the residential unit we found only two people who used the service to be the subject of a DoLS, this was despite the residential unit caring for significant numbers of people who lacked capacity and were not free to leave of their own accord. For example, staff reported to us that one person who used the service would frequently ask to leave the unit but was prevented from doing so. This person was not the subject of a DoLS.

We spoke with the regional manager and acting manager about this and asked that a review of each person who used the service on the residential unit was completed in order to identify those people who may require a DoLS application to be made.

We looked at how the service adhered to the principles of the Mental Capacity Act 2005. Specifically, we looked at how the service sought consent and assessed the mental capacity of people who used the service. We looked at four care plans and found a variety of documents that related to mental well-being, mental capacity and consent. However, we found inconsistences in the way information was recorded and gaps and omissions were present across all four care plans. For example, one person who used the service had been deemed as lacking capacity but this person had been asked by the staff to consent to care by signing their own care plan.

We also found one person who used the service had been deemed as requiring an MCA assessment but we found no evidence to support this had been done. Furthermore, the service had not completed their own assessment as an interim measure or demonstrated how they were acting in the person's best interest.

We spoke with care staff to ascertain their understanding of MCA and DoLS. We were told training in this area was delivered via short online e-learning modules. However, we found that staff did not have sufficient working knowledge of this legislation or its practical application when providing care and support. This meant we could not be satisfied that the care and support being delivered to people who used the service, was always done so by staff who understood the principles of the MCA and acted in accordance with it.

This is a breach Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to the Need for consent.

During our inspection we looked at the meal time experience for people who used the service at Kenyon Lodge. On both the nursing and residential unit we found tables to be well presented with table cloths, cutlery, condiments and a fresh flower. People who required help

with eating and drinking were offered appropriate levels of support. However, on both units we found the meal time service was rushed, in particular we found the service on the nursing unit was chaotic and noise levels were unacceptably high.

One person who used the service told us "The food is nice. Its good food. I don't leave anything." Another commented "The food is pretty good. You get a choice between meals. You get soup or sandwiches for one meal and a hot meal at other times." A third person told us "The food is reasonable. It can get a bit boring with the same things on the menu each week. I can ask for a drink whenever I want."

During our inspection, we identified two people who used the service who had been assessed as a high risk of malnutrition. We case tracked these people to see how the service was meeting their additional nutritional and hydration needs. We did this by looking at care plans and other associated documentation, such as weight charts, food and fluid charts and a malnutrition universal screening tool (MUST) used by the service.

By looking at these records, we were able to see that both individuals had a history of weight loss and that oral intake of food and fluid was reduced. We could see that appropriate referrals had been made to the local NHS community dieticians. Following dietetic assessment, each person had a comprehensive nutritional action plan prescribed which was placed in their respective care plans.

However, after reviewing all the available information, we found no evidence to support how the service had implemented the nutritional action plans as prescribed by the dietician. Specifically we found the recording of weight and food and fluid was inconsistent and gaps in recording were present. Additionally, we found no evidence to demonstrate how food and drink had been fortified or whether additional supplements had been provided.

We spoke with staff about this to ascertain their understanding of those people at a high risk of malnutrition and it was evident they lacked insight into the importance of nutritional action plans and did not understand how they should be implemented.

We raised our concerns with the regional manager and acting manager and referred our concerns to the local authority safeguarding team.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Meeting nutritional and hydration needs.

Inadequate

Is the service caring?

Our findings

We asked people who used the service at Kenyon Lodge whether they thought the service was caring; one person told us "The staff are good. I've enjoyed being here most of the time." Another commented "Staff are kind and respectful. I enjoy a joke with the staff. Staff make my friends welcome and keep [my relative] informed of things." A third person commented "Some staff treat me with kindness and others are a bit sharp. Some staff listen to me and others don't."

A visiting relative told us "Staff are caring towards residents. I'm made welcome and given a cup of tea. I can ask staff any questions I want to." Another relative told us "I come here very regularly. [my relative] has never said the staff have been nasty. [My relative] is doing fine.

During our last inspection of Kenyon Lodge in May 2015, we were told that arrangements for delivering end of life care (EoLC) were under review. This was due to the on-going investigation of a safeguarding incident. As part of the review, the local NHS Clinical Commissioning Group (CCG) was not commissioning any new placements at Kenyon Lodge for people who required end of life care. Additionally, as part of the review, Kenyon Lodge had voluntarily agreed to not accept any new EoLC referrals. For those people already being cared for at Kenyon Lodge with an existing EoLC pathway in place, additional clinical support was provided by the local NHS district nursing service.

At the time of this inspection, we found the review of EoLC was still on-going at Kenyon Lodge and clinical support continued to be provided by the local NHS district nursing service. During our inspection, we were told four people who used the service were in receipt of EoLC. We case tracked one of these people to ascertain whether their needs were being met. We did this by looking at their care and treatment records and other associated documentation.

We found documentary evidence that the person who used the service had a diagnosis of a condition that was likely to deteriorate. We that found they had been seen by their GP six days prior to our inspection and at that time, a decision was made to commence this person on an EoLC pathway. Documentary evidence demonstrated the GP had communicated this information to the nursing staff at Kenyon Lodge.

We found further written entries in the care and treatment records which indicated throughout this period, the person was continuing to deteriorate. However, since the decision had been made to commence an EoLC pathway, we found no evidence to support that any such referral had been made, including a referral to the NHS district nursing service.

As a consequence of this, the person who used the service did not have access to specialist palliative care professionals throughout the six day period since being commenced on an EoLC pathway. The early intervention of palliative care professional's is crucial to ensure those people nearing the end of life, are able to do so in a dignified and comfortable manner.

We raised our concerns with a registered nurse on duty at Kenyon Lodge and they told us they were "unclear" as to how and when to make a referral. We found this lack of awareness unacceptable given the support and advice that was readily available from the local NHS with regards to end of life care.

We looked at EoLC training and professional development for both registered nurses and carers at Kenyon Lodge and found this to be inadequate. We spoke with two registered nurses and it was evident they lacked the necessary knowledge to enable them to deliver an acceptable standard of EoLC.

We shared our concerns with the regional manager and acting manager at Kenyon Lodge. We also referred our concerns to the local NHS CCG and local authority adult safeguarding team.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Safe care and treatment.

During our inspection, we observed an incident on the residential unit involving one person who used the service not being treated in a caring or dignified manner. This person was observed to be leaving a toilet in a state of partial undress and It was evident they had not been able

to fully tend to their own personal care needs. We then observed a member of care staff approach this person and simply pull up their clothing in a public space without first tending to their personal care needs in private.

We immediately approached the member of staff and asked them to assist this person back into the bathroom and to tend to their personal care needs in private.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We completed two SOFI observations; one on the nursing unit and the other on the residential unit. Both observations lasted 30 minutes.

On the nursing unit we observed ten people who used the service being supervised by two care assistants. People were sat in various types of adaptive seating around the outside of the lounge. A television was located in the lounge with the volume very loud. No subtitles were displayed on the screen. Three people who used the service had been seated by staff in close proximity to the television but appeared to have no interest in watching television.

We observed two care assistants bring a hoist and wheelchair into the communal lounge in preparation to move a person who was unable to walk. We noted this person appeared confused and was unable to communicate their needs verbally. Both care assistants were talking between themselves and there was minimal interaction with the person who used the service whilst the hoist sling was being fitted. Throughout this interaction we observed neither care assistant attempt to offer reassurance or explanation to the person being moved. Furthermore, during the hoisting manoeuvre, the underwear of the person who used the service was exposed.

As a consequence of the incidents we observed, the staff involved had failed to protect the privacy and dignity of people who used the service.

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

On the residential unit, we completed our SOFI at the end of lunch time service. We observed seven people who used the service that were already seated in the communal lounge and three care staff were bringing others back from dining room into the lounge.

During this time, we observed that people who required attention in the communal lounge were required to wait as not enough staff were available to help. Additionally, we observed people were not always supervised in the communal lounge as staff were busy engaged on other duties.

Some of the interactions between staff and people who used the service were not always appropriate. For example, we observed one member of staff who made persistent attempts to reason with a person who was living with dementia. This was despite the person who used the service clearly lacking awareness of what was being said to them and demonstrated a lack of understanding and/or training around the correct way to care for someone living with dementia.

However, we did observe a number of instances during our inspection where staff interacted with people who used the service in a kind and considerate manner. On one occasion we observed a care assistant knock on the door of a person's bedroom and wait to be admitted before entering. The conversation which took place was very pleasant and respectful in nature.

Inadequate

Is the service responsive?

Our findings

During our inspection we looked at a sample of eight care plans to understand how people who used the service had their individual needs met. This included to what extent people who used the service and/or their legal representatives had been involved in planning and agreeing their own care, treatment and support.

In each care plan we found a variety of documents relating to nursing and personal care. These included continence, nutrition, mobility, medication, skin integrity and daily records. Documentation also provided an opportunity to record information about personal history, care planning, social assessment and mental well-being.

One person who used the service told us "Staff wash and dress me. I choose my own clothes but staff do get my clothes muddled up or lost despite my room number being on all my clothes. I do complain about this and staff do find my missing clothes." Another person commented "They've been very short staffed but it's a bit better lately. I have a buzzer at bedtime. Staff forget to give it to me and when I've left it on the chair I have to get a rolled up newspaper to try and get it."

Visiting relatives told us "[My relative] chooses when she wants to go to bed and when she gets up. Staff have told [my relative] they can please themselves. [My relative] gets a bit confused but she does sometimes get clothes which are not hers. The washing is done regularly and she's always kept clean."

In each of the eight care plans we looked at, information was not consistently presented in a format which was easy to understand. Records were chaotic with gaps and omissions throughout. In a number of care plans where gaps had been identified, a 'post it note' had been inserted with a comment stating 'needs filling in'. We found the care plans failed to effectively demonstrate peoples likes, dislikes, personal preferences and personal life story. We also found insufficient evidence to demonstrate how people who used the service, and/or their lawful representatives, had been involved in planning and agreeing their own care and support.

When a 'review' of a care plan had taken place, we found these were very brief and non-informative. For example, in August 2015, one person who used the service had a comprehensive review completed by a mental health professional. In this review, a number of key points had been identified for the service to follow in order to meet this person's individual needs. However, since the review had taken place, we found no evidence to support how the service had acted on the recommendations of the mental health professional. Furthermore, three reviews of the care plan had taken place since August 2015 and the reviews simply stated 'no change plan'.

We also looked at how Kenyon Lodge managed the transition of individuals between services. We case tracked one person who used the service who had recently moved to Kenyon Lodge from hospital. We established that prior to their hospital admission, this person had been living in the community in supported accommodation which specialised in the care of people with a learning disability. However, we found the transitional process, from initial assessment through to admission into Kenyon Lodge had been poorly managed. The key issues we identified included:

- The pre-admission assessment completed by Kenyon Lodge was not sufficiently enough person-centred to determine whether the proposed placement was suitable and could meet this person's individual needs.
- Information was not shared by the previous care provider in a timely manner.
- Professionals from the local authority had not sought reassurance that Kenyon Lodge had sufficient numbers of suitably qualified and experienced staff to manage people with complex needs.
- After being placed into Kenyon Lodge, the person had multiple episodes of behaviours that challenge, two of which required hospital attendance. We found communication between all agencies responsible for on-going support and assessment was inadequate, even after a protection plan had been put into place by the local authority.

During our inspection we referred our concerns with the local authority adult safeguarding team

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Person-centred care.

Kenyon Lodge employed two activity coordinators. Information was displayed on a number of notice boards

Inadequate

Is the service responsive?

around the service giving details of various activities. These included a knitting club, visit by a live singer and other activities such as board games and arts and craft. Holy communion was also available to people of faith.

One person who used the service told us "We do go out in the garden now and again. Staff have taken me into the local town. I enjoyed that. We have games and jigsaws. All sorts of things but I would like to do more. I get bored. There used to be more activities than now." Another person who used the service commented "I play dominos and scrabble with other residents. The activity coordinators arrange activities. I'm invited to join things going on."

A visiting relative told us "I don't think [my relative] takes part in any activities. Staff play songs for residents. They had a gospel choir in earlier this year." Another relative commented "A singer comes in and I've seen [My relative] join in with a game. I've also seen [my relative] using hand instruments and enjoying it."

We looked at how the service dealt with complaints. Information was clearly displayed in the reception providing information on how to make a complaint. The service had a complaints policy and procedure which included timescales for providing a response. We saw that each complaint received into the service was logged. However, we looked at the complaints file and found this to be disorganised. Complaints were mixed up with safeguarding investigation paperwork and it was difficult to separate the two. Furthermore, we found one complaint which had been received into the service dating back to 2014 appeared to not been resolved.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. Temporary day-to-day management cover was provided by a nurse manager from another service within the Abbey Healthcare group and oversight was provided by a regional manager.

A new manager had been appointed to Kenyon Lodge and they were currently applying to register with CQC. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run

During our inspection we found a lack of co-ordinated leadership, which was impacting on the quality of care provided. Day-to-day clinical and operational leadership of staff was inadequate and the provider, Abbey Healthcare, had failed to provide sufficient oversight to recognise and respond to emerging issues.

One person who used the service told us "The managers are like buses, they keep coming. I feel sorry for the staff really, they don't seem to know if they are coming or going with this regular change. I believe we're getting a new manager. I wish they would let us know what was going on as its worrying." Another person commented "I know who the manager for this floor is. [The manager] seems to be a happy person.

A visiting relative told us "My main concern at this home has been the change of manager. I've seen what I consider to be excellent staff leaving to go to other homes and this is a result of changes of management." Another relative told us "I don't know who the manager is. I'd speak to one of the staff who has worked here a long time and they would put things right."

One registered nurse told us "We are trained and experienced nurses but get no support in developing our skills and knowledge. It's like groundhog day working here and its professionally embarrassing when district nurses attend to deliver end of life care or site a butterfly needle. I feel that as long as this arrangement is in place, the service will not develop us at all." A care assistant told us "We're being expected to do things without any direction or training. I really don't know what the management think we are. I'm fed-up as I keep getting angry about it."

We looked at how accidents and incidents were audited and found the service did not have effective systems in place. For example, on the residential unit, records demonstrated that during July and August 2015, 23 people who used the service had an 'unwitnessed fall'. The service was unable to demonstrate if any overall analysis of these incidents had taken place in order to identify trends or contributory factors. We also found ineffective systems for audit and quality assurance of care plans, as the service had failed to identify errors and omissions in recording.

People were able to provide feedback to the service by using a suggestion box and 'review us' cards located in the reception area. Additionally, a 'you said – we did' notice board was displayed which provided responses to suggestions made. However, we found that involvement of people who used the service and/or their representatives through the use of residents or relatives meetings was not consistent.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Good governance.

Following our last inspection of Kenyon Lodge in May 2015, CQC awarded a performance rating of 'Requires Improvement'. The law states that providers must display this rating. However, on arrival at Kenyon Lodge on 6 October 2015, we found the service was not displaying its performance rating. We spoke with the regional manager about this and action was then taken to display the performance rating.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to Requirement as to display of performance assessments.

Providers are required by law to notify CQC of certain events which occur in the service. Records indicated that Kenyon Lodge had failed to notify CQC of several notifiable events. For example, we were not informed when one person who used the service was injured and taken into

Inadequate

Is the service well-led?

hospital, and we were not informed by the provider when changes to the management of the regulated activities had occurred. We are following this up outside the inspection process.