Kent House Care Home Limited

Kent House Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Kent House Residential Home is a care home providing personal care to up to 25 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 21 people using the service. Accommodation is arranged over three floors and a lift is available to assist people to get to the upper floor.

People's experience of using this service and what we found
People told us they were happy and felt safe living at Kent House. However, we found the service was not consistently well managed and this left people at risk. The registered manager did not know people well and did not have the required oversight of their care. The provider had not achieved their aim of continued improvement and the quality of the service had deteriorated since our last inspection.

Checks and audits of the service had not always been effective and some shortfalls we found had not been identified. The registered manager had not always completed the required actions to improve the quality and safety of the service. Staff had not always been recruited safely and checks on their character and conduct had not been consistently completed before they worked with people. When concerns had been identified by the provider, action had been planned to address these.

We did not find people had come to harm at the service however, action had not been consistently planned to protect people from identified risks, including choking, pressure ulcers and epilepsy. Medicines were not always stored or applied safely. People received their medicines when they needed them.

Infection control risks at the service were not consistently managed. For example, the registered manager allowed people into the building before confirming a negative COVID test result. They were not following national guidance for new people moving into the service and had not assessed and mitigated any risks in relation to this.

People had been asked for their views of the service and these were positive. Communication from the registered manager was not always clear. People were not always aware of changes at the service. Staff did not have all the information they needed to keep people safe and well. Including how to check pressure relieving equipment was working effectively.

There were enough staff working at the service to provide the care people needed. People told us staff were kind and caring and they felt safe in their company. Staff worked together as a team and shared their knowledge of people to provide their care consistently. The provider was open and honest about improvements they had identified and the action they were taking to make the improvements.

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

Rating at last inspection
The last rating for this service was good (published 2 September 2017).

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

We received concerns in relation to leadership, identifying and managing risks, the accuracy of records and the effectiveness of quality assurance processes. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kent House Residential Home on our website at www.cqc.org.uk.

We undertook this inspection at the same time as CQC inspected a range of urgent and emergency care services in Kent and Medway. To understand the experience of social care providers and people who use social care services, we asked a range of questions in relation to accessing urgent and emergency care. The responses we received have been used to inform and support system wide feedback.

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

We have identified breaches in relation to identifying and managing risks, medicines management, infection prevention and control and safe staff recruitment at this inspection.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.
Please see the action we have told the provider to take at the end of this report.

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

Special measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Kent House Residential Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people and one relative about their experience of the care provided. We spoke with six members of staff including the registered manager, senior care worker, carers, chef and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included multiple medication records and three staff files in relation to recruitment. A variety of records relating to the management of the service, including checks and audits and action plans were reviewed.

After the inspection
We viewed 10 people's care records, training records and policies and procedures. We continued to seek assurance from the provider about people's safety and improvements they were making to the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not effectively managed. Although risks had been assessed, action had not always been planned to mitigate risks. Detailed guidance had not been provided to staff about how to keep people safe. Some guidance was out of date and other information was contradictory.
- People were not protected from the risk of developing pressure ulcers. Some people used special air flow mattresses to reduce the risks, however checks on the equipment had not highlighted when it was not working correctly. One person at risk of developing pressure ulcers told us they were very uncomfortable sitting on their bed. We found the mattress, which had been installed the day before, had deflated and they were sitting on the hard bed base. This increased the risk of them developing a pressure ulcer. Adequate checks had not been completed to ensure the mattress was working effectively. We observed the alarm on another person's mattress sounding to tell staff it was malfunctioning. The person's relative told us it did this regularly. No action had been taken to ensure the mattress was always working correctly.
- Care had not been planned to support people with epilepsy. The registered manager was not aware one person had had a seizure at the service and they did not know what the person's seizures looked like. A staff member had witnessed the person having a seizure and described it in detail, along with the action they took to support the person to remain safe. The staff member had used their experience and skills to care for the person. People were at risk because other staff did not know what to do and specific guidance was not available to them.
- Detailed guidance had not been consistently provided to staff about how to safely move people. Again, staff relied on their skills and knowledge to move people safely. We observed staff safely support one person to transfer from a wheelchair to a chair. The person told us they felt safe when staff supported them to move. However, there was a risk staff would not move people safely as detailed guidance was not available for them to follow.
- Some people had lost weight and were waiting to see the dietician. Care had not been planned to reduce the risk of them losing more weight. Staff recorded what people ate but no action was planned when people ate or drank very little. The chef fortified everyone's food with additional calories. However, we would expect detailed guidance to be available to staff about how to encourage people to eat more, such as offering their favourite meals and snacks.
- Detailed guidance had not been provided to staff about how to mitigate the risk of people choking. Some people required the consistency of their food to be modified to reduce the risk. No guidance was available to staff about the required consistency of modified drinks and one person's food. Whilst staff consistently described the consistency to us, there was a risk not all staff would modify food and drinks to the correct consistency to keep people safe.

The provider and registered manager had failed to plan people's care to mitigate risks to them. This placed

people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Accidents and incidents had not been analysed over a period of time to understand changes in people's needs. For example, one person's care plan stated they were at high risk of falls but had not fallen. Accident records showed the person had fallen five times between October 2021 and January 2022. Action had not been taken to mitigate the risk of the person falling again and risks to them continued.

● An accident log was maintained which included what had happened and action taken. Accidents were analysed each month looking at the time and place they occurred. A report was produced as to why accidents may have happened, and action taken in relation to each one. The provider's January 2022 audit found this process had not been followed by the registered manager. For example, a review of a person's care plan was required following a fall, but this had not happened. A falls alert mat had been put in place, but guidance had not been provided to staff about it's use. This left the person at risk of further falls.

The registered manager had failed to monitor and mitigate risks relating to the health and safety of service users. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People's medicines were not always managed safely, and the provider's policies did not always reflect national guidelines. In 2020 one person had been prescribed medicines to keep them comfortable at the end of their life. The person was well and did not need the medicine. Staff were not aware one medicine expired approximately two weeks after our inspection and had not asked the GP to review it. There was a risk if the person needed the medicine it would not be effective.

● The provider did not have a detailed procedure in place to dispose of unwanted medicines. Their policy did not reflect national guidelines around the storage of unwanted medicines. We observed some medicines stored loose in an unlocked cupboard with no records of what they were. Others were stored together and the name and strength of medicine, quantity and person they were prescribed to was not recorded. The stock levels of medicines could not be checked to ensure they were accurate and that medicines had not been misappropriated.

● Medicine patches had not been applied in line with the manufactures guidance to reduce the risk of people's skin becoming damaged. The manufacture recommended new patches should not be applied to the same site for three to four weeks. Staff had only left a gap of one week and this placed people at risk.

The registered provider and registered manager had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other medicines risks were well managed. We observed staff supporting people to take their medicines and chatting to them about what they medicines were for. Medicine administration records were complete, and guidance was in place for staff about 'when required' and topical medicines.

Preventing and controlling infection

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. During our inspection the registered manager allowed some visitors to enter the service before the result of their COVID-19 test had been confirmed. Other visitors were completing a COVID-19 test before they attended the service and were providing evidence of negative result.

● We were somewhat assured that the provider was meeting shielding and social distancing rules. The registered manager was not aware of the latest guidance.
● We were somewhat assured that the provider was admitting people safely to the service. The registered manager was unable to describe to us the national guidance they were required to follow when new people were planning to move into the service. This included the requirement to complete a specific COVID-19 test before and immediately after admission. When one person was unable to isolate, the registered manager had not assessed and mitigate the risk of them spreading COVID-19. Other people had isolated in line with guidance.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service required redecoration in places and some areas did not appear to be clean.
● We were somewhat assured that the provider's infection prevention and control policy was up to date. The registered manager had reviewed the COVID-19 risk assessments and contingency plan but had not updated them to reflect the current government guidance.

The registered provider and registered manager had failed to fully control risks of the spread on infection. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● The provider had systems in place, which followed national guidance, to support people to receive visitors. There were no restrictions on visiting and people received visitors regularly.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Staffing and recruitment
● People were not protected by safe recruitment practices. Disclosure and Barring Service (DBS) checks had been completed. However, one staff member had worked unsupervised with people before their DBS check had been received. No risk assessment had been completed and the registered manager had not taken steps to protect people from possible risks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Robust checks had not been completed on staff's conduct in previous roles, to ensure they had they skills and experience they needed. Only one reference had been obtained for one staff member and no further checks had been completed on their conduct. A full employment history with any gaps in employment and the reasons for leaving had not been obtained for all staff.

The registered provider and registered manager had failed to operate effective processes to safely recruited staff. This placed people at risk of harm. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's needs. People told us there were always staff available if they needed them. Staff responded promptly to people's requests for support. We reviewed staff rotas and found

there were consistent numbers of staff on duty.

Systems and processes to safeguard people from the risk of abuse

● People were protected from the risk of abuse. People told us they felt safe living at the service and staff were kind and caring.

● Staff had completed safeguarding training and were confident to raise concerns to the registered manager or provider. They knew how to raise concerns outside of the service and information about whistleblowing was displayed around the service.

● The provider had supported the local authority safeguarding team to complete safeguarding investigations. They had acted on recommendations and put action plans in place to implement changes and check they had been effective. An action plan was in place following a recent safeguarding visit and the improvements required were clear and specific.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

● The provider and registered manager did not have good oversight of the quality and challenges at the service. The provider's aim for 'Continuous and Never-ending Improvement' had not been achieved and the quality and safety of the service had declined since our last inspection. Systems the provider had in operation to review the quality of the service had not been consistently effective and some of the shortfalls we found had not been identified.

● Checks completed by the registered manager were not robust and did not demonstrate shortfalls had been identified and addressed. The provider had action plans in place to address concerns they had found. However, robust action had not been taken to address the specific concerns and the information had not been used in a wider context to make improvements. For example, they had noted in December 2021 one person did not have a care plan in place to reduce the risk of pressure ulcers, this was not in place at the time of our inspection. Action had not been taken to ensure detailed guidance was in place for everyone who was at risk of developing pressure ulcers.

● The registered manager did not recognise the need for them to continuously learn and develop their practice. We found they had not kept up to date with national guidance around diabetes and epilepsy. The provider had discussed continuous improvement with the registered manager and courses had been booked to support them develop in their role. These included workplace culture, self-management and performance management.

The registered manager and registered provider had failed to consistently assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recognised the registered manager's checks were ineffective and increased the level of checks they completed from November 2021. They were aware further improvements were required to the auditing process and had engaged an external consultant to begin completing monthly audits shortly after our inspection. The provider's role would then be to develop action plans and support the management team to improve the quality of the service.

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

● The provider had a clear set of aims and objectives, which included effective leadership. Leadership at Kent House was poor, and this had left people at risk of harm. Despite the provider being open and honest

with us about shortfalls at the service, these were not recognised by the registered manager or the provider's quality assurance systems.
● The registered manager had worked at the service for over six months but did not know people well. They were unable to provide us with accurate and up to date information about people's needs. This included basic information such as the equipment people needed to move safely and very recent changes in their health or medication. Care plans they had written were inaccurate and people and staff had not been involved in developing them.
● The registered manager left the provider's employ following our inspection. The provider appointed a new manager and a handover process was planned. The new manager had experience of managing care homes for older people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Working in partnership with others
● The provider had a governance system in place to support the registered manager lead the service effectively. However, policies and processes had not been consistently followed and this had led to shortfalls at the service. These included poor medicines management, infection control, care planning and staff recruitment.
● The registered manager had not kept up to date with changes in the national guidance around COVID-19. These were shared with them by the provider when they occurred and were also available from external sources including the governments website. COVID-19 management processes in operation at the service had not been reviewed to ensure they reflected current guidance and kept people safe.
● Staff meetings had been held but detailed minutes had not been kept for staff to refer to. For example, the outcome of a medicines audit had been discussed but records had not been maintained of the improvements needed to staffs' practice. No records had been maintained of staffs' suggestions or concerns. Therefore, the provider and registered manager were unable to check actions taken had been effective.
● The registered manager had not ensured staff understood their roles and responsibilities. Before our inspection the local authority safeguarding team had raised concerns about the effectiveness of staff's checks on pressure relieving equipment. The provider had required checks be added to the electronic care recording system so this could be monitored. However, the registered manager had not told staff what to check and how. Staff were checking the equipment was set correctly but not that it was functioning correctly. Equipment malfunctions had not been identified and this had left people at risk.
● Staff told us communication from the registered manager was not always effective. They told us on one occasion they had not been informed a new person had moved into the service or the care they required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they were happy at the service and their care was provided in the way they preferred. They were asked for their views on areas of the service regularly and their feedback had been positive.
● People had been asked for their views at a residents meeting in April 2021. Information had also been shared with them about changes to visiting arrangements and improvement works. However, no further meetings had been held to keep people informed of changes at the service and understand their views.
● Staff had been asked for their views. Feedback received showed staff had raised concerns around communication from the management team. They had also shared this with the provider. An action plan had been implemented and analysis showed staff morale was increasing and communication had improved.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● The provider understood their responsibilities under duty of candour. They were open and honest with us about the shortfalls they had found at the service and the action they were taking to address them.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider and registered manager had failed to operate effective processes to safely recruited staff.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to plan people's care to mitigate risks to them. This placed people at risk of harm. The registered provider and registered manager had failed to ensure the proper and safe management of medicines. The registered provider and registered manager had failed to fully control risks of the spread on infection.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and registered provider had failed to consistently assess, monitor and improve the quality and safety of the service. The registered manager and registered provider had failed to consistently assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We served a warning notice.