Abbey Healthcare (Westmoreland) Limited

Kendal Care Home

Inspection report

Kendal Care Home
Burton Road
Kendal
Cumbria
LA9 7JA
Tel: 01539 790300
Website: www.abbeyhealthcare.org.uk

Date of inspection visit: 30 September and 6 October 2015.
Date of publication: 29/12/2015

Ratings

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

Overall summary

This unannounced inspection of Kendal Care Home took place over two days on 30 September and 6 October 2015. During our previous inspections on 8, 9 and 12 February 2015 we found the service was not meeting all the regulations.

This was because at our inspection on 8, 9 and 12 February 2015 there was not verifiable evidence that all staff in the home had received induction training and appropriate training for their roles. Care plan assessments did not always reflect a person-centred strategy and changes were not always reflected in care plans. The registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness.

We also carried out a focussed inspection on 2 June 2015 following concerns raised by other agencies and individuals in relation to the levels of suitably qualified staff being deployed in the home to meet people's needs. We found on the day of our visit, 2 June 2015, that there was an adequate level of staff on duty to provide basic

Summary of findings

personal and nursing care. However the nursing support available to people did not reflect an emphasis on person centred nursing care but more on completing nursing care tasks.

Following the inspection on 2 June 2015 the registered provider wrote to us and gave us an action plan saying how and by what date they intended to improve training provision and recording, care planning and person centred care. At the inspection on 30 September 2015 we found that the care plan assessments and reviews of assessments to help ensure that people received care that met their needs were still not satisfactory. We also found that the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness. Staff training was being better organised and monitored but some staff still lacked appropriate training and support for their roles. Whilst we could see changes had begun to improve service provision in these areas they had yet to be fully effective.

At this inspection we also found that there were others breaches of regulations that had an impact on people living in the home. These were in medicine management, recruitment of staff, making sure that care planning was person centred and that all needs had been assessed and risks well managed. We found that systems had not always been effective in making sure people's nutrition and hydration needs were well monitored and not all records required by regulation were up to date. We found that a systematic approach to determining the range of skills needed and gender mix of staff on duty to meet people's preferences and needs not always being used. Agency staff were being brought in to try to maintain staff numbers. Some agency staff had not been well supported in their roles and responsibilities in the home

Kendal Care Home provides nursing and residential care for up to 120 older people, some of whom are living with dementia. The home is over three floors and has a passenger lift for access to these. There are three suites in the home and all the bedrooms are single occupancy with ensuite facilities. Each of the three units has communal dining and lounge areas. There is a cinema room for people to use. The home is set back from the main road, with level access grounds. There is ample car parking for visitors. During our inspection there were 75 people living there.

The service did not have a registered manager in post at the time of this inspection or at the time of our inspection in February 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager had resigned from their post in March 2015 and their replacement left in August 2015 before registering with CQC. The registered provider is currently trying to recruit a suitable person for this post.

We found that on the residential unit people has some very positive things to say about the way the unit was run, the unit manager and their care and support. The two other units where there was nursing care provided for people, some of whom were living with dementia, were perceived less positively by relatives. They told us about the lack of leadership and management on the units and the frequent use of agency staff who did not know people well.

We found that the registered provider had started to make improvements in providing a consistent training programme for staff and providing mandatory training. However we found that training for specific roles and responsibilities was not consistent for all care and nursing staff to support them to safely effectively fulfil the requirements of their roles. This was evident because staff had not worked within the requirements of the Mental Capacity Act 2005.

We found that the management of medicines in the home did not always follow policies and procedures and current best practice and medicines were not always given as prescribed by the doctor. Most of the people we looked at had photographs and their allergies recorded on their medicines records which reduces the risk of medicines being given to the wrong person or to someone with an allergy and is in line with current guidance.

The systems used to assess the quality of the service had not identified all the issues that we found during the inspection. Whilst we found that some aspects of the quality monitoring processes were being done well others were less well monitored. The standard of some clinical record keeping was not adequate. The registered

Summary of findings

provider had not ensured that an effective system was in place to make sure the nutritional and hydration needs of people were accurately recorded and monitored. We also found that care and risk assessments had not always been reviewed and updated.

We found that people living at Kendal Care Home were able to see their friends and families as they wanted and go out when they wanted with them. There were no restrictions on when people could visit them. We could see that people who were able to made day to day choices about their lives in the home and were able to follow their own faiths. People living there and visiting relatives told us that staff were polite and caring and "Work extremely hard".

We have made a recommendation about making sure confidential health checks were carried out with people before they started work. Confidential health questionnaires help the registered provider to support physical or mental health conditions which are relevant to a person's capability for the role.

You can see what action we told the provider to take at the back of the full version of the report.

This unannounced inspection of Kendal Care Home took place over two days on 30 September and 6 October 2015. During our previous inspections on 8, 9 and 12 February 2015 we found the service was not meeting all the regulations.

This was because at our inspection on 8, 9 and 12 February 2015 there was not verifiable evidence that all staff in the home had received induction training and appropriate training for their roles. Care plan assessments did not always reflect a person-centred strategy and changes were not always reflected in care plans. The registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness.

We also carried out a focussed inspection on 2 June 2015 following concerns raised by other agencies and individuals in relation to the levels of suitably qualified staff being deployed in the home to meet people's needs. We found on the day of our visit, 2 June 2015, that there was an adequate level of staff on duty to provide basic personal and nursing care. However the nursing support available to people did not reflect an emphasis on person centred nursing care but more on completing nursing care tasks.

Following the inspection on 2 June 2015 the registered provider wrote to us and gave us an action plan saying how and by what date they intended to improve training provision and recording, care planning and person centred care. At the inspection on 30 September 2015 we found that the care plan assessments and reviews of assessments to help ensure that people received care that met their needs were still not satisfactory. We also found that the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness. Staff training was being better organised and monitored but some staff still lacked appropriate training and support for their roles. Whilst we could see changes had begun to improve service provision in these areas they had yet to be fully effective.

At this inspection we also found that there were others breaches of regulations that had an impact on people living in the home. These were in medicine management, recruitment of staff, making sure that care planning was person centred and that all needs had been assessed and risks well managed. We found that systems had not always been effective in making sure people's nutrition and hydration needs were well monitored and not all records required by regulation were up to date. We found that a systematic approach to determining the range of skills needed and gender mix of staff on duty to meet people's preferences and needs not always being used. Agency staff were being brought in to try to maintain staff numbers. Some agency staff had not been well supported in their roles and responsibilities in the home

Kendal Care Home provides nursing and residential care for up to 120 older people, some of whom are living with dementia. The home is over three floors and has a passenger lift for access to these. There are three suites in the home and all the bedrooms are single occupancy with ensuite facilities. Each of the three units has communal dining and lounge areas. There is a cinema room for people to use. The home is set back from the main road, with level access grounds. There is ample car parking for visitors. During our inspection there were 75 people living there.

Summary of findings

The service did not have a registered manager in post at the time of this inspection or at the time of our inspection in February 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager had resigned from their post in March 2015 and their replacement left in August 2015 before registering with CQC. The registered provider is currently trying to recruit a suitable person for this post.

We found that on the residential unit people has some very positive things to say about the way the unit was run, the unit manager and their care and support. The two other units where there was nursing care provided for people, some of whom were living with dementia, were perceived less positively by relatives. They told us about the lack of leadership and management on the units and the frequent use of agency staff who did not know people well.

We found that the registered provider had started to make improvements in providing a consistent training programme for staff and providing mandatory training. However we found that training for specific roles and responsibilities was not consistent for all care and nursing staff to support them to safely effectively fulfil the requirements of their roles. This was evident because staff had not worked within the requirements of the Mental Capacity Act 2005.

We found that the management of medicines in the home did not always follow policies and procedures and current best practice and medicines were not always given as prescribed by the doctor. Most of the people we looked at had photographs and their allergies recorded on their medicines records which reduces the risk of medicines being given to the wrong person or to someone with an allergy and is in line with current guidance.

The systems used to assess the quality of the service had not identified all the issues that we found during the inspection. Whilst we found that some aspects of the quality monitoring processes were being done well others were less well monitored. The standard of some clinical record keeping was not adequate. The registered provider had not ensured that an effective system was in place to make sure the nutritional and hydration needs of people were accurately recorded and monitored. We also found that care and risk assessments had not always been reviewed and updated.

We found that people living at Kendal Care Home were able to see their friends and families as they wanted and go out when they wanted with them. There were no restrictions on when people could visit them. We could see that people who were able to made day to day choices about their lives in the home and were able to follow their own faiths. People living there and visiting relatives told us that staff were polite and caring and "Work extremely hard".

We have made a recommendation about making sure confidential health checks were carried out with people before they started work. Confidential health questionnaires help the registered provider to support physical or mental health conditions which are relevant to a person's capability for the role.

You can see what action we told the provider to take at the back of the full version of the report.

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

The service was not always safe.

The registered provider did not have a systematic approach to determining the skill and gender mix of staff on duty to meet people's preferences and needs. Agency staff had not been supported to safely fulfil their roles and responsibilities in the home.

People were not protected against the risks associated with use and management of medicines. The management of medicines in the home did not follow policies and procedures and current best practice.

Staff had been recruited safely with all relevant security checks in place. However confidential health checks had not been carried out with people to help make sure they were suitable or if they needed reasonable adjustments to perform their role.

Staff we spoke with in the home knew how to recognise possible abusive situations and how it should be reported.

Is the service effective?

Inadequate

The service was not always effective.

Care and nursing staff had not always been given the training, learning and development to make sure they could effectively and safely fulfil the requirements of their roles.

Systems in place to make sure people were always protected from improper treatment, as set out in the Mental Capacity Act 2005, were not effectively applied by staff in the home.

The systems in place were not effective to make sure the nutritional and hydration needs of people were accurately recorded and monitored.

Is the service caring?

Good

This service was caring.

We saw that staff in the home attended to care needs as promptly as they could and gave people the time to express themselves.

People's privacy was being promoted and we saw that where staff engaged with people it was positive, friendly and polite.

People were able to see personal and professional visitors in private. We could see that people had been supported to attend religious services and take communion as they wanted.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

The registered provider had not made sure that each person received appropriate person centred care based upon an on-going assessment and review of their needs.

Support was provided to follow their own interests and faiths and to maintain relationships with friends and relatives and local community contact.

There was a system in place to receive and handle complaints.

Is the service well-led?

Inadequate 

The service was not well- led.

There was no registered manager in post at the time of the inspection. The home had not had a registered manager since March 2015.

Due to the changes in management and lack of management stability over the last 6 months improvements to the service delivery have not made good progress.

There were systems to assess the quality of the service provided but these were not being effective to make sure the service maintained accurate records and good governance and service oversight.

Kendal Care Home

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.

We visited the home on 30th September and on 6 October 2015 2015. Our inspection visits were unannounced and the inspection team consisted of five Adult Social Care (ASC) Inspectors, an inspection manager and a pharmacist inspector.

During our inspection we spoke with people who lived in the home, relatives/visitors, nurses, care staff, ancillary staff, including domestic and activities staff. We spoke with two visiting health care professionals, the acting manager, the regional manager, a relief manager, the unit managers and the newly appointed activities and training manager. We observed the care and support staff provided to people in the communal areas of the home and at meal times. We spoke with people in communal areas and in private in their bedrooms.

We looked in detail at the care plans and records for 13 people and tracked their care (three on the residential unit, five on the nursing unit and five on the nursing unit for people living with dementia). We looked at records that related to how the home was being managed. We looked at the recruitment records for 18 staff working in the home and the agency staff profiles.

We looked at records, medicines and care plans relating to the use of medicines in detail for people living on all three units. We observed medicines being handled and discussed medicines handling with staff. We checked the medicines and records for 12 people (four on the residential unit, five on nursing and three on the dementia units). We spoke with six members of staff including two ward managers, a registered nurse, two registered agency nurses and a senior carer with responsibility for medicines.

Before our inspection we reviewed the information we held about the service, including information we had asked the registered provider to send to us on daily staffing levels. We also contacted local commissioners of the services provided by Kendal Care Home to obtain their views of the home. We looked at the information we held about notifications sent to us about incidents and accidents affecting the service and people living there. We looked at the information we held on safeguarding referrals and applications the manager had made under deprivation of liberty safeguards. We looked at information sent to us by health care professionals involved in providing care and support to the people living there to get their views.

Inadequate

Is the service safe?

Our findings

We spoke with people who lived at Kendal Care Home and their relatives, on all three units, about life in the home and about the staff availability.

On the ground floor residential unit people who lived there told us they were "happy" and felt safe living there. One person told us "I am very happy, I have everything that I need, all the staff know me well". Another person told us "I love it, the staff are terrific, They [staff] take me out, they open my doors and I can look after my plants".

Relatives also had positive things to say about the residential unit. We were told "[Relative] has everything they need and could not be better looked after. The feeling that gives you cannot be explained when you have to leave them". A relative told us that their family member had "started living again" since coming to the unit. On the day of the inspection we found that the residential unit had a unit manager and two permanent care workers, one of whom was a senior carer and they were looking after 17 people. A new member of staff was also on induction shadowing senior staff.

We spoke with people living on the first floor nursing unit and visiting relatives. Relatives told us that the staff worked "extremely hard" and "do their best". One relative told us that "overall" their relatives care was "good" but that there were not always enough staff. We were told "The staff are always changing or being moved" and "They [relative] get to know someone and then they're gone or moved" and "The place is run on agency staff". We were told "Agency staff are okay but they don't have the same commitment as the regular staff".

Relatives on the nursing unit told us they had found staff did not know people who lived on the unit well. We were told "The nurses don't notice when something is different because they don't know them [people living on unit] well enough to be aware something has changed". One relative told us that they had telephoned the unit to ask about their relative and the nurse who spoke with them talked to them about a different person. They said they had been checking because their relative had received bad news and wanted to make sure they were alright but the agency nurse did not know about that.

We were told by people on the nursing unit that the nursing staff were "often very busy" and "just left to cope". A relative told us, "We waited 23 minutes for someone to come for help to the toilet, they apologised for the wait, but that's no good". Another relative told us that they found that their relative was being left in bed for long periods and they had visited and found them still in bed at 3.30 in the afternoon. They told us when they asked why they were still in bed the reason given by staff on the unit was "There are not enough staff".

On the nursing unit a person living there told us "It's good here but they don't have enough staff, I ring and they could come immediately or it could be three quarters of an hour. That's the worst thing the staff are always busy". Another person who live there told us "At night there were two men on and I have said I prefer a woman to put my creams on. I am not comfortable with young men doing this and so say I don't want the cream on". We were told by another person who lived on the unit "Sometimes there is only one female about at night so you have to put up with it".

We visited the second floor unit where people who were living with dementia lived. A relative told us, "[Relative's] room is beautiful and there is no smell, there are very kind staff and they're very friendly and get me a cup of tea when I get here". We were told "[Relative] is looked after very well but they [staff] are run off their feet, they're understaffed definitely". A relative told us "The carers are okay but the night staff are not so good, mostly agency and men". Another relative who visited regularly told us "Communication is a real problem here with so many different nurses and one doesn't seem to know what the other one is doing".

At our previous inspections 8, 9 and 12 February 2015 and 6 June 2015 we had found that while there were adequate numbers of staff being made available to support people the staffing levels, could fluctuate and lacked continuity . We found at this inspection that the registered provider was keeping numbers of staff up to acceptable levels using agency staff. However the registered provider had not always used a systematic approach to determining the range of skills and experience needed and the gender mix of staff on duty to meet people's preferences and needs.

We saw that agency staff had been used on all shifts to help maintain the staff establishment and to be sure there were enough numbers of staff. It was evident from what we saw

and what people living there and visiting told us that the inconsistent deployment of those staff and frequent changes in staffing was having a negative impact on people's care and quality of life.

We found on the inspection that two agency nursing staff were working on and running the nursing unit . Both the agency nursing staff were on their second shift working in the home and neither had received a safety induction to the home. On the unit where people were living with dementia there were two permanent staff on duty. We raised this situation with the acting manager and they swapped nursing staff from the dementia care unit to have a permanent staff member supporting agency staff on the nursing unit. We saw that a nurse had also been brought from another of the registered provider's homes to work on the nursing unit at different times as well. Staff had been moved around units to help maintain numbers as needed and were working additional shifts to try to cover. This meant that people living there could not be sure that the staff supporting them had the necessary skills, experience and understanding of their conditions to provide the right care.

We asked agency staff about their support and information provided to help them when they came to work on a nursing units. We asked agency nurses about arrangements for handover information when they came on duty. They told us that they had not had been given written handover information when they came on duty. A formal handover would help them with information they needed to be immediately aware of such as changes in condition and behaviours. It was also to draw a nurse's attention to specific needs, preferences and risks. Agency staff told us in order to find out what the current situation was for all the people they were responsible for they had to read through all the care plans. We were told there was not time to do that properly and they had found communication was" not good" for agency staff coming on duty when they were not familiar with the unit.

We spoke with agency staff on the nursing unit and found that those on duty had not received an induction to the home and its safety and emergency procedures. We raised this as a safety issue with the acting manager and they began to address this straight away. Those on duty already were given a full induction to the home environment and fire procedures before the inspectors left. We were given verbal assurance that all agency staff coming on duty to do shifts over the week would complete this induction to the building and emergency procedures and have this recorded. Evidence of this having been done and recorded was provided following the visit.

We found from speaking to people in the home, looking at rotas and from information we had requested from the acting manager that there were times when on night shift the nurses on duty on the dementia care unit were all from an agency. We also found night shifts when there were only male carers on the dementia care unit and one female carer who moved between units. This meant that a female carer may not be available to support someone who wanted that. It was evident that gender and skill mixes on the nursing and dementia care units were still not consistent and stable.

On the day of the inspection on the dementia care unit there were two nurses and six carers for the 31 people living on the unit. We saw that 15 of the 30 required two staff for their moving and handling needs and personal care, one person needed three staff for personal care, 12 required one staff member and three people were independent. This was a high level of dependency and staff told us that some people were doubly incontinent or required to be helped to the toilet frequently by staff. We asked staff how they managed this level of dependency. We were told that "The unit leader always tries very hard to have six staff on and two nurses and deploys them sensibly".

The service used a dependency assessment to help assess the numbers of staff they needed based upon people's dependency and individual needs. However we saw that experience, skill mix and gender mixes of staff were not being given sufficient consideration when providing staffing on units especially given the high number of agency nursing and care staff being used on shifts. We could see from records that requests for agency staff had been consistently high with six care assistants already needed for one week.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not always used a systematic approach to determine that sufficient staff were deployed with the range of experience and skills needed on each unit and ensure the gender mix to safely meet people's preferences and needs.

Inadequate

Is the service safe?

We found that the management team did not have profiles of qualifications and registration confirmation for all agency nurses working there. We raised this concern with the acting manager who was able to provide confirmation by the end of the day from the agencies being used so we could be sure that agency nursing staff were fit to practice and had the training to carry out their roles.

The staff recruitment files showed that a Disclosure and Barring Service (DBS) check had been completed before they had started working in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults.

Over the two days of the inspection we looked at the recruitment records and checks being done in the home on the new staff working there. We noted that the registered provider had not carried out health checks when recruiting 12 of the18 staff whose records we looked at. This check was to consider people's physical and/or mental health in line with the requirements of the roles and if any reasonable adjustments were required.

We looked at the way medicines were being managed and handled in the home. We found that medicines were not always being given as prescribed by the doctor. One person was taking a medicine for their stomach that should have been taken an hour before food, but this did not happen at the correct time. The same person was taking a medicine at night to reduce their risk of urinary tract infections. The medicine was not given on one night as prescribed and there were missing signatures on the MAR (Medicines Administration Record) chart for other nights. So we did not know if it had been given as prescribed or not.

A second person was given a liquid pain killer that had passed the 90 days for safe use since it was opened on 29 May 2015. The date for when the bottle had been opened had not been recorded on it but we could see the date the record of when the first dose had been given. The medicine had past its date to be used by a month previously. A third person was prescribed a barrier cream to protect their skin. It had not been applied as directed by their doctor.

A fourth person who was on a medicine to reduce inflammation in the body had not been given it as prescribed for several months. During the inspection there was no record of this medicine being stopped by the GP. We asked the home to contact the person's doctor and the medicine was recommenced the following day.

A fifth person was on a medicine to relieve agitation when required, however, they had been given the medicine on most mornings. We could not see any recent medicine reviews or care management plans to ensure it was being given appropriately.

We checked the quantity levels recorded by the home for medicines belonging to five people. The quantities recorded for medicines belonging to two people were different to what was recorded in the home. This meant that these medicines could not be fully accounted for. The quantities for two people could not be accounted for as the amount from the previous MAR chart for one person had not been recorded and for the other person the previous MAR chart could not be found. The records for the controlled drugs cupboards were well kept (medicines controlled under the Misuse of Drugs legislation) and the quantities were recorded fully.

The recommended refrigerator temperatures for the safe storage of some medicines were not being recorded every day. One of the fridges we saw had not been fully closed and had been left ajar. This meant the temperature would not be correct. The same refrigerator had a catheter swab for one patient that should have been sent to the hospital to check whether the person had an infection. The swab could have contaminated the other contents of the fridge and should not have been kept in the medicines fridge. The catheter swab should have been sent for testing the same day or day after it had been obtained.

This was a breach of Regulation 12 (1) (The proper and safe management of medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the management of medicines in the home did not follow the services policies and procedures and current best practice.

The registered provider had systems in place across the service to make sure people living there were protected from abuse and avoidable harm. Staff working on the unit told us they had received training in safeguarding adults. We saw information on all the three units on what to do if anyone, staff, person living there or visitor, suspected someone was being abused in some way or at risk of abuse

Inadequate

Is the service safe?

or harm. This meant staff and people using or visiting the service had information on what to do so they could act themselves. A relative told us "The last manager was good with a safeguarding matter we had and dealt with it well. We felt that was good".

We recommend that the registered provider seeks advice and guidance from a reputable source on undertaking confidential checks on health for prospective employees in respect of requiring any reasonable adjustments.

.

Inadequate

Is the service effective?

Our findings

People living in the home expressed a range of opinions on the meals provided. We were told "Foods good, not found anything I don't like yet". "The food is usually good" and "Cooks reasonable food, today its chicken and ham pie, I believe" and also "Good food but little variety, we get fish, veg and have roasts at the weekend" and also that it was "A bit boring".

A relative commented that they felt the food was not well presented but their relative always had a choice and seemed to enjoy it. A relative of a person on the nursing unit told us how they had come to visit and found slices of cold toast left on the bedside table for their relative who was in bed and needed to be sat up to eat it and have it within reach.

On the nursing unit some people took their meals in bed. A relative told us they came in at meal times as they felt "it helps out". We were told that a person went round with drinks for people and staff were "supposed" to make sure they had the drink but that they (staff) did not always have the time.

At our previous inspections 8, 9 and 12 February 2015 and 6 June 2015 we had found that records we saw indicated that areas of staff training were not up to date within the home. Records did not provide evidence that staff had completed training that was mandatory. At this inspection we found that training needs were being identified and training was being organised and records were being kept up to date of the mandatory training done. The service now had a 'Training and Activities Manager' who had reviewed training needs and taken information from staff appraisals and from staff feedback and had started to implement the programme. However some training was still required to make sure all nursing staff could respond correctly to all people's nursing needs especially at the end of life.

Training records indicated that staff had not received training on supporting people at the end of life. Training records did not indicate that nursing staff had received this training or held post registration nursing qualifications or training in palliative care. We were told that staff had received some informal training on the use of equipment used in palliative care from the visiting community nurse practitioner. As nursing and care staff were supporting people at the end of life they required this training to support people and to make sure they provide care that reflected best practice and were competent to use the equipment required.

There was a training matrix in place recording the training staff had done and what they needed. We could see that 'mandatory' training had been provided and this included moving and handling (theory and practical). Further updates and training on moving and handling training was organised for the following month to help make sure all staff had done this. Training was being planned so all staff could complete additional training relevant to their roles such as dementia awareness, person centred care, conflict resolution and basic training on handling behaviour that could challenge the service. Staff had received safeguarding training as part of their mandatory training. We noted that some new staff had still to complete this following their induction training.

At the time of the inspection staff working on the dementia unit did not have accredited training on restraint, or managing challenging behaviour. None of the staff on the dementia unit had done accredited training such as the Prevention and Management of Violence and Aggression(PMVA) and Management of Violence & Aggression (MOVA).These are training courses to provide staff with the skills to deal with violence or aggression during the course of their work and who need to employ skills from conflict management, breakaway and/or physical restraint.

We saw that external trainers had been contacted to provide 'breakaway training' within the next month. This is training that teaches staff how to avoid or how to 'break away' from an assault. However it had yet to be provided. Staff we spoke with on the dementia care unit agreed this type of training was needed and were not aware of any specific training or policy provided by the organisation.

We saw that staff had access to e-learning for training as well as practical training and had been given a deadline to complete their mandatory elements. There were 12 units to be completed and staff were paid for the time to do this.

We saw that individual nursing staff had been able to attend training to support their clinical skills and provide appropriate care to people. This included male catheterisation courses and one nurse had attended a course to enable them to carry out continence

assessments. However not all permanent nursing staff had done a range of training required by their roles so people could not be sure that all the nurses caring for them had all the skills needed. We saw that new staff were starting the Care Certificate. The 'Care Certificate' is an identified set of standards that health and social care workers need to adhere to in daily working life.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not provided the support and systems for care and nursing staff to have the training, learning and development to make sure they could effectively fulfil all the requirements of their roles. Agency staff had not been supported to safely fulfil their roles and responsibilities in the home.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA) and DoLS provide legal safeguards for people who may be unable to make decisions about their care. Some people who lived at the home were not able to make important decisions about their care due to living with dementia or mental health needs. We spoke with staff to check their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with demonstrated an awareness of the codes of practice. However, training records indicated that not all of the care staff had received training on the MCA and DoLS. The permanent registered nurses were recorded as having done so except for those on sick leave.

However staff did not demonstrate a clear understanding of the safeguards in regard to a practical situation we found affecting a person living there. We saw evidence in care plans and from speaking with staff that action had been taken to control or restrain a person living on the dementia care unit. A care plan stated that a person became aggressive during personal care and staff had been injured whilst trying to give this care. Staff told us this "Happens all the time".

We did not see any evidence of this having been assessed and or advice sought from a person qualified in this field.

There was no evidence in the care plans or risk assessments to show how the staff had come to use restraint. Behaviour monitoring charts did not refer to it and there were no records of a review of the management of the person's behaviour. The person was subject to a deprivation of liberty order but that did not indicate or authorise the type of restraint being used. Staff told us that they had not received any accredited training that would allow them to restrain a person lawfully and safely. Therefore staff on duty were not competent or confident in this although it was required for their roles on the unit. As a result people were at risk of receiving improper treatment while receiving care. We spoke with the acting manager immediately so they could address this straight away.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured the systems in place were effective to make sure people were always protected from improper treatment and that staff always worked within the requirements of the Mental Capacity Act 2005 and deprivation of liberty safeguards.

All of the care plans we looked at contained a nutritional assessment and we observed the lunch time meal on the units. On the residential unit we observed people were able to remain at the tables as long as they liked. The atmosphere was calm and sociable and people chatted with the staff and other people living there. Some people had chosen to have their meal in their rooms and this was provided and one staff member remained in the dining room throughout the meal to supervise and help if requested.

We saw that staff offered people snacks and drinks and throughout the day. This included soft drinks, and alcohol with their meals if requested. Nutritional monitoring on the unit was being done and weights were checked monthly and recorded. However some nutritional records had not been added up to show if the required amount of liquids had been taken by some people.

At lunchtime on the dementia care unit 14 people needed assistance to eat their meals and take their drinks and 15 needed their food and fluid intake monitoring recording. We looked at these records and found that they were not always being kept up to date and some were not accurate. We observed a person at lunch time that ate a small amount of carrots from their main meal, a full portion of fruit crumble and custard, five biscuits, a cup of tea and a

glass of fruit juice. The food diary for the meal said the person had eaten "Few spoonful's of main meal and declined pudding". The information that had been recorded was not accurate.

On the nursing unit some people's nutritional assessments were completed some time ago and did not reflect the people's current needs. We looked at food and fluid balance charts and saw on records in people's room that the fluid intake, in order to maintain adequate hydration, over a 24 hour period were low. For one this was recorded as 530mls for one day and for another it was 100mls recorded as given. The latter person had a poor nutritional status and difficulty swallowing. There was not clear information in the care plan or on the fluid chart on the amount of fluid that the person should be taking.

There were inconsistencies in the fluid balance charts and food diaries we saw on both the nursing and dementia care units. A care plan record for one person on the nursing unit on the day of the inspection said they had two rashers of bacon an egg and beans for their breakfast but the food diary in their room had no breakfast recorded at all. The same person had no record of an evening meal on the food diary.

On the dementia unit we found a beaker of tea that would hold 200mls and there was 125mls left in it. The fluid chart stated 150mls of it had been drunk but that did not match the remaining amount of tea. The level of total fluid intake required had not been stated so staff did not know what the optimum level was for that person. Over a six day period for this person the food and fluid records for this person had not been completed fully or added up correctly

We could not tell from these care records what information was accurate so we could not assess what the people were actually eating and drinking. Therefore staff would not be able to monitor accurately food and fluid intakes and no one was monitoring the information to make sure it was being obtained correctly.

This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured that the systems in place were effective to make sure the nutritional and hydration needs of people were accurately recorded and monitored.

Good

Is the service caring?

Our findings

We asked people who lived Kendal Care Home about how they were cared for and how staff supported them to live as they wanted. On the residential unit people praised the way the staff supported them and spoke highly of the unit manager. We were told "It's a wonderful place, well worth the money"

One relative told us the unit manager was "wonderful" and the staff "very welcoming" and "very supportive". Another said "The staff are exceptionally caring". Another relative told us, "It's not for want of the staff trying to do their best that things get missed".

We were given examples by people living there and their families of times when they had been well supported by the unit manager and the staff to deal with difficult times, such as following bereavements and making adjustments to loss. We were told by a relative, "The staff are exceptionally caring and [unit manager] is so ready to help and ensure all the residents have what they want".

We spoke with people living on the nursing unit and visiting relatives. One person we spoke with on the nursing unit told us" They're [staff] very nice and pleasant. I have never seen any nastiness from anyone". We spoke with visiting relatives of the people living there who told us that the staff were "caring".

Where people were living with dementia there was signage to show people what different areas were for. This was to help people with memory problems to be able to move around their home more easily and more independently. We saw that there were examples of a caring approach by staff during daily interactions. For example we saw that staff did offer people reassurance when they showed signs of distress.

There were information leaflets and booklets in the home to inform and support people and families. This included information about the registered providers, the services offered raising concerns and about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

The nursing and care staff we spoke with understood the importance of providing good care at the end of a person's life. Care plans contained information about people's care and treatment wishes should their condition deteriorate.

We also observed care staff on the three units knocking before they entered people's rooms. We saw that staff maintained the privacy and dignity of the residents when assisting them with mobility and offered reassurance and explained what they were doing. We saw that bedroom doors were always kept closed when people were being supported with personal care. All bedrooms at the home were for single occupancy so people were able to spend time in private if they wished to. All the bedrooms had ensuite toilet and shower facilities so people had privacy for their personal care needs. People we spoke with told us that they saw their doctors in their own room when they visited.

Bedrooms we saw had been personalised with people's own belongings, such as photographs and ornaments to help people to feel at home. We saw staff talking to people in a polite and friendly manner. They called people by their preferred names as stated in their care plans. Throughout the time we spent in the home we saw that people had free access to their own rooms at any time and some people chose to remain in their own rooms for a lot of the day. One person told us "I do have a choice and I choose to stay in my room".

Requires improvement

Is the service responsive?

Our findings

People living at Kendal Care Home told us that staff helped them take part in activities and pastimes they enjoyed. People on the residential unit told us about going out, seeing their visitors and being able to attend religious services and follow their own faiths. The home had a programme of organised activities and dedicated activities staff to support this. Activities were going on in the dementia unit and we saw that the coordinator was sitting with people talking about films and film stars they remembered. A relative told us, "They do put on activities, that has improved lately".

One person living on the nursing unit told us, "I did art class this morning, it was alright, rather dull but the staff are well meaning". Another comment was "The activities girls work hard but it's pretty trivial stuff, no real challenge". A relative told us "Little mental stimulation as such". One visitor told us their relative was getting weaker and could not do the activities they once did. They told us "They don't change the activities to suit people, they need to change them to meet what [relative] can do now, not what they could do when they came in". We looked at this person's plan and found their social needs and the risk of social isolation had not been reassessed in light of their changed condition.

On the residential unit we looked at four care plans in detail to assess how individual care needs and risks to people were being assessed, planned for and managed. People's care records showed that their individual needs had been assessed when they came to live there. The information gathered was used to develop individual care plans. Where possible people were being supported to make their own daily choices and take part in activities outside the home as well as within. We saw that a moving and handling assessment had identified that a person needed to use a wheelchair mobilising over any distance or outside the home There was no risk assessment and plan in place for its safe use and to prevent the person falling from the wheelchair. We saw that the person had been taken out in the wheelchair that day.

On the dementia unit a relative told of a person living there told us "The nurses and carers themselves are very good I have no complaints about them". We had received information before the inspection from people who had made complaints to the service and who felt they had not been responded to quickly or well investigated. We looked at the home's complaints records and could see that some needed a response. The acting manager had been dealing with a backlog of such issues and were working through and responding to them.

The service had a complaints procedure that was available in the home for people. People who lived on the residential unit told us they had not felt the need to make a complaint but would feel comfortable raising anything they were not happy about with the unit manager.

Information on people's preferred social, recreational and religious preferences were recorded in individual care plans. People's care records showed that their needs were being assessed prior to admission to the home. The plans that were developed indicated that people had their personal and health assessed and recorded following admission. The assessments included personal and daily care needs and preferences, their skin integrity and risk of falling, mental health, nutrition and mobility and moving and handling needs. However, people's assessed needs, were not always being reviewed frequently. In some cases, this meant that people were not having their individual needs met as they changed.

We found evidence that people were being referred to other health professionals and services for treatment and assessment on the nursing units for example occupational therapy and dieticians. However this was not always done in a timely way on the dementia care unit. We saw that one person had been assessed as having swallowing difficulties in December 2014 and again in June 2015 but it was August 2015 before there was an assessment by the Speech and Language therapist.

On the unit where people were living with dementia we saw that people had risk assessments in place for personal risks, such as using bedrails and nutrition, although care plans were not being always done to support this. There was variation in the depth of care planning on dementia unit and we found some clear person cantered plans that reflected risks and managed them and others less so. We saw that the care plan in place for a person who had been restrained was not being followed by staff and contained contradictory information.

On the nursing unit we found that risk assessments had been carried out for people living there to identify risks but these had not been consistently reviewed and updated. We looked at risk assessments for one person who had

Requires improvement

Is the service responsive?

deteriorated both physically and mentally but the risk assessments had not been updated to reflect an increased risk from social isolation, reduced physical activity and changes in mental health. This meant that people might not receive support that was based on current risks. It also meant that visiting healthcare professionals could not rely on the accuracy of that information when carrying out care assessments. On the day of our inspection a meeting for continuing healthcare had to be postponed as one person's current care and risk assessments had not been reviewed and updated so they could not be sure they were accurate. Nursing staff told us doing the paperwork needed was "a real issue" and "We know all the care plans need redoing".

This was a breach of Regulation 9 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not made sure that each person received appropriate person centred care based upon an on-going assessments and reviews of their needs.

Inadequate

Is the service well-led?

Our findings

A relative we spoke with on the residential unit told us "I don't know why something went wrong a few months ago but it did. The management changed I can't find out why". A relative on the nursing unit told us "The managers are always changing, they need a strong manager". Another relative said "It's such a shame they can't get the right manager, this place could be so good".

Relatives we spoke with on the nursing unit commented upon the need for effective management on each unit and told us "What the unit lacks is proper management and leadership".

We asked staff about how the service was being managed and led. We were told " We've had four different managers already so lots of things just don't get taken forward or just don't happen". We were also told "We have some great expertise in this building but it's so ad hoc " and " We just need some stability"

The home did not have a registered manager in post as required by their registration with the Care Quality Commission (CQC). The registered manager had resigned in March 2015 and had deregistered with CQC. Another manager had been recruited and took up the post in June 2015 but left the service in September 2015 before completing registration with CQC. The home had not a registered manager in post since March 2015. This lack of management stability and continuity had significantly impacted upon the progress in implementing changes and improvements in the service.

However an acting manager and quality management team had been put in place by the registered provider to help provide some stable management and support to staff and. They had just started a new programme of reviews and quality monitoring. They were also actively recruiting new staff and a suitably experienced manager. Work had begun on implementing a more comprehensive training programme for the permanent staff. The registered provider had informed CQC of the resignations of the former managers and has provided a plan to indicate how the service would be managed until a suitable manager has been recruited and registered.

The registered provider had a system in place to monitor and report back to them on quality monitoring issues and assurance monthly. This required the acting manager to carrying out audits and send the findings of their checks to the provider as part of a larger organisational quality monitoring system. There were also monthly visits from the regional management.

At our previous inspections 8, 9 and 12 February 2015 we had found that the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for effectiveness so that the systems in use identified where improvement was needed.

At this inspection we could see that the acting manager was being more effective in quality monitoring in some areas with the monitoring of equipment, premises maintenance and cleaning. However we could see the overall monitoring and checking systems in the home were still not been used effectively when monitoring other areas including, care plans, medication management, records and making sure all staff had the right training for their roles. This was evident from the shortfalls we found in records and practices. Monitoring had also not been effective in recruitment, the recruitment records had been audited in July 2015 on a monitoring visit by the then regional manager .This audit stated that the recruitment files were correct but our checks found that no pre-employment health checks had been carried out on the new staff.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider was not operating an effective system and processes to make sure the service maintained accurate records and practiced good governance.

The acting manager and the quality management team had identified that there were significant shortfalls in aspects of the service provision and the management structures and lines of accountability in the home. They had in place detailed action plans to address the areas identified as requiring improvement and were working with commissioners, stakeholders and CQC to achieve and maintain the required improvements. Dates to achieve improvements had been stated and those responsible for the action identified. This process was being monitored as part of the local authority quality monitoring procedures. Support was being given by those commissioning the service. Training and support requirements had been identified and offered and being utilised. The service was not taking new admissions whilst the quality improvement

Inadequate

Is the service well-led?

and safety issues were being addressed. In our discussions with the quality management team they had been open to the feedback from the inspection team and could evidence they had started to make changes whilst accepting that it could not be achieved quickly or without significant resources.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The registered provider had not made sure that each person received appropriate person centred care based upon an on going assessment and reviews of their needs. Regulation 9 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The management of medicines in the home did not follow the home's policies and procedures and current best practice about managing medicines. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met. The registered provider had not ensured systems were in place to make sure people were always protected from improper treatment and that staff always worked within the requirements of the Mental Capacity Act 2005 and the deprivation of liberty safeguards. Regulation 13 (1) (2)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met. The registered provider had not ensured that the systems in place were effective to make sure the nutritional and hydration needs of people were being accurately recorded, monitored and met. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered provider had not always used a systematic approach to determining the range of skills needed and the gender mix of staff on duty to meet people's preferences and needs. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered provider had not provided the support and systems for care and nursing staff to have all the training, learning and development to make sure they could effectively fulfil all the requirements of their roles. Agency staff had not been supported to safely fulfil their roles and responsibilities in the home. Regulation 18 (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider was not operating effective systems and processes to make sure the service maintained accurate records and practiced good governance. Regulation 17 (1) (2)

The enforcement action we took:
Warning Notice issued. Timescale: 18 December 2015.