Mrs P Kent

Kent Lodge Residential Home

Inspection report

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Ratings

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

Overall summary

We carried out this inspection on 9 March 2015. This inspection was in response to concerns raised by the Local authority Safeguarding team and to see if the Provider had made the improvements required following an unannounced comprehensive inspection at this service on 13 and 17 February 2015. At the inspection in February we had found several continued breaches of legal requirements.

Following the inspection in February, we asked the provider to take action to make improvements as we found evidence of major concerns in relation to the monitoring of the quality and safety of the service. There was a failure to ensure that service users were protected from the risks associated with improper operation of the premises. This meant that the safety and welfare of people using the service was at risk and the provider was failing to provide a safe, service. There was a continued lack of training and supervision support provided for staff. The provider was not meeting the requirements of the law as they did not protect people against the risks of receiving care or treatment that was inappropriate or unsafe.

Summary of findings

We formally notified the provider of our escalating and significant concerns following our comprehensive inspection on 13 and 17 February 2015 and ongoing emerging risk and concerns shared with us by stakeholders. We informed the provider that we were in the process of making a decision with regards to their continuing failure to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the lack of management within the home. We placed a condition on their registration to stop them admitting any further people to their service. We asked the provider to inform us immediately of the urgent actions they would take with immediate effect to protect people and raise standards.

We received a response to the urgent action letter on 6 March 2015. This contained a basic action plan but did not address all of the requirements of the urgent action letter. This was further evidence of our lack of confidence in the provider's ability to understand the issues and independently ensure that the service provided safe and effective care.

We carried out this inspection on the 9 March 2015 following further concerns identified by the local safeguarding authority and to check if improvements had been made as described in the provider's action plan. This inspection was unannounced.

This report only covers our findings in relation to the previous breaches. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Kent Lodge Care Home' on our website at www.cqc.org.uk

Kent Lodge provides accommodation and personal care support for up to 30 older people who require support including people living with dementia. On the day of our inspection there were 21 people living at the service.

At this inspection we continued to have major concerns regarding the lack of action taken by the provider to safeguard people. There was a continued lack of leadership of the service as the service had continued to not have a manager registered with the Care Quality Commission (CQC) as is required by law. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. On 6 March 2015 we were informed by Suffolk County Council that the manager was no longer working at the service and that the provider would be taking over full management control at the service until a new manager could be recruited.

The provider continued to not provide staff with guidance in the actions they should take to deliver care in such a way as to meet people's individual needs and to safeguard them from harm. People's safety continued to be compromised in a number of areas. This included the continued lack of recording and analyses of accidents and incidents as well as a continued lack of guidance for staff in responding to emergency situations. The provider had failed to identify areas of the service that were unsafe and failed to take action to protect people from the risks of harm.

We were not assured that people's choices and rights were being respected. Staff had still not received training in the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). The provider did not demonstrate any understanding of their roles and responsibilities in safeguarding people and taking steps to follow the principles of the MCA. They were not fully meeting the requirements of the Deprivation of Liberty Safeguards.

There was insufficient planning to support people's wishes and preferences regarding how they wanted to be cared for at the end of their life. There was also insufficient planning to promote and support people's individual leisure interests and hobbies. We were therefore not assured that the planning and delivery of care supported people's individual needs, wishes and preferences.

The service was not run in the best interests of people using it because their views and experiences were not sought. Improvements were needed in the ways that the service obtained people's views and used these to improve the service.

Staff did not demonstrate that they had the required knowledge to be able to safeguard people and report any safeguarding concerns to the relevant safeguarding authority.

Summary of findings

We found there continued to be a number of continued breaches. 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

Action had not been taken to improve the safety of the service. The provider did not identify, assess and manage risks relating to the health, welfare and safety of people.

Risks to people's safety had not been assessed. The provider continued to not provide staff with guidance in the actions they should take to deliver care in such a way as to meet people's individual needs and to safeguard them from harm.

People were not protected from the risks associated with unsafe or inappropriate operation of the premises.

Is the service effective?

Inadequate

Action had not been taken to improve the effectiveness of the service.

The provider continued to fail to put in place suitable arrangements for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them.

Care was not provided in such a way that met people's individual care needs. There was a lack of action taken to protect people's care and welfare.

Staff had not received adequate training, guidance and support to meet people's individual needs and ensure their health, welfare and safety.

Is the service caring?

Requires improvement

(Text unchanged from comprehensive inspection)

Is the service responsive?

Inadequate

The service had not taken action to provide care that was responsive to people's needs.

Care plans did not contain enough information about people's needs for staff to deliver responsive care. People were not provided with the opportunity to be involved in the planning and review of their care.

People did not have their individual needs, wishes and preferences assessed in relation to how they lived their daily lives, interest and hobbies and how these could be supported and provided for.

Is the service well-led?

Inadequate

Action had not been taken to ensure the service was well-led. The provider failed to sustain any improvements in the quality and monitoring of the service. The same regulations identified in previous inspections were again non-compliant. This placed people using the service at risk of receiving inappropriate and unsafe care.

Summary of findings

The service was not well led. The management of the service lacked direction and positive leadership.

People were put at risk because there was a continued lack of systems for monitoring the quality and safety of the service.

Kent Lodge Residential 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 carried out this focused unannounced inspection of Kent Lodge on 9 March 2015. This inspection was completed to check that improvements had been made to meet legal requirements planned by the provider after our comprehensive inspection 13 and 17 February 2015 had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, is the service effective, is the service responsive and is the service well-led. This is because the service was not meeting legal requirements in relation to these questions asked.

The inspection team consisted of two Inspectors.

Before our inspection we reviewed the information we held about the service, this included the provider's action plan.

We spoke with the local authority safeguarding team and reviewed all other information sent to us from other stakeholders such as Environmental Health and community nursing services.

We spoke with three people who were able to verbally express their views about the service and four people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also observed the care and support provided to people and the interactions between staff and people throughout our inspection.

We looked at records in relation to four people's care. We spoke with five members of staff, including care staff, senior care staff, domestic staff and the provider. We looked at records relating to the management of medicines, staff training, and systems for monitoring the quality and safety of the service.

Prior to our inspection we had received concerns about the service provided; these had been reported to and investigated by the local authority. The local authority had kept us updated with the support that they were providing to the service to assist them to improve the care and support provided to people. During our inspection we looked to see what action had been taken as a result of these concerns.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspections of Kent Lodge on 13 and 17 February 2015 we found that the provider had continued to fail to take action to ensure people's health and welfare because risks to people's health, welfare and safety had not been properly assessed. We identified continued, significant concerns with the way people were being supported with their pressure care needs, also nutrition and hydration.

We found at this focused inspection there was a continued failure to produce care plans to evidence any planning of people's care, treatment and support. People's medical conditions such as those diagnosed with diabetes and epilepsy had continued to not be assessed and the delivery of their care had not been planned to meet their health, welfare and safety needs. The provider continued to not provide staff with guidance in the actions they should take to deliver care in such a way as to meet people's individual needs and to safeguard them from harm.

At the start of our inspection we asked the provider if there was anyone one being cared for in bed. They told us there was no one who required bed care. Care staff later told us there were in fact two people being cared for in their beds 24 hours a day 7 days a week.

Repositioning charts found in one of these people's rooms, identified as requiring bed care contained instructions for staff to, 'Turn this person every two hours when in bed'. From February to the 9 March 2015; we found gaps of up to 11 hours where there was no record of any support provided to reposition this person to avoid further deterioration to pressure areas and no recording of any personal care support including any change of continence aids. Two senior staff we spoke with told us that they had not monitored the repositioning charts and we could not confirm that staff had carried out the repositioning of people as instructed by community nursing staff.

Community nursing staff told us that this person had been diagnosed with a Grade 1 pressure ulcer. There were no care plans or risk assessments with action plans in place which would guide staff as to how this ulcer should be managed. This person's care had not been planned and delivered in line with their individual care needs. We were therefore not assured that the welfare and safety of this person had been safeguarded and that appropriate care and treatment was being provided.

Another person assessed by community nurses as at high risk of developing pressure ulcers and required repositioning every two hours. Gaps in their repositioning records showed us that this person had not been repositioned for up to 26 hours. Staff told us this was due to a lack of training, management leadership and the inconsistent deployment of staff which led to confusion as staff had not been deployed effectively and staff did not know who had been delegated to be responsible to reposition people. Senior carers told us they did not monitor the reposition charts and had not delegated individual staff appropriately to check that the planning and delivery of care met service user's individual needs.

The provider did not to take proper steps to ensure that people were adequately protected against the risks of inappropriate or unsafe care by regularly reviewing their needs and revising their plan of care. We found four people who staff told us had been identified as at risk of malnutrition due to poor appetite and poor health. There were no care plans and risk assessments with action plans in place which would guide staff in the actions they should take to deliver care and treatment appropriately and protect the welfare and safety of people.

Community nursing staff told us that they had concerns about the lack of staff skills and knowledge as to skin deterioration issues which put people at risk of acquiring pressure ulcers. Staff told us they had not received any training in recognising and prevention of pressure ulcers.

For one person who had been diagnosed with epilepsy and diabetes, when asked, staff could not tell us what type of diabetes this person had been diagnosed with. There were no care plans or risk assessments in place to guide staff in the planning and delivery of care to ensure that this person's health, welfare and safety needs would be met. Care and kitchen staff told us they had not received any training in caring for people diagnosed with diabetes, epilepsy and other medical conditions. They also gave conflicting accounts as to how they believed they should support this person. The provider was unable to show if staff had received adequate training, guidance and support to meet this person's individual needs and ensure their health, welfare and safety.

Inadequate

Is the service safe?

This demonstrates a continued breach of Regulation 9 of the Regulated Activities Regulations 2010.

During our comprehensive inspection 13 and 17 February 2015 we found that people and others having access to the service were not protected against the risks associated with unsafe or unsuitable premises. We found the front door to the service was left unlocked and the building unsecure throughout the day. Although there was a book for people to sign in and out, we observed people coming into the building without staff oversight. Staff and the manager told us that it was common practice for the front door to be left unlocked throughout the day until night staff locked the door. The lack of appropriate measures in place in relation to the security of the premises put people at risk as unauthorised people could have open access to the premises.

During this inspection we carried out a tour of the building accompanied by a senior carer. They told us the home had five bathrooms of which only two were fit for use. At our previous inspection the 13 and 17 February 2015 we identified one downstairs bathroom to be without heating. The manager told us they would action repair of the heating to this room immediately. At our focused inspection 9 March 2015 we found that the heating had not been repaired and staff continued to support people with their personal care using this bathroom. Two care staff told us that this bathroom had been without heating all winter and the lack of heating had been reported to the manager on several occasions. They also told us that this bathroom had been used throughout the winter to bathe people. When asked how staff ensured the bathroom was warm enough they told us they would close the window and pull down the blind.

When asked about these inadequate arrangements for ensuring that the temperatures in the bathrooms were suitable the provider told us they were not aware of the heating failure. They also confirmed that there was no system in place to monitor the temperature of the bathrooms. This demonstrated a failure to protect people from the risks associated with bathing in cold rooms and did not protect people from the risks associated with unsafe or inappropriate operation of the premises.

We found three bathrooms without hot water. There were no robust systems for regular testing of water temperatures when supporting people with bathing. There were no thermometers in all but one bathroom. Care staff told us that a shortage of hot water was an ongoing problem in bathrooms and in particular two rooms 9 and 11. We tested the water in these rooms. We found the water to be running cold in both these rooms. Staff confirmed that they supported people on a daily basis with their personal care using water from these rooms. A review of water temperature testing carried out by the manager in November 2014 showed a lack of hot water had been identified in room 9 and records stated mixer valves had been ordered. The provider could not provide any evidence that repairs had been carried out to ensure people had access to hot water to provide for their personal care needs. This meant there was a failure to ensure that people were protected from risks associated with inadequate maintenance of the premises.

We identified at our comprehensive inspection on 13 and 17 February 2015 toilets without soap and hand sanitizer. We also identified several broken, chipped and stained toilet seats and commodes throughout the building. The manager told us they would rectify these issues immediately. At this inspection we found two bathrooms without hand soap or sanitizer and one bathroom and toilet did not have paper towels. The broken toilet seats identified at our previous inspection were still in place and continued to place those individuals using these toilets at high risk of falling as toilet seats were loose. There was also a continued risk of injury to the skin from wood that was split and could pinch skin, as well as the risk of infection. This demonstrated a failure to ensure that people were protected from the risks associated with inadequate maintenance of the premises.

We observed five fire doors wedged open contrary to fire regulations with people's personal ornaments and commodes. When we pointed this out to staff, no action was taken to free up the fire doors. As a result risks to people persisted; fire doors must be kept close in order to limit the spread of a fire. Wedging them open presents no barrier to fire and will allow a fire to spread quickly. The provider had not taken action to protect people from risks associated with improper operation of the premises.

During our comprehensive inspection 13 and 17 February 2015 we identified concerns with people's access to the sluice room and laundry room where chemicals were stored on open shelving. A visit from Environmental Health officers (EHO) on the 6 March 2014 also identified these areas as hazards to people's safety and instructed the

Inadequate

Is the service safe?

provider to take action to restrict access to these rooms. During our focused inspection on the 9 March 2015 a locksmith arrived at 11:45am to install a lock to the sluice room door. We observed that even after the locksmith had completed installing the lock, this room was still left open throughout the day with the key left in the lock. No lock had been fitted to the laundry room and this remained open throughout our visit. The risk to people's safety remained as access to these areas had not been restricted.

We found that the provider had failed to take action to address a number of concerns that had been identified by EHO inspectors with regards to the safe storage and handling of food. Food stored in the fridge such as jelly and cream was found uncovered and not dated. Missing wall tiles had not been replaced. Paper towels had not been provided next to the kitchen basin. No system had been put in place to record a thorough examination of hoist slings. The risks to people's safety remained as action had not been taken by the provider to safeguard people from the risk of harm.

This demonstrated a failure to protect people from risks associated with improper operation of the premises.

This demonstrated a continued breach of Regulation 15 (1) (a) (i) of the Regulated Activities Regulations 2010.

Inadequate

Is the service effective?

Our findings

During our comprehensive inspection 13 and 17 February 2015 we found that the provider had continued to fail to put in place suitable arrangements for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them.

We were not assured that people's choices and rights were being respected. Staff had still not received training in the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). The provider did not demonstrate any understanding of their roles and responsibilities in safeguarding people and taking steps to follow the principles of the MCA 2005. They were not meeting the requirements of the Deprivation of Liberty Safeguards.

We continued to have major concerns as care plans had not been updated and continued not to identify whether or not people had the capacity to make decisions about their everyday lives. No assessment of mental capacity had been carried out for people whose movement had been restricted by the use of bed rails. No referrals to the local safeguarding authority had been made in support of people who lacked capacity to ensure best interest assessments had been carried out by those qualified to do so. There was no explanation in people's records as to why consent had not been sought. Without this staff could not tell us that they were ensuring people's consent was being sought and respected.

This meant that there was a continued breach of Regulation 18 of the Regulated Activities Regulations 2010.

Staff told us they had not been supported in their roles by the previous manager and the current provider as they had not received training relevant to their role. New staff appointed within the last two years had not received any induction training. Kitchen staff responsible for the preparation and cooking of food had had not received training in safe food hygiene or health and safety and all staff had not received safe moving and handling training. This meant the provider had not taken action to mitigate risks and protect people from the risks of unsafe or inappropriate care.

Staff had not been provided with opportunities to acquire further skills and qualifications that are relevant to the work they undertake. Staff also told us they did not receive regular support with supervision and annual appraisals to enable them to discuss their training and development needs.

The provider's policy and procedure for supervision of staff stated that every staff member would have two monthly supervision meetings. The provider had failed to adhere to your own policies and procedures as staff told us these that these continued not to take place. This meant that staff had not been provided with the opportunities they needed to discuss their training and development needs or opportunities to talk through any issues about their role, or about the people they provided care, treatment and support to. The provider continued to fail to support staff through a regular system of appraisal that promoted their professional development and reflected relevant regulatory and/or professional requirements.

The provider's action plan told us they had arranged training for staff in a number of subjects such as nutrition, food hygiene the safe moving and handling of people all scheduled to take place on the 10 March 2015. We noted that the moving and handling training was booked to last only one hour and not all staff had been allocated access to this training. We expressed concern that this training would not provide staff with a demonstration of the full range of moving and handling manoeuvres to equip them with the skills and knowledge they would need to adequately assess people's needs and mobilise people safely. The provider told us they were unaware of the shortfall and would look into this.

This meant that there was a continued breach of Regulation 23 of the Regulated Activities Regulations 2010.

We visited one person in their room who staff had confirmed was being cared for in bed 24 hours a day, 7 days a week. This person did not have access to a call bell as this was tied up against the wall despite the fact that staff told us this person had the capacity to use the call bell if they needed to. No one could explain why the bell was out of reach or how this person could alert staff if they needed help. Fluid charts did not have a record of dates or times when fluid had been provided by staff. Senior staff confirmed to us that no monitoring of fluid charts had been carried out. Staff also stated that they did not know how often they were required to attend to this person. Staff told us they offered fluids when they could but also told us there was no system of consistent staff delegation to

ensure they received regular fluids as their needs had not been appropriately assessed. We could not be assured that this person had been effectively monitored and supported to drink sufficient amounts to meet their needs and to avoid the risk of dehydration. This demonstrated a failure to plan and deliver care in such a way as to meet people's care needs.

Daily records showed us that this person's GP had advised staff to monitor their weight on a weekly basis. There was evidence of only one monitoring of weight recorded since 18 February 2015. There were no care plans in place with actions to describe for staff how to support this person with their nutritional intake and actions to safeguard them from the risks of malnutrition and dehydration. This demonstrated a failure to assess this person's care needs and provide care in such a way that met their individual care needs and protected their care and welfare.

Between 12:45pm and 2:40pm we observed three people struggling to eat their meals within two communal lounges. At no point during this time did staff attempt to provide support to people. Staff were observed walking through the lounges without any acknowledgement of these people. We observed on person who struggled to eat their meal and used their fingers to try to eat mashed potato, sausages & cauliflower. The majority of their meal ended up on the floor and on their clothing. Another person was observed to frequently fall asleep and only managed to eat a third of their meal between 12:45pm to 2:30pm when staff took away their meal without offering further support. A third person managed to eat their main meal but this took them from 12:45pm to 2:40pm when staff arrived to take away the empty plate and put in front of them their pudding. We saw that there was no planning of how care and support should be provided to people during meals. The fact that people were struggling to eat and not eating enough presented a risk of malnutrition. The lack of support for people during meal times presented a risk of choking. This demonstrated a failure to assess people's needs and deliver care in such a way as to meet these needs. It was also a failure to ensure that people's health and welfare were maintained.

One person assessed by their GP as at risk of inadequate nutrition and hydration was not being adequately monitored. We visited this person in their room. There was a beaker of water on a nearby table but no fluid chart in place to record any fluids consumed. There were no fluid charts located elsewhere and this was confirmed by the senior carer on duty. Staff could not demonstrate the arrangements in place to ensure that this person had been supported to drink sufficient amounts to meet their needs and to avoid the risk of dehydration. We found that there were gaps in Malnutrition Universal Screening Tools (MUST) records from 19 May 2014 to 31 January 2015. The scoring of risk was incorrectly calculated. The action plan guided staff to weigh weekly. We found gaps of up to six weeks where there was no recorded monitoring of this person's weight. These gaps meant that it there was potential that risks were not being monitored so that any deterioration could be addressed in a timely manner, planned for and delivered appropriately. This person's last recorded weight was on the 31 January 2015. Staff could not provide any explanation for there being no further records and could not confirm to us whether or not they had been weighed at all since this date.

We observed staff feeding the same person whilst the person was lying flat on their bed. This put them at risk of choking and inhaling food which could lead to a risk of them contracting pneumonia. The service had failed to refer this person to a specialist Speech and Language Therapist team (SALT) to obtain specialist advice on how to support them safely and appropriately with their nutritional needs. The provider told us they were unable to confirm that any actions had been taken to safeguard this person or any attempts made to seek professional guidance from a specialist. There were no care plans in place to guide staff on how to support this person with their nutrition and no actions to safeguard them from the risks of malnutrition and dehydration. This demonstrated a failure to carry out an assessment and planning to deliver care in such a way as to meet this person's identified care needs.

This meant there was a continued breach of Regulation 9 of the Regulated Activities Regulations 2010.

Requires improvement

Is the service caring?

Our findings

(Text unchanged from comprehensive inspection)

Inadequate

Is the service responsive?

Our findings

At our comprehensive inspection on 13 and 17 February 2015 we found that people did not always receive personalised care that was responsive to their needs. Care plans did not contain enough information about people's needs for staff to deliver responsive care.

At this focused inspection we found a continued lack of suitable systems in place such as needs assessments, care plans and risk assessments to ensure that people's needs had been assessed, care and treatment planned, monitored and reviewed to meet people's health, welfare and safety needs. The provider could not provide us with any information to support that they had made any progress in mitigating the risks to people and ensuring that they were provided with care that met their needs and kept them safe.

There was insufficient planning to support people's wishes and preferences regarding how they wanted to live their daily lives and how they wished to be cared for at the end of their life. We were therefore not assured that the planning and delivery of care supported people's individual needs, wishes and preferences. The provider had not taken action to provide care that was responsive to people's needs.

There was a continued lack of information with regards to people's medical histories, a lack of information with regards to people diagnosed with dementia with no details as to the type of dementia and no guidance for staff in supporting people with behaviour that may present with distressed reactions to others or their environment. Care plans did not include an assessment of risk and offer solutions or strategies for staff to follow. There was no clear guidance as to how people should be supported to mobilise or what their hobbies, interests or aspirations were.

There was no visible sign of any activities taking place. People's individual needs for social stimulation, community inclusion and access to group activities had continued not to be assessed. There was no planning to promote and support people's individual leisure interests and hobbies. People told us, "There are no activities other than those you organise yourself", "Staff are too busy, they do their best", "There is no plan of activities we sometimes have chats and maybe a quiz" and "Sometimes the church people come in."

This meant that there had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection 13 and 17 February 2015 we found that the provider had failed to sustain any improvements in the quality and monitoring of the service. The same regulations identified in previous inspections were still being breached. This has placed people using the service at risk of receiving inappropriate and unsafe care.

We found at this focused inspection that the provider continued to not have systems in place to identify, assess and manage risks to people who used the service and others. No environmental risk assessments had been carried out. The provider confirmed that they did not protect people against the risk of unsafe and inappropriate care as there were insufficient systems to record accidents and incidents. Where people had sustained bruising to their body or had acquired pressure ulcers, these had not always been recorded. Where incidents of falls had been recorded or bruising noted on body maps these had not been investigated. Staff had not been provided with guidance as to what action they should take to protect people from further incidents. This meant that themes and trends had not been identified. People were put at risk of repeated incidents as actions had not been identified or evidence of lessons learnt.

On 6 March 2015 the service was inspected by Environmental Health Officer's (EHO) who identified concerns around the lack of management control and training of staff. Significant training issues were identified relating to the lack of training in safe moving and handling techniques and the use of lifting devices. Further there was a lack of staff training in risk assessment, checks of moving and handling equipment, sluice room hazards, asbestos and no management safety checks or risk assessments. There was a lack of cleaning equipment available and unsafe storage of cleaning equipment. Significant concerns were found in relation to food safety, the unsafe storage of food, poor management monitoring and safety audits, cooks without food safety training, poor standards of cleanliness within kitchen area, lack of systems for structural cleaning, lack of sanitizers. In addition they took immediate action to reduce the service Food Hygiene Rating from 5 (very good) to 1(major improvement necessary).

There was a continuing failure to put in place systems to regularly assess, monitor and drive improvement in the quality and safety of the service. The provider confirmed that there were no quality monitoring systems to regularly assess and monitor the quality of the service. People were not consulted with and had not been involved in important decisions about their care, treatment and support.

The provider continued to not provide staff with supervision and appraisal. Staff told us they had not received opportunities for supervision and staff meetings for two years. The provider did not have arrangements in place to provide staff with training to enable them to deliver care and treatment to people safely and to an appropriate standard. This meant that staff had not been provided with opportunities to discuss their training and development needs.

We found that there were no plans in place to guide staff in emergency situations, such as the outbreak of fire. Staff told us they had not received training in fire prevention and guidance in what to do in the event of a fire. When we toured the premises we saw that people had continued to be put at risk of doors being wedged open. No environmental risk assessments had been produced to guide staff in actions they should take to protect people from the risk of harm. Staff told us they had not received training in any fire evacuation. The provider did not have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services in order to mitigate the risks arising from such emergencies to service users.

This demonstrated a continued breach of Regulation 10 of the Regulated Activities Regulations 2010.

The provider when asked could not provide us with any evidence to demonstrate that they had made any progress in mitigating the previously identified risks to people and ensuring that they were provided with care that met their health, welfare and safety needs and protected their rights. In response to our concerns identified at this inspection we escalated our concerns to the local authority safeguarding team at Suffolk County Council (SCC) to ensure that these people were safeguarded from harm. The local authority responded by visiting the service on the 11 March and put in place a protection plan with actions to safeguard people identified as at risk of neglect and harm.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to protect people against the risk of receiving care or treatment that was inappropriate or unsafe by means of the carrying out of an assessment of needs; and the planning of care to ensure the welfare and safety of service users.** Regulation 9 (1) (a) (b) (i)(ii)(iii)

The enforcement action we took:
We have formally notified the provider of our proposal under Section 17 of the Health and Social Care Act 2008 to cancel their registration as a service provider in respect of the above regulated activities at Kent Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not protect service users, and others who may be at risk, against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable them to regularly assess and monitor the quality of the service provided in carrying on the regulated activity. They also failed to identify, assess and manage risks relating to the health, welfare and safety of service users and other who may be at risk.** Regulation 10 (1) (a) (b) (2)

The enforcement action we took:
We have formally notified the provider of our proposal under Section 17 of the Health and Social Care Act 2008 to cancel their registration as a service provider in respect of the above regulated activities at Kent Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	The registered person did not ensure that service users and others had been protected against the risks associated with inadequate maintenance of and unsafe and suitable premises. Regulation 15 (1) (b)(c)(I)

The enforcement action we took:
We have formally notified the provider of our proposal under Section 17 of the Health and Social Care Act 2008 to cancel their registration as a service provider in respect of the above regulated activities at Kent Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People were not protected against the risks of receiving care and treatment without establishing whether or not they had capacity to consent. The staff and the provider had not been provided with training in understanding their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Regulation 18 1 (a) (b)

The enforcement action we took:
We have formally notified the provider of our proposal under Section 17 of the Health and Social Care Act 2008 to cancel their registration as a service provider in respect of the above regulated activities at Kent Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that staff received appropriate training, supervision and appraisal in order to obtain the skills and knowledge they required for the work they were to perform. Regulation 23 (1)(a)(b)

The enforcement action we took:
We have formally notified the provider of our proposal under Section 17 of the Health and Social Care Act 2008 to cancel their registration as a service provider in respect of the above regulated activities at Kent Lodge.