Anchor Trust

Kirklands

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 8 February 2016 and was unannounced.

Kirklands is owned by Anchor Trust which operates residential and other care services for older adults. The home is situated in a residential area of Cockermouth and was purpose built twenty years ago. It is within walking distance of all the local amenities.

Kirklands is registered to provide accommodation and personal care for up to 40 older people, some of whom may be living with dementia. Accommodation is provided on two floors and all bedrooms are single ensuite rooms. There is a lounge and dining room on each floor.

There is a registered manager in post at Kirklands. 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.

People who used this service told us that they were happy at the home. One person said; "All I can say about this place is that it is good. You get your meals brought to you, my room is kept clean and the girls (staff) are kind. I would tell anyone to come here."

Another person told us; "I like it here better than I thought I would. I was able to bring some of my things from home with me to brighten my room. I get help when I need it and my visitors can come any time. I can have what I want to eat, the food is very good and I get well fed."

A third person added; "It is generally exceptionally good here. The help I need is increasing rather than decreasing but the staff usually come to help quite quickly. The staff are respectful and nice but there are occasions when you feel like you could have been spoken to in a better manner."

There were sufficient numbers of staff on duty during the daytime to meet the needs of the people who used this service. However, the night staff told us of the difficulties they experienced in trying to meet the needs of people who used this service during the night. One of the people we spoke to also told us that they did not always receive the support they needed during the night.

People who used this service were not properly protected from the risks of receiving unsafe or inappropriate care. This was because care plans and risk assessments had not been reviewed and updated as people's needs changed.

With the exception of creams and ointments, medicines were managed appropriately and safely. Where people needed help and support with their skin care, risk assessments, care plans and medicine administration records had been poorly maintained.

On the day of our visit the home was generally clean, tidy and there were no unpleasant odours. Housekeeping staff told us that they were not familiar with the cleaning schedules in place at the home and highlighted some of the difficulties they experienced when cleaning some of the individual bedrooms.

Staff received training and supervision to help them carry out their role safely and appropriately. There were some gaps in their training particularly in relation to personal planning.

People who used the service told us that the food and drink provided was "very good" and that there were always plenty of choices available. We observed the service of the lunch time meal, which confirmed everything we were told by the people that lived at Kirklands.

The home had adaptations to help people move around the home safely, for example there were hand rails, a passenger lift and stair lift available. Communal areas and individual bedrooms were clearly signed to help people orientate themselves around the building.

We observed staff supporting people who used this service. Staff spoke kindly and were discreet when supporting people with their personal care needs. People were treated with respect and dignity and wherever possible encouraged to be as independent as possible.

We found that care planning and assessments of people's needs was not always carried out in a person centred way.

The service had a process in place to help ensure people were able to effectively raise concerns or complaints or compliments with the provider. There were systems in place to enable people to comment on the standard and quality of the service they experienced.

People who used the service told us that they knew the manager of the service and that she was approachable. Staff also said they felt well supported in their work by the management team at the home.

We have made a recommendation about the control and prevention of infections, particularly in relation to maintaining a clean and appropriate environment.

We found breaches of the following Regulations:

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were placed at risk of receiving care and treatment that did not meet their individual needs and personal preferences.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not receive their creams and ointments as their doctor intended.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks of receiving unsafe care, treatment and avoidable harm.

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective monitoring systems were not in place to help ensure complete and accurate records in respect of each person using this service had been maintained. This placed the health, safety and welfare of people who used this service at risk.

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the home was not appropriately staffed and people who used the service did not receive the care and support they needed, particularly during the night time.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments had not been reviewed and updated to reflect people's changing needs or when accidents or incidents had occurred. This meant that people who used this service remained at risk of harm or injury because the provider had not taken steps to mitigate risks.

There were not always a sufficient number of staff on duty during the night to meet the diverse needs of people who used this service. This meant that there were times when people did not receive the support they needed, when they needed it.

The administration of some medications (creams and ointments) was not safely and effectively managed. This meant that people who used the service did not receive their topical treatments as their doctor had intended.

Is the service effective?

Good

The service was effective.

Staff at the home received training and supervision to help ensure they carry out their role safely and effectively. There were some gaps in staff training, particularly around personal planning.

The registered manager acted appropriately with regards to the application of the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

People who used this service were appropriately supported with their nutritional and hydration needs.

Is the service caring?

Good

The service was caring.

People who used this service were respected and had their dignity protected by the staff supporting them.

Staff provided people with explanations and information when they were supporting people with their care needs.

People who used this service were able to see their friends, family and other visitors when they wanted to, and in private if they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive to the needs of people.

Care plans and support records were not person centred and did not reflect accurate and up to date information about people's care needs and preferences.

Overall people who used the service told us that they usually received the help they needed when they needed it, although there were some exceptions during the night.

There was a complaints process in place at the home. People who used the service had access to this. We found that the provider had dealt with any complaints that had been raised, appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People who used the service knew who the registered manager was and knew that they could speak to her if they wished.

Staff felt supported by the management team at the home.

People were asked for their views on the standard and quality of service they received.

Care records were kept securely but auditing processes for these documents were not robust. There were gaps and inconsistencies in the way in which people's needs were recorded and kept up to date.

Kirklands

Detailed findings

Background to this inspection

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

This inspection took place on 8 February 2016 and was unannounced.

The inspection was carried out by one adult social care inspector.

Prior to the inspection we checked the information we held about the service, including information provided by health and social care professionals.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke to four people who used the service and one relative who was visiting the home. We spoke to six members of staff who worked at home, including the registered manager and we observed staff supporting people with some of their care needs. We looked at a sample of three care records including care plans, risk assessments and medication administration charts. We looked at a sample of staff recruitment records. We also looked at a sample of the records that the home is required to maintain with regard general maintenance of the home and equipment.

Requires Improvement

Is the service safe?

Our findings

One of the people we spoke to told us that; "The staff come and help me when I need it. They are very good."

Another person told us that staff, "Come quickly when I buzz during the day. There are issues at times with one aspect of my care needs. Staff don't act as quickly as I would like and there are times when one or two things don't get done."

We noted from the information we held about the service that people and their personal possessions were not always kept safe.

The provider had told us about an incident of alleged financial abuse of a person who used this service. Although the provider followed the correct protocols for reporting the allegations, and had notified the police and safeguarding team, further incidents of this nature continued to be alleged by other people who lived at Kirklands over a period of one month. During our visit to the home the registered manager told us about the measures that had been put in place to try to reduce the risks of this happening again.

When we spoke to staff about safeguarding and protecting people and their possessions, they told us that they had received training in this subject. Staff knew about and told us of the procedures that had been put in place to help keep people's valuables and personal possessions safe. However, we received further information after our inspection, to indicate that the measures had not been effective.

We found that there was a high incidence of falls occurring at the home. We checked a sample of care plans and risk assessments during our visit to Kirklands. These records showed that people had suffered falls, sometimes resulting in injuries such as fractured bones. We found that falls risk assessments had not been reviewed or updated following falls. These documents did not contain any strategies to help mitigate risks and help staff support individuals with their mobility needs safely.

The provider collected information about the number of falls each month but it was unclear as to what the provider had done with this information to help identify common themes or reduce risks. The provider told us of a new system that was being introduced at the home to help the service manage falls and the associated risks, but these were not in place at the time of our visit.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were not protected against the risks of receiving unsafe care; treatment and avoidable harm because the provider did not have robust processes in place to assess, manage and mitigate risks.

We looked at the way in which the service managed people's medicines. We found that there were good systems in place for the administration and management of most medicines. However, when we looked more closely at the management of ointments, creams and lotions we found that these types of medicines

were not safely managed. We could not find any records to confirm that this type of medicine was administered as the doctor intended. Medicine administration records were not completed and when we asked a senior carer about this, they told us that the administration of creams would be recorded in people's individual care plans. However, when we checked, this was not the case.

We also noted that some of the people that used this service had skin conditions that required treatment and observations. Skin care plans had not been completed or had not been reviewed and updated as people's needs changed. There was insufficient information about the use of skin creams and ointments where these had been prescribed by the doctor.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive their medicines as prescribed because the provider did not safely and appropriately manage and administer medicines.

We looked at the staffing levels at the home during our inspection. Prior to our visit we had received information that indicated there were not always sufficient numbers of staff on duty at the home. On the day of our visit there were sufficient numbers of staff on duty. During the day we observed, and people told us that staff attended to their needs quickly when needed.

The day staff we spoke with told us that they thought the staffing levels were appropriate. However, the night staff told us that this shift was "very stretched". They told us that people who used this service had "varying" levels of dependency and a range of care needs at night. Some people needed night checks hourly, whilst others were checked every two hours. In addition to this, we found that there were people who were unsettled at night and needed extra support and monitoring. One of the care records we looked at described a strategy for supporting this person at night. The record stated that these strategies "Reduces the risk due to only three staff on shift." This indicated that there were insufficient numbers of staff available to manage this person's needs safely.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home was not appropriately staffed and people who used the service did not receive the care and support they needed, particularly during the night time.

On the day of our visit we found the home to be clean and tidy and there were no unpleasant odours. We noted that some surfaces in bathrooms and kitchenettes had porous surfaces. These were difficult to clean effectively in order to reduce the risks of infection control and prevention. The registered manager told us of and provided us with information about planned improvements for the home. These included bathrooms and laundry areas although not all of the plans had been approved at the time of our visit.

We spoke with the housekeeping staff during our visit. They told us that they were provided with sufficient cleaning materials and equipment to help ensure the home was clean and hygienic. We were told that there is housekeeping cover in the home every day, including the weekends. Housekeeping staff had been provided with training with regards to infection control and prevention. We were told that cleaning schedules were in place to help ensure the home was thoroughly cleaned. However, the housekeeper told us that they were not aware of "any fixed" schedules and also said that it was "difficult to clean people's rooms at times because they spend all their time in there or have equipment that is hard to get round." We spoke to the manager about these matters during our inspection.

We recommend that the service considers current guidance on the control and prevention of infections, particularly in relation to maintaining a clean and appropriate environment.

Good

Is the service effective?

Our findings

One of the people that lived at Kirklands told us; "All I can say about this place is it is good. I would tell anyone to come here. The girls (staff) are kind and not at all rude. I get well fed and am putting on weight. The girls are very particular, very careful and know what they are doing."

Another person, who had not been at the home very long, said; "I like it here better than I thought I would. I get help from staff when I need it; they (staff) have been very good to me. The food is really good, we get well fed and plenty of drinks."

We spoke to staff that worked at the home. They told us about the training and support they had received to help them carry out their roles safely and effectively. We checked the staff training records and observed staff supporting people who used this service to help verify what staff told us.

We observed staff using safe moving and handling techniques when supporting people with their mobility. Staff provided good explanations of procedures when using mobility equipment. This helped to reassure the people they were supporting.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed.

When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We looked at the way in which the service protected the rights of people who may lack the capacity to make particular decisions.

The provider had policies and procedures in place with regards to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLs). There was a system in place to help the provider monitor and keep track of any applications that had been made with regards depriving someone of their liberty.

We observed the service of the lunchtime meal. Staff helped people to get to the table and seat them comfortably. The tables were laid with condiments, napkins and cutlery for people to help themselves to. There was a choice of meals served from the hot trolley with plenty of fresh vegetables. Where people needed a soft diet, these meals were presented in an attractive manner to encourage people to eat it.

Not everyone ate in the dining room, some people chose to have their meal in the privacy of their own room. We saw the choice of meal plated up, covered and taken to each room.

The staff assisting with meal service observed good food hygiene practices, hands were washed and clean aprons were worn. Where people needed support to eat their meal, staff sat down and assisted in a discreet and gentle manner. We observed lunchtime to be a pleasant and sociable experience for people who lived at Kirklands.

We observed that staff were very good at encouraging people to eat and drink throughout the day. People who used the service confirmed to us that this was "normal" practice.

We looked at a sample of nutritional care plans and records. Where people had been identified at risk of poor nutrition, progress notes recorded what people had eaten and drank. Body weights had been monitored and where necessary the advice of a speech and language therapist had been sought.

Kirklands is a purpose built care home. There are communal lounges, dining rooms and assisted bathrooms on both floors. People who use the service are able to access all areas of the home via stairs, passenger lift or stair lift.

Good

Is the service caring?

Our findings

The people we spoke to during our visit to this service all told us that they were happy with the staff and the service. People told us that the staff were "kind and not rude". One person said; "The girls (staff) are very particular and very careful." People told us that staff attended them "quickly" when needed and we observed on the day of our visit that call bells were answered promptly. People who used this service did not have to wait long for assistance when needed during the day. However, another person we spoke to said; "The help I need is increasing rather than decreasing but the staff usually come to help quite quickly." They told us about one aspect of their night care needs that was not always attended to as "quickly as I would like."

The staff we spoke to told us that they were able to read people's individual care plans. They also told us that they received an update of people's conditions and care needs at the start of each shift. Staff were able to give us detailed accounts of people's individual care and support needs and how these needs were met.

People who used this service were enabled to remain as independent as possible. We observed that some people were able to make themselves drinks and snacks with minimal supervision and we were told that people who used this service were encouraged to keep a key to their own room wherever possible. The people we spoke to during our visit confirmed this to be correct.

We observed staff supporting people with their daily needs. We noted that there was a friendly and pleasant atmosphere in the home. Staff provided people with explanations, particularly where equipment was being used or when people were being supported with their mobility. The explanations helped to reassure people and reduce any anxieties they had.

We noticed that people who used this service appeared well groomed and well cared for. When people needed help with their personal care needs, staff managed this well and ensured people were supported in private and in a dignified manner.

During our visit to the home we observed staff interacting with people who used this service. These interactions were not always to carry out support with personal care needs. We noted that staff took time to sit and chat with people, play games or participate in other social activities. Staff told us that they saw this type of interaction as "a pleasant and important" part of their role.

At the time of our visit there were no people requiring special care at the end of their lives. Staff told us about the things that would be put in place to support people reaching the end of their lives. These included support from community nurses and ensuring people had appropriate medication from their doctor to help keep them comfortable.

The provider told us that the service was in the process of formalising end of life care in line with national guidelines. Training for staff was planned with input from the community nurses and the hospital admission prevention nurse.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with during our visit to Kirklands told us that staff came "quickly when buzzed" and "I get help when I need it." One person told us that staff did not always act as quickly as they would prefer with "one aspect" of their care needs.

The provider gave us a copy of the staff training matrix. This showed that not all of the staff at the home had received training in the subject of personal planning.

When we checked people's care record we found that they were not person centred and did not reflect up to date information about people's current care and support needs.

One of the care records we looked at belonged to a person who had been at Kirklands for approximately six weeks. Although they had been involved in the development and preparation of their care plan, there were a number of areas relating to their daily living needs that had not been addressed. Their care plans did not demonstrate a person centred approach towards meeting their individual needs. For example, their life story and social interests had not been recorded. A care plan relating to their emotional well-being was also incomplete. This person was placed at risk of receiving care, treatment and support that was not personalised specifically for them.

Another person's records stated that their chair had been moved to outside the office to "prevent" another particular person from sitting by them. These measures placed this person at risk of social isolation.

We looked at the care records of a third person who used this service and found that their care plans had been reviewed without them as they were in hospital.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used this service were placed at risk of receiving care and treatment that did not meet their individual needs and personal preferences.

However, one of the other people we spoke to during our visit to Kirklands told us about the activities they were able to take part in. These included 'helping' in the kitchen and laundry. We checked this persons care records and found that these activities had been appropriately documented with risk assessments in place to help ensure the safety of this person.

We looked at the ways in which the service managed complaints and concerns. We found that the service had a complaints process in place and this was available to people who used or visited this service. We saw evidence of a complaint being processed at the time of our visit. We noted that the provider was dealing with this appropriately, keeping clear records of actions taken and responding within agreed timescales.

We also saw that where concerns had been raised in satisfaction surveys, these had been followed up with actions taken to remedy issues.

People who used this service, visitors and staff all told us that they knew who they should raise any concerns with. Most people told us that they were confident that their concerns and comments would be dealt with quickly and appropriately. However, one person told us that their remote control for the TV was missing and had been since they moved into the home several weeks ago. They told us that they had raised this with staff at various times but nothing had happened. We raised this with the manager and staff during our visit. A member of staff told us that a TV remote control had been purchased and it was taken to the person's room as soon as we mentioned it.

Requires Improvement

Is the service well-led?

Our findings

People who used this service and the staff that worked there were all familiar with the registered manager of the service. People told us that the registered manager was "approachable" and "listened" to what they had to say to her.

Staff told us that they felt supported by the management team and regularly met with them as a team and as individuals.

We looked at samples of records relating to people's care and support. Although these had been kept securely in order to maintain confidentiality, we found that there were gaps and inconsistencies in the way in which people's care needs were monitored, recorded, reviewed and kept up to date. For example, care plans and risk assessments had not been reviewed and updated as people's needs changed. This placed them at risk of receiving inappropriate care and treatment. Effective auditing systems would have helped the registered manager to identify that important information was missing from individual care records and to take swift action to address these shortfalls.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Complete and accurate records in respect of each person using this service had not been maintained. The monitoring systems in place were not effective and this placed the health, safety and welfare of people who used this service at risk.

We looked at a sample of the maintenance records kept at the home. We found that equipment had been regularly serviced and maintained. There were systems in place for assessing and improving the quality of the service.

The provider used an independent organisation to carry out customer satisfaction surveys. The provider showed us a copy of the latest survey results. The results of the survey showed that people who used this service were generally satisfied with the care and support they received.

People told us that they were asked about their views of the service they received. They told us that meetings were sometimes held where they were able to discuss the support they received and the activities on offer. This helped to make sure that people were provided with a platform to have their say on the standard of service and running of the home.

The manager told us about the environmental improvements that were due to commence in the home. These included refurbishment of the kitchen, laundry and some internal decorations. There was also a long term maintenance plan in place for the home.

The home was regularly visited by the provider's operations manager. Their visits included assessments of the quality of the service and environment. This helped the provider to maintain oversight of the standard and safety of the home and make improvements in a timely manner.

There was a registered manager in post at the home at the time of our visit.

Providers of health and social care services are required to notify us, the Care Quality Commission, about important events that happen in their services. When we checked the information we held about this service we found that the registered manager of Kirklands had informed us of significant events as required and we were able to check whether action had been taken when necessary.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services were placed at risk of receiving care and treatment that did not meet their individual needs and personal preferences. Regulation 9 (1) (3) (a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services did not receive their medicines as their doctor intended. Regulation 12 (2) (g). People who use services were not protected against the risks of receiving unsafe care, treatment and avoidable harm. Regulation 12 (1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems to assess, monitor and mitigate the risks relating to health, welfare and safety of people using this service were not in use. Complete and accurate records in respect of each person using this service had

not been maintained.

Regulation 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services did not receive the care and support they needed, particularly during the night time. The home was not appropriately staffed. Regulation 18 (1)