NE Lifestyles Limited

Kibblesworth

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2, 3, 9 and 10 July 2018. The inspection was unannounced: staff in the service did not know we would be carrying out an inspection.

At our last inspection in June 2017 we rated the service as requires improvement. We made recommendations regarding medicines and having person-centred care records. At the time there was not a registered manager in post. of our last inspection A new manager had been appointed and had yet to make their application to register with CQC. During this inspection we found breaches of regulations 9, 11, 12, 17 and 18. These appertained to the lack of person centred records, lack of consent obtained from people, unsafe care and treatment, lack of effective systems to monitor the service, out of date records, and lack of appropriate support to staff.

Kibblesworth is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 16 people in one adapted building. At the time of our inspection 13 people were living at Kibblesworth. The home specialises in providing care to people living with an acquired brain injury.

At the time of our inspection there was no registered manager in post. 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.

Appropriate governance arrangements were not in in place to monitor and improve the service. Deficits we found during our inspection had not been identified when the limited audits in use had been applied to the service.

The service failed to use the guidance provided by National Institute of Health and Care Excellence on managing medicines in care homes. As a result, we found there were unsafe practices in managing the administration, storage and disposal of people's medicines.

Staff had not completed daily roadworthy checks on the mini bus since January 2018. Arrangements were put in place during our inspection to re-commence these checks.

Checks were carried out on a regular basis to ensure people were cared for in a building which was safe. However, we found no fire drills had been carried out in line with the provider's policy since December 2017.

People were sometimes put a risk of unsafe care through records which were out of date or inaccurate.

Pre-employment checks were carried out on permanent staff before they began working in the service. Staff

had not been supported with training, supervision and appraisals. Agency nurses were working at service every day. Checks were not carried out on the agency staff to see if they were registered with the Nursing and Midwifery Council and were competent to meet people's needs. Inductions into the service for agency staff failed to include any information on clinical practices. A new induction checklist for agency nurses was introduced to the service together with more rigorous checks on their competence before our inspection was concluded.

During our inspection visit furniture which could not be cleaned to reduce risks of infection spreading were removed. The home was clean and tidy throughout.

People who used the service were restricted with bedrails without having either their consent obtained or their capacity assessed with best interest decision being made. This meant the provider did not always meet the requirement of the Mental Capacity Act. Although staff including the manager had not been trained in Deprivation of Liberty Safeguards, applications had been made to local authorities to keep people safe.

Staff employed in the making of meals understood people's dietary needs and how to make meals look appetising for those people who needed soft or pureed diets. The kitchen was clean with daily, weekly and deep clean practices in place.

Relatives told us they had not seen people's care plans and they had not been invited to relative's meetings. We found the involvement of relatives in the service was limited.

Since the last inspection one complaint had been made to the service. This had been considered and a response provided to the complainant.

An occupational therapist (OT) and an assistant occupational therapist were employed in the home. They assessed people's needs and worked with them, their relatives and staff to put in place plans to promote people's well-being.

Relatives spoke with us about the lack of stimulating things for people to do. Activities had been put in place by the OT for some people. We found people mainly spent their day in the lounges or their bedrooms watching TV. We made a recommendation about this.

People and their relatives made positive comments to us about the caring nature of the staff. Staff protected people's privacy but needed training and understanding about dignity when supporting people to eat.

Further work was needed in the service to ensure care staff and occupational therapy staff were working together to meet people's needs.

Partnership working with professionals outside of the home was evident in the records.

Staff understood about the need for confidentiality. Records were locked away and were inaccessible to other people.

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

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.

People's medicines were not managed in safe way.

Fire drills had not taken place in the service since December 2017.

Staff employed on a permanent basis in the service underwent pre-employment checks to ensure they were fit to carry out their roles but agency staff did not.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training, supervision and appraisals were not up to date.

The service did not always follow the Mental Capacity Act and subsequent good practice guidance.

Kitchen staff were aware of people's dietary needs and how to present people's food in an appetising manner.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst staff presented as kind and caring toward people we found the care they were giving was not informed by staff training and support.

Staff respected people's privacy and knocked on their bedroom doors before entering.

People who used the service and their relatives made favourable comments to us about the staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans required further personalisation. We found inaccuracies in the documents which put people at risk of unsafe care.

Staff were given guidance by the occupational therapist on what activities were required to improve people's well-being. We made a recommendation overall about engaging people in activities to increase stimulation.

The provider had a complaints process in place. One complaint had been received and investigated since the last inspection. The complainant had received a response.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems were not in place to monitor the quality of the service.

Records in the home were not always up to date or accurate.

A survey of the views of people who used the service had their relatives had been carried out. The responses were largely positive.

Kibblesworth

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.

Although the service was due to be re-inspected the inspection was prompted in part by concerns raised by local authority commissioners.

This inspection took place on 2, 3, 9 and 10 July and was unannounced.

Inspection site visit activity started on 2 July and ended on 10 July. It included speaking to people who used the service and their relatives as well as speaking to staff. On 9 July we spoke with relatives by telephone. We reviewed records used in the service.

The inspection team consisted of two adult social care inspectors, an adult social care assistant inspector and a specialist advisor. The specialist advisor had a background in nursing care.

Before we visited the service, we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in supporting people who used the service, including commissioners and care managers. Information provided by these professionals was used to inform the inspection.

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

During our inspection we spoke with seven people who used the service and 10 of their relatives. We also spoke with 15 staff including two directors, the manager, the occupational therapist and their assistant, the nurse on duty, team leaders, members of care staff, domestics kitchen and maintenance staff.

We looked at the care records of seven people in detail and observed how people were being supported. We also looked at the personnel files for six members of staff and records relating to the management of the service, such as quality audits, policies and procedures. We also carried out observations of staff and their interactions with people who used the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we recommended the service considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes. During this inspection we found the arrangements for the storage, administration and disposal did not meet the recommended guidance.

There was unsafe dispensing of medicines. We found the nurse on duty was constantly interrupted by members of staff. There was no sink in the treatment room available to wash hands whilst dispensing medication. All medicines were dispensed in treatment room and then taken to residents in plastic baskets without the medicines administration record (MAR) sheet. When people refused or were asleep, their medicines were kept in clinical room and given later. We also found people's medicines were put into pots and left in the cupboard for later administration. This placed people at risk of receiving the wrong medicines. We drew the attention of the provider to this issue and they addressed our concerns.

There was evidence of people not receiving medication and no reason to say why documented on the rear of the MAR sheet. MAR records were incomplete with missing signatures. People had been prescribed transdermal patches; these are patches applied to the skin through which people receive their dose of medicine. One person's separate transdermal patch records did not coincide with MAR sheet and had not been completed for two days. On another patch record there was no record of the patch being removed. The manager told us the person removed it themselves.

When staff needed to obtain people's topical medicines they knocked on the clinic door, the nurse gave them a basket with people's medicines and the nurse signed the MAR. Once the staff had applied a person's topical medicine they knocked on the clinic door again and then signed the MAR sheet. When a member of staff followed this procedure, we found the records of the topical medicines were inaccurate. One topical medicine had been prescribed in August 2017; there was no date of opening and another topical medicine had been discontinued but was still on the topical medicines record. We checked other people's topical medicines and found similar concerns.

PRN medicines are prescribed for people to be used on an 'as and when required' basis. We found the guidance for staff dispensing such medicines needed to be updated and provide information on what steps staff needed to take before they were appropriately administered.

Controlled drugs are those liable to greater misuse and require separate storage. Although the controlled drugs records showed there were no stocks, we were unable to check as the nurse on duty could not find the key for the cupboard. Medicines to be disposed of were on the floor in bags which were open and accessible. The disposal of medicines book was incomplete. To ensure the safe disposal of medicines two staff are required to sign the book. There were no double signatures in the disposal book. As a part of their action plan to improve the service the provider told us they had locked these medicines away.

People's medicines were stored in a manner which meant they were difficult to trace in the clinical room. We found one person's dietary needs stored on top of a waste bin in a cupboard alongside a fridge for

medicines. There were no fridge temperature checks in place.

The service had a mini bus which was used each day to transport people to appointments. We found daily check were in place for staff to document if the mini bus was roadworthy. However, the checks had not been completed since January 2018. The mini bus had facilities to secure people in wheelchairs. We asked staff what training they had received in using the bus. Staff told us they had no training. We pointed this out to the directors who agreed they would immediately address this issue. On our last inspection visit they told us the administrator would not be carrying out regular checks on the mini bus and everyone would be trained by the occupational therapist (OT) on how to safely secure people in the bus.

Gas and electric certificates for the home were in date. Checks were carried out on a regular basis to ensure people lived in a safe environment. These included regular checks on water temperatures and the fire alarm. However, the provider's guidance on fire drills was not followed. The guidance stated that fire drills were to be carried out every month. The last recorded fire drill was 7 December 2017. This meant fire evacuation procedures had not been rehearsed and new staff had not had the opportunity to put into practice how to evacuate the premises. During the inspection the provider told us they had employed a new maintenance person who, once in post would be taking forward the fire drills.

Policies and procedures were in place to manage any risks to staff. Information about people's risks were stored in different places. We found where risks such as behaviour which may challenge staff was identified but no guidance was given to staff on how to mitigate the risks.

This was a breach of 12 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Pre-employment checks were carried out by the provider. Staff were required to complete an application form which detailed their previous experience and training. References were taken up to assess if a prospective staff member was of good character. Disclosure and Barring Service (DBS) checks were carried. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and prevents unsuitable people from working with children and vulnerable adults. However, we found checks on agency nurses who were employed on every shift throughout the week were not in place. The administrator arranged for agency nurses. Profiles of the agency nurses were submitted to the service. No checks were carried out to see if the nurses had the experience to deal with people's complex needs or to see if they continued to be registered with the NMC. During our current inspection visit a director told us they had put in place new arrangements to ensure agency staff were competent to meet the needs of people who used the service.

This was a breach of 18 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives felt their family members were safe living at Kimblesworth. One person said they were, "Quite happy" and said, [Name] is quite safe. Other relatives spoke of the security arrangements in the home and felt people were safe in the home due to the locked front door and the key pad systems.

Accidents and incident records had been set up by the previous manager. The new manager told us she had continued the process. We also found the occupational therapist who was employed in the service kept records of people's falls and made referrals where necessary to other professionals. We spoke with the provider about the duplications of these records and they agreed to consider the issue.

Records showed regular checks were carried out on the building to keep people safe. In one person's room we found their shower wall was damaged and we saw staff had attempted a temporary solution to repair. We asked the manager about maintenance procedures and they were unable to tell us how they would address the repair. The maintenance person with the manager later agreed to carry out the repair.

Cleaning was on-going throughout our inspection to manage the risks of cross infection. The home was clean and tidy. The laundry room was organised and tidy and infection control practices were in place in relation to soiled laundry. The storage areas for chemicals and PPE was well stocked and stored securely. However, we found some furniture was worn and broken to the point that cleaning could not be sufficiently carried out to reduce cross infection. We drew this to the attention of the management team who removed the furniture.

When the service had been acquired in 2016 by the current provider a registered manager had been employed by the service. Insufficient monitoring had been carried out by the provider. As a result, the senior managers in the service had learned lessons regarding oversight of the service and had put an action plan in place at the request of CQC to improve the service.

People and their relatives had mixed views about the number of staff on duty. One person said, "They haven't got the staff" and "I have to wait a long time for staff to come when I press the buzzer." One relative told us they had always seen staff in the lounge or dining room with people. Another relative said they found their family member, "Always have people (staff) around." We looked at the staff rotas and found there were consistent numbers of staff on duty. Staff told us there were enough staff on duty to meet people's needs. Each morning the team leader allocated staff to care for people using the service on a white board. We found there were enough staff for the team leaders to direct to care for people. On the last day of inspection, the team leader had allocated timeslots for people's care, training sessions and the recording of daily notes.

Although not all staff had received updated training in safeguarding vulnerable adults staff were aware of their duty to safeguard people in their care and felt able to raise issues through their line manager.

Requires Improvement

Is the service effective?

Our findings

One director told us the provider acquired the service on 22 August 2016. Since that date the five staff records we reviewed showed staff had not received supervision or appraisals. Supervision is a meeting which takes place between a staff member and their supervisor to discuss any concerns they may have, their progress and their training needs. Staff confirmed they had not received supervision. On the last day of inspection staff showed us a supervision matrix and explained how this would be used going forward.

The manager sent us their training matrix to show when staff had received training. Although staff had recently received training in epilepsy staff training had not been updated in safeguarding adults. Staff had also not received training relevant to the conditions of people who used the service such as Huntington's disease.

Although staff new to the service underwent an induction we found the induction processes for agency staff to be insufficiently robust. The induction for agency nurses included an orientation around the home but failed to include information on clinical processes. As a result, the nurse on duty was needing to find their way around and people were still getting their breakfast medicines at lunch time. This meant people were not getting their medicines in a timely manner.

This was a breach of 18 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found staff including the manager had not received training in the MCA and DoLS. On our last inspection day, the training manager for the service told us they were funding an external trainer to train staff. Applications had been made to the relevant body to request authorisation to keep people safe. Where requests had been made and these were granted CQC had been notified.

Consent arrangements were not evident on everyone's file. We spoke with a director who told us people using the service did not have the capacity to consent to live at Kibblesworth. People who used the service had bed rails in place which restricted their movement. Mental capacity assessments or best interests' decisions were not in place to address these issues. The provider agreed to address this issue as a matter of urgency.

This was a breach of 11 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke to us about the food in the home. One person said, "The meals are rubbish and taste nasty." Other people said, "We get to choose our food weekly and if we don't want it there is another choice" and "Food has much improved as before the menu was repetitive." One person in their survey response wanted to eat more curried food. A member of staff who spoke to us explained how an acquired brain injury can adversely impact on a person's sense of taste which in turn made them critical of the food on offer. They described working with one person to sample foods to check which taste was preferable to them. A relative said, "The food is very similar day in and day out." Another relative felt the food served was more suited to children's needs.

The kitchen was clean and tidy. Daily, weekly and deep clean practices were in place. Food temperatures were checked and recorded. Fridges were stocked and were clean. Kitchen staff were aware of people's dietary needs and how food should be presented for people who needed their diet to be pureed. During mealtimes staff were very busy as there were some people who required assistance eating on a 1:1 basis. The service had in place the Malnutrition Universal Screen Tool (MUST) to check if people were at risk of malnutrition. These were not used to document people's weights. A separate weights record was made by staff. Relatives were confident people were not losing weight. There were people using the service whose weight and nutritional intake was monitored. Where staff identified a decline in weight referrals were made to a dietician. We looked at care records for people who were being monitored for fluid intake to reduce the risk of dehydration. Each person's target fluid intake was not documented and their daily intake amount changed daily with no rationale. We found no one was at risk of dehydration.

People using the service ate in the dining room or in the lounge. Staff were efficient in attending to people with their meals and drinks. Staff took time to check if people were happy with their meal or if they required a drink.

People using the service were supported by staff to attend appointments with other healthcare services. Relatives felt staff responded quickly to meet people's needs.

Relatives had mixed views on the levels of communication between them and the service. One relative found the communication to be, 'poor' whilst another relative told us staff get in touch at the, 'slightest little thing'. A handover document was used by staff to pass pertinent information between shifts. The team leaders gathered information each morning on people's needs including their appointments. The information was passed onto staff as team leaders allocated staff their tasks for the day.

In people's care files we found people had detailed information gathered before they were admitted to the home. This assessment provided staff with background information about people's preferences, any head injuries and ways to keep them safe. One relative told us their family member was "Really well looked after."

The building was on three floors with bedrooms on both floors. The lounges and dining room were on the ground floor. Corridors were wide and accessible for wheelchair use. People had access to an outdoor garden where a smoking shed was provided. Each person had their own room with en-suite bathrooms. Rooms had been adapted for people who required hoists. Hoists were installed to ceilings to enable people to move from their beds to their bathrooms with assistance.

Requires Improvement

Is the service caring?

Our findings

Whilst we observed staff to be caring when they engaged with people living in the home it was evident from the issues we found the provider was not ensuring the service was caring overall. This included training staff in how to care for people with brain injuries.

During a lunch time we carried out observations, we saw staff assisting people with their meals. On one occasion a person was receiving their lunch from a staff member who was standing over the person whilst they were feeding them. The staff member did not engage in conversation with the person although they talked with other people and staff in the room. We overhead a member of staff talking to a person and telling them they were a 'Good boy'. This did not display respect or dignity for the adult using the service.

People who used the service were invited to comment on the staff. Their comments included, "The staff are very nice and I am happy", "The staff are friendly and co-operative" and, "The staff are really pleasant and helpful." One person said, "The staff are nice but they don't treat me like a person."

In the resident's satisfaction survey to which seven people responded, 100% of respondents said staff knock on their bedroom doors before entering and rated the level of privacy afforded to them by staff to be either good or very good.

Relatives made positive comments to us about the staff. One relative made a distinction between the old and the new staff. They told us the old staff were "lovely" but they didn't recognise the new staff and were concerned they did not understand how to cope with their family member. Other comments included staff were, "very friendly" and relatives told us they were always greeted when they entered the home.

A residents meeting had been held and people's wishes noted. The manager was unable to provide us with minutes of previous meetings to show people had a consistent voice in the service. Relatives we spoke with had no recollection of having been invited to a relative's meeting. People and their relatives we spoke with were not aware of their care plans as they were not involved in decisions relating to these. This meant involvement in the service by people and their relatives was limited.

Relatives we spoke with visited their family members on a regular basis. Some were concerned about the approach staff took towards their family members to engage them. For example, relatives were intervening to deliver people's personal care because staff had failed to engage people to bathe.

People were encouraged by staff to be independent. For example, we observed staff supporting people to walk independently. "Staff aren't helping people maintain independence, my son came in able to use a knife and fork, he can't use one now."

An advocacy service was advertised on a notice board. We saw relatives as the natural advocates for people were speaking to staff who used the service. One relative felt that staff did not always listen. Another relative discussed with us how to get their family member out more in the community. The manager was aware of

previous discussions but we found no progress had been made to assist this person go out.

Staff had addressed issues of equality and diversity. Arrangements were in place to meet the religious needs of one person. Disability issues were addressed through referrals to other practitioners and adaptations to the building.

Staff understood about the need for confidentiality. People's information was stored in lockable cupboards and behind locked doors. On our last inspection visit to the home staff were receiving training on the General Data Protection Regulation (GDPR). This is a regulation in EU law on data protection to ensure people's privacy is protected.

Requires Improvement

Is the service responsive?

Our findings

People's care records were maintained and stored in a disjointed manner. Care plans were stored in a staff office downstairs. Letters to people were stored upstairs in the manager's office. Staff wrote daily notes on a sheet and then the team leader transferred them onto an electronic system. Staff were also allocated time to document daily care and events on the electronic system. The occupational therapist (OT) held separate records and developed care plans to address specific issues. These were stored in a different office previously used as a sluice room for staff to sign. We found the records were confusing and did not give staff an overview of people's needs.

One person was described as 'aggressive' and their care plans told staff they may need to intervene using 'MAPA' techniques. MAPA stands for the management of actual or potential aggression and is a method of holding people when they pose a risk to themselves or others. We found no records to suggest this technique had been used with anyone using the service. We asked the manager and the directors about the use of this technique. They told us it was not used in the service. Later in the person's file was a care plan for the use of Diazapam to reduce the anxiety and distress. This was not linked to the person's behaviour support plan, nor did it give guidance to staff on what strategies to take before using their medicine.

Records were not always accurate. One person's smoking cessation records failed to give staff the necessary advice to look for side effects of smoking cessation products.

In one person's record we found a comprehensive plan for the use of Percutaneous endoscopic gastrostomy (PEG) feeding. This is a way of ensuring people get the nutrition they need directly into their stomach. On the same day as the plan was written we found the manager had reviewed the plan and written nothing was to be put down the PEG. This meant the plan suggested that they did not need to receive food, fluid or medicines via a PEG. We spoke to the manager about this and they told us it was a typing error. This meant an agency nurse reading the plan would be given conflicting advice.

When staff had identified a care need we found there was an absence of care planning. For example, one person was identified at being at risk of aspirational pneumonia but their breathing care plan said there were no concerns. Another person was at risk of becoming incontinent during a seizure but a plan for meeting their continence was not completed.

In one person's 'Psychological and Emotional' plan descriptions were available to staff on the person's conditions, but there was no guidance in place to tell staff how to support the person when they became distressed. This meant people were put at risk of inappropriate care.

This was a breach of 12 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended that the service finds out more about training for staff, based on current best practice, in relation to person centred care. We spoke with relatives who told us they had not

been involved in developing people's care or treatment or seen people's care plans.
Information in people's care plans were not always person centred. For example, we found one person needed their prescribed topical medicines and a fact sheet on topical medicines had been inserted into their file which was not personalised. Care plans described people's responses when they became distressed but failed to include how the person may wish to be treated when they became upset. One person with complex mental health needs had no emotional support plan,

This was a breach of 9 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Body maps which showed for example people's bruising were found by a member of the inspection team in a plastic pocket on the wall in a very small room known as 'the hub'. We asked the manager about how the body maps should be stored. They told us they should not be on the wall and they should be stored with people's other records such as falls information.

Reviews of people's care plans were not taking place on a regular basis to ensure care plans and risk assessments were correctly documented and up to date. In some records we found reviews had not taken place for the last five to six months.

People had 'Do Not Attempt Resuscitation' (DNAR) forms in place. These gave instructions to staff that in the event of a person stopping breathing they should not be resuscitated. However, we found in the MAR sheets held in the clinical room and accessible to agency nurses, one person's DNAR record was due for renewal in 2017. According to those records the DNAR had not been renewed. In their care files we found the directive had been renewed. This meant the person was at risk of receiving inappropriate treatment.

This was a breach of 17 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people during the inspection about what they do during the day. People told us, "I am not able to go out and would like too", "There is nothing here for me to do, I feel like I am sitting in a prison camp" and "There is nothing for people to do." Relatives expressed concerns about the lack of stimulus for people in the home and told us "My son spends too much time in bed, they aren't getting him up and out." One person's relative told us how their family member liked to cook their own food but said, "I don't think this happens now." We observed people spent a significant amount of time watching TV in their own rooms or in the lounge. There was some confusion amongst relatives about activities and how they were paid for. One relative told us said the home had refused to take people out as they did not receive funding for this. Another relative wanted to pay for additional time so their family member could have 1:1 staff time when the mini bus was free.

We spoke with staff about how people access the community and carry out activities they enjoy. One staff member told us it was about 'planning ahead' so they knew when they could access the mini bus so people could get out and about. They spoke about a recent trip to the seaside where three people were taken out and visits to a local café where one person liked to go. Relatives spoke with us about going out with people to the local pub.

During our inspection two group activities were held by an occupational therapy assistant. Staff had timetables on the walls of their office to show when staff were expected to carry out tasks with people to promote their well-being and recovery. However not everyone had an activities plan based on their preferences which staff could use without direction from the OT.

The provider had a complaints process in place. Nearly all the relatives we spoke with told us there had been no need for them to make a complaint. One relative said they had "Never needed to make a complaint" and described the home as a "Godsend." We saw there had been only one complaint since the last inspection. The complaint had been responded to in an appropriate manner.

The Accessible Information Standard was introduced by NHS England in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the service was working towards this standard. One person was engaged each morning to prepare a notice board giving the date and weather for others. Work carried out by the OT involved using pictorial tools to help people to focus and make decisions.

End of life discussions had taken place with family members and they were included in decisions not to resuscitate people should they stop breathing. Advanced decisions had been put in place for people's future care needs.

Requires Improvement

Is the service well-led?

Our findings

The previous registered manager had left the service and deregistered with CQC in May 2018. A new manager had been appointed from within the staff team and had been in post for approximately one month. Staff felt able to approach the manager and one staff member told us, "[the manager] knows people inside out." Relatives had mixed views about the manager. Most of the relatives we spoke with described the lack of visibility of the manager and said they did not see them when they visited. One person described the manager as, "Lovely." Another person said, "I haven't had to deal with the manager much." We found the manager had yet to receive management training. A director told us this was at the planning stage.

Audits to regularly monitor, assess the quality of the service and ensure the risks to people using the service were not in use. The new manager had, with the assistance of another registered manager from another service began to use the provider's overarching audit tool. However, the medicines audit carried out failed to identify the deficits we found during out inspection. The manager said there was a 10 points medicines check in place and staff were required to sign these. Agency nurses were signing the check to say there were no gaps in the MAR chart. We found this was inaccurate as there were gaps where there were no signatures. We asked to see care file audits. The manager told us there were no care file audits in place. This meant there were no effective systems in place which ensured the service could identify and make improvements.

Records in the home had not been reviewed. We found records which were inaccurate and did not reflect people's needs or the services on offer.

This was a breach of 17 Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the last inspection report the manager at the time told the inspector a survey would be carried out in October 2017. The survey had recently been carried out in 2018. Four relatives and eight people who used the service had replied to the survey. The comments were largely positive. Relatives we spoke with confirmed they had received the surveys.

We found the home was trying to focus on a broad spectrum of needs and the culture in the staff team was at times divided. Care staff were task orientated whilst occupational therapy staff tried to engage them in carrying out support to people in a therapeutic approach. The occupational therapist (OT) wrote care plans and advised staff when they were in place. Instead of working as a team to promote people's well-being the occupational therapist had put systems in place to monitor what the care staff were doing. For example, monitoring arrangements had been put in place by the OT to ensure people received personal care and their weights were correctly monitored. Valuable OT time was spent monitoring the work of the care staff. A director acknowledged they had experienced some staff who had been resistant to the involvement of the OT.

Staff meetings were not always taking place. The manager told us she had meetings with the team leaders who were meant to have meetings with their staff team. The manager told us team meetings had not always

taken place as there had been a vacant team leader post. A new team leader had recently been appointed. There were no meetings led by the manager to the whole team to share the providers wider strategy and vision for Kibblesworth. Staff told us meetings were mainly for care staff and housekeeping were not involved but 'messages' were passed on. We found there was not a cohesive system of governance in the home which included the involvement of all staff.

Since the last inspection referrals had been made by the OT to other professionals. We saw there was partnership working with psychologists, speech and language therapists and professionals working in disability services.

During this inspection we wrote to the provider and asked them to provide us with an action plan to make the necessary improvements to achieve a rating of 'good'. They provided us with an action plan which covered the deficits we found during the service. On the last day of this inspection visit we found changes had begun to occur and there was momentum in the service to make the required changes.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to out collaboratively with relevant people an assessment of people's care and treatment needs Regulation 9 (3) (a). The provider had failed to enable and support relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible. Regulation 9 (3) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that the care and treatment of service users was provided with the consent of the relevant person. Regulation 11 (1)

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 The provider failed to do all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (b). The provider failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Regulation 12 (2) (c). The provider failed to ensure the proper and

safe management of medicines Regulation 12 (2) (g).

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 provider failed to have systems in place which were operated effective to comply with Regulation 17 The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (2) (a) The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c)

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 The provider had failed to ensure staff employed in the service had received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, Regulation 18 (1)