

Barchester Healthcare Homes Limited

Kingfisher Lodge

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

We undertook an unannounced inspection on 5 June 2018. The last comprehensive inspection of the service took place in April 2017. We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance.

During this inspection we checked that the provider was meeting the legal requirements of the regulation they had previously breached. You can read the report from our last inspections, by selecting the 'All reports' link for, Kingfisher Lodge on our website at www.cqc.org.uk

Kingfisher Lodge 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. Kingfisher Lodge can provide care and support for up to 60 older people, some whom are living with dementia. At the time of our inspection there were 48 people living at the service.

The service provides accommodation in purpose built premises. The service is over two levels and has three areas Chaffinch, Lark and Robin. There are communal lounges and dining rooms. There was access on the ground floor to a large, secure, well-appointed garden area. This had shrubs and bright flowers, raised flower beds and ample seating. A balcony area was available on the first floor.

There was a 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.

Training had been reviewed and changed in regards to The Mental Capacity Act (2005). Competency assessments monitored knowledge gained from training. New documentation had been introduced in regards to consent to care and treatment. However, despite this revised training we found that consent to care had not always been completed in line with legislation and guidance.

Changes to the governance systems had made improvements. However, prompt progress had not always been taken to address shortfalls identified. The provider had not identified the mismanagement of some records and that people's experience of staffing required further analysis.

Staff said they were well supported in their role through an induction, regular supervision and ongoing training. The service was bright, clean and well maintained. People had access to a safe and attractive garden. The environment was suitable for people living with dementia. People had space to move about safely and independently. There were private, communal and outdoor areas for people to spend their time in.

People were supported by staff who were kind and caring. People were treated with dignity and respect. Staff demonstrated passion and pride in the care and support they undertook. People had developed good relationships with staff and this enabled effective care strategies to be implemented. There was a constructive staff culture which had a positive impact on people's well-being.

A varied programme of activities was available and people were involved in choosing future activities. There were systems in place to obtain feedback from people and relatives through meetings, reviews and surveys. Actions were taken to suggestions made.

The service had developed local community links by events and fundraising activities. Visitors were welcomed at the service and support was offered to relatives. Care plans were person centred. People received effective support with their health needs.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a recommendation about advanced care plans. 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?

Good ●

The service was safe.

Assessments identified risks to people.

Medicines were managed safely.

Recruitment procedures were followed.

Systems were in place to manage the premises and equipment safely.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Decisions about care and treatment were not always taken in accordance with the Mental Capacity Act 2005.

The service was meeting the requirements of the Deprivation of Liberty Safeguards.

Staff were supported in their role by an induction, training and supervision.

People were supported with nutrition and hydration needs.

Is the service caring?

Good ●

The service was caring.

Staff were kind and caring and spoken of highly by people who used the service.

Staff took pride in the care and support they delivered.

People's families and friends were welcomed and supported by the service

Is the service responsive?

Good ●

The service was responsive.

Care plans were person centred.

Activities were provided at the service. People could contribute to the choices of activities.

People and relatives felt comfortable in raising complaints and concerns.

Is the service well-led?

The service was not well-led in all areas.

Governance systems had been reviewed and changed. Shortfalls that required quality improvement had not always been identified or responded to effectively.

There was a positive staff culture.

Positive feedback was received about the management of the service and the improvements being made.

The service had developed good links with the local community.

Requires Improvement 

Kingfisher Lodge

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.

The inspection was carried out by four inspectors, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. We looked at the information in the PIR and other information we held about the service, including notifications. Notifications provide information about specific incidents and are required to be submitted to the Commission.

Some people at the service were living with dementia. This meant they were not always able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

During the inspection, we spoke with nine people living at the service, five relatives and 15 staff members. This included the registered manager and senior staff. We looked at 10 people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Is the service safe?

Our findings

The service was safe. People said they felt safe living at the service. One person commented, "I feel safer here than I did at home or going out." Another person said, "I have care 24/7 and they remind me to do things." A relative said, "I feel assured when I leave that my relative is safe and well cared for."

Risk assessments had been completed for areas such as falls, mobility, malnutrition and skin integrity. When risks were identified, the plans contained guidance for staff on how to reduce the risks. For example, we looked at the plan for one person who had a high risk of falling. The plan informed staff to ensure walkways were clear and to make sure lighting was adequate. Staff were also guided to encourage short walks to improve the person's stamina and confidence and to be aware that the medicine the person was taking could increase their risk of falling.

Risk assessments took account of people preferences. For example, one person liked their door locked at night. This had been fully assessed so that night checks were personalised to the person's wishes. When people needed staff to use moving and handling equipment detailed. We observed staff using equipment as guided. In some cases, when specialist equipment was being used, there were also photographs in place to inform staff.

Some people had been assessed as being at risk of developing pressure ulcers. The plans contained details of any pressure relieving equipment in use and how often people should have their position changed. Positional change charts we looked at showed that people had their positions changed in accordance with their care plan guidance. However, one person's mattress setting guidance did not correspond. Their care plan and mattress check form stated different settings. A senior staff member said the person might have requested the lower setting for comfort reasons. This information was not documented.

Another person had a pressure ulcer. There was a wound plan in place, which stated that a photograph should be taken every two weeks. Due to the lack of photographic equipment available quality photographs could not be obtained. The lack of regular photographs meant staff were not following care plan guidance and there was a risk they would not be able to accurately monitor the wound for signs of deterioration or improvement. We also found one entry in the person's daily records which was inaccurate. A senior staff member immediately ordered a new camera and said they would discuss record keeping with staff.

The provider used an assessment tool which gave guidance around the staffing numbers required. Rotas we reviewed demonstrated that staffing numbers were adhered to. On some occasions this was reduced by one staff member usually due to staff sickness. There were currently three full time vacancies at the service which were being covered by existing staff and agency staff. The use of agency staff had reduced as the service continued recruitment. An ongoing induction programme run by the provider meant staff could begin promptly after successful recruitment. Admissions were being managed carefully by the provider to ensure suitable staffing was in place to support people adequately.

We observed that call bells were answered in a timely manner. We used the Short Observational Tool for

Inspection (SOFI). This indicated that people in communal areas of the service received care and support when required. Feedback we received from people and staff about staffing provision has been commented on in the well-led domain of this report.

Medicines were managed and administered safely. Previous improvements had been embedded and sustained. Medication Administration Records (MAR) we reviewed had been signed in full. This showed that people received their medicines as prescribed. There was a checking process in place for staff to confirm all charts had been signed at the end of each shift. Nurses we spoke with commented that this system was effective. Photographs of people were at the front of MARs to aid identification. These had all been dated to indicate they were a true likeness of people. People's preferences for how they liked to take medicines had been recorded.

Some people had been prescribed additional medicines on an as required (PRN) basis. In these instances PRN protocols were in place. PRN protocols provide information about other actions staff might take before resorting to the use of them. These were person centred and detailed when and why people might need extra medicines. For example, the protocol for one person detailed the person suffered from chronic back pain and that repositioning might relieve any discomfort.

When people had been prescribed topical medicines such as creams and lotions, instructions for staff were clear on when and where to apply these. Medicines were stored safely, including those that required additional security in accordance with legal requirements. Regular stock balance checks were completed. The temperature of the clinical rooms and the medicines fridges were monitored. Records showed these were at the correct level. People commented their medicines were managed well and given regularly. One person said, "I don't have to worry about it." Another person said, "Excellent, no complaints."

Incidents and accidents were reported and recorded. These detailed a description of the incident and accident, the action taken at the time and who had been informed. Analysis occurred of incident and accidents to enable any patterns or trends to be identified. For example, it was noted for one person that incidents were occurring at a particular time of day. A behaviour chart was introduced to monitor this further.

A policy was in place for safeguarding people. Staff we spoke with were clear about different types of abuse that can occur and their responsibility in identifying any concerns. One staff member said, "Safeguarding is acting in a service user's best interest." The service had followed the provider's procedures when concerns had been raised and notified appropriate agencies such as the local authority and Care Quality Commission. Actions had been taken as a result of concerns raised.

Regular checks on the environment and equipment were conducted to ensure these were safe and fit for purpose. These included electrical, mobility and fire safety equipment. Regular fire drills and practices took place to ensure staff were confident in the procedures to follow in an emergency. Personal plans were in place to support people in an emergency evacuation.

A business continuity plan was in place which outlined plans to follow in unforeseen circumstances such as gas failure, catering disruption or severe weather.

The provider's recruitment procedure was followed before new staff began working at the service. Staff files showed photographic identification, a minimum of two references, full employment history and a Disclosure and Barring Service check (DBS). A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. Staff qualifications and registrations had been checked.

Infection control policies and procedures were in place and adhered to. The service was clean and well maintained. A relative said, "It is always clean and tidy." We observed staff wearing personal protective equipment such as gloves and aprons at appropriate times. Laundry colour coded systems were in place to separate different types of laundry, to reduce the risk of cross contamination.

Is the service effective?

Our findings

At the last inspection, the service received a recommendation to evaluate the Mental Capacity Act (MCA) 2005 training provided to senior staff, and to consider introducing a competency assessment. This was to ensure that consent to care and treatment was sought in line with legislation and guidance. As at the last inspection documentation in relation to MCA was of a poor standard, incomplete or inconsistent.

The Mental Capacity Act (MCA) 2005 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Some people had sensor mats in place to reduce the risk of them falling by alerting staff to movement. We looked at the care plans of eight people who had these mats in place. For example one care plan said, "Has an alarm mat in place on her bedroom so staff are alerted when she tries to get out of bed." However, people's capacity to consent to these mats had not been assessed, despite indications within their care plan that they may lack the capacity to consent to this decision. This was confirmed by a senior staff member we spoke with.

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

We reviewed examples of when people's capacity to consent to specific aspects of their care had been assessed. People's responses were clearly recorded. Decisions showed that relevant people were included and why other options were not in the person's best interest. For example, one person was having their medicines administered covertly. This is when medicines are disguised in food or drink. The person had been assessed for their capacity to consent to this process and because they lacked capacity a best interest decision meeting had been held. Records showed input had been sought from the GP, the pharmacist and the person's family. The decision to administer medicines this way had also been reviewed.

The provider had fulfilled the recommendation. MCA training for all staff had been reviewed and reflected best practice, a competency assessment was included in the training. The training and competency assessment were repeated by staff annually. New documentation had been introduced so decisions about care were made in line with legislation and guidance and the information gathered was of good quality.

Staff demonstrated sound knowledge of the MCA and good give examples of how they implemented the principles of the MCA in their work practice. For example, one staff member described how the different methods they used to support people in choosing their clothes for the day. Another staff member described how they wrote things down for one person as they found it easier to make decisions this way. Staff had a laminated prompt card which outlined the principles of the Mental Capacity Act, as well as providing brief information about Deprivation of Liberty Safeguards and the Duty of Candour.

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made for people and any conditions in place had been met.

Induction and personnel files showed that staff had undertaken a wide range of training. Although there were certificates of attendance and evidence of training completion, individual induction files had not been updated. For example, we looked at five staff induction folders, but only one of these had been signed to indicate that the staff member had completed their induction and that this had been reviewed six and twelve weeks after the person had started in post. Similarly, induction and training which was to be provided by the service was not signed as having been completed in folders. Staff were able to tell us about their induction and confirmed that they had received adequate training for their role, but records did not consistently reflect this.

We reviewed training records and saw staff training was up to date. Staff commented positively about the training they received from the provider. One staff member said, "The training is very good. My training is up to date and you can request extra if you want." Another staff member told us about their initial training, "I had three days of training including dementia, safeguarding, DoLS and MCA. The last day was practical moving and handling." Staff, including those who did not work in a care role, had undertaken dementia awareness training. People told us that staff had adequate training and skills to care for them. A staff member commented on the clinical training provided, "We attend specialist training too. Like syringe driver training, flu vaccination and catheterisation."

Staff told us they had regular supervision sessions. Supervision is where staff meets with their line manager to discuss their development and performance. This was documented in individual files and records were up to date. Staff said they are regularly observed in practice by senior staff, and they feel well supported by colleagues and managers. One staff member said, "I have supervisions every six to eight weeks and an annual appraisal. I have been able to tell them any concerns I have. I feel I am listened to and they have done things as a result."

The environment had been considered and adapted in line with people's needs. A recognised training programme was being adopted which focused on the environment for people living with dementia. Doors were brightly coloured identifying bathrooms and toilets and were clearly signed. People's names were displayed on their rooms. Access to the lift was kept secure by a code, which was available to people to use if appropriate. There were pictures and memorabilia displayed around the service of significant events, films and news items appropriate to the age of people living at the service. People were able to move around the service as they wished and access the garden independently.

People's nutrition and hydration needs were assessed and their preferences had been documented. When risks were identified, specialist advice and support was sought. Plans were reviewed regularly. Guidance was available for staff. For example, one plan detailed, a specific type of lightweight cup a person preferred to use. We found some examples where record keeping needed strengthening. For example one person's recommendation from speech and language therapist (SALT) in regards a textured and fortified diet had not been added to the food monitoring charts. Food and fluid monitoring charts had been completed. These were checked on a daily basis to ensure people had eaten and drunk enough. When staff had offered food or drinks and people had refused, this had been documented.

Feedback received about the food at the service was mixed. One person said, "I can't fault it. Always have a choice." Another person said, "Nicely prepared and presented." A relative said, "Mum always enjoy her food

here." However, we received some less positive comments. One person said, "Breakfast OK, but otherwise poor." Another person said, "There is a lack of selection in the evening."

People were asked what they would like to eat at mealtimes. We observed people being supported in their decision making by being shown the meal on a plate or being directed to read the menu, which was displayed on each table. People were given alternatives which were not on the menu if they did not like or want the food that was being offered. Tablecloths and flowers were in place to make the dining environment attractive. People received the time and support they required at mealtimes. We observed one person during lunch who had a pureed diet. The meal was presented attractively. The person was given choices for each course. Staff were able to support the individual to ensure there was suitable cutlery, offering alternatives when they observed that the person was finding something difficult. Snacks and drinks were available for people to help themselves to in different locations around the service. One person said, "In the foyer you can make a hot drink if you want to anytime."

A food and nutrition group met every month, and a 'Nutrition care and dining experience' audit was carried out three times per year. This aimed to ensure consistency, safe practice and standards compliance. The completed audits had action plans which identified improvements, although there was no record of when, or if, actions had been completed or changed. For example, an action from the January 2018 audit stated, "Jugs of juice to be available on each table at mealtimes". At the mealtime we observed, juice was poured by staff from communal jugs. It was not clear whether this change had ever been implemented.

People had access to ongoing healthcare. People told us their health needs were supported. One person said, "I am satisfied with the nurses input." A staff member said, "We have a good relationship with the local surgery. The GP visits weekly." Records also showed people were reviewed by SALT, the tissue viability nurse and the enablement team.

Is the service caring?

Our findings

People were supported by staff who were kind and caring. One person said, "The quality of care is excellent." Another person said, "The staff are so caring and lovely." A relative said, "The staff are fantastic." A staff member said, "I think the care here is brilliant. I've never met more kind, hardworking, dedicated staff. They really do care about the residents."

We observed staff speaking with people in a respectful, friendly and reassuring way. One person said, "Staff are very friendly." Another person said, "I have never heard staff talk in a detrimental fashion." We observed positive relationships between people and staff. People responded well to staff. For example, staff were laughing and talking with people about what they had done the previous evening.

The atmosphere was relaxed and calm. One person said, in relation to the atmosphere, "If you can't be happy here, I don't know where you would be happy." Another person spent much of their time moving around the lounge and corridor area, often seeking reassurance from staff members. Staff all greeted and spoke with the person, giving reassurance and answering the person's questions in a patient and considerate way.

The service had received several compliments. One compliment read, "Whenever I visited I always felt Kingfisher Lodge was a home from home. So lovely and clean and fresh. And all of your staff could not have been more attentive and pleasant." Another compliment said, "The wonderful staff really do put the care into caring. We know they are doing a job but not only did they do it in the most excellent manner possible but they went that extra mile over and above what would be expected."

Staff told us how they respected people's privacy, choices and upheld people's dignity. Staff said if people did not wish to receive care, this was respected and people would be asked again later. Relatives we spoke with confirmed this occurred. One staff member said, "I make sure when I give personal care that the curtains are drawn and always explain what I am going to do and put a towel over people when washing."

Staff spoke of being proud of the work and care they provided. One staff member said, "It makes me proud to think I have done my very best for the people and their families." Another staff member said, "I am proud when I make people laugh. Some people don't laugh very often so I try to have fun with them and make it feel like home."

Family and friends told us they were welcomed at the service to visit at any time. One relative said, "I can come in and visit whenever I want. I come in most days, at different times. The staff always make time to speak with you."

Relatives told us how they felt well supported themselves by staff. Staff recognised and supported relatives' individual circumstances. One relative said, "Staff have helped me understand my relatives' condition." Another relative said, "They [Staff] have supported me in making my decision to have respite for my relative." We observed relatives visiting and spending time with their loved ones in different areas of the

service. One person said, "When it was my birthday my family brought in fish and chips and we sat in the lounge and ate them."

Is the service responsive?

Our findings

People received care and support which was responsive to their needs. One staff member said, "It is important to give people person centred care. Giving them time and choice."

People were assessed prior to the service to ensure the service could meet their needs. One person said, "The manager came to the house and went through things. I am very satisfied."

Care plans gave information regarding people's background and history. For example, people's previous employment, family and relationships and significant life events. People's preference and routines were described. For example, one care plan documented the types of clothes and make up a person liked to wear. Another detailed what they liked to wear to bed, how many pillows they slept with and whether they preferred the door open or closed. This type of information enables staff to deliver care personalised to people's wishes. People's preference in regards to the gender of care staff supporting them was documented. Staff we spoke with knew people's personal preferences and interests well. We found care plans to contain a large quantity of documentation. We highlighted to the registered manager and senior staff that care plans could be reduced where information was no longer relevant. This would enable information to be found more easily and any inaccurate recording identifiable. The registered manager told us that care plans contents were in the process of being reorganised.

Advanced care plans were in place but these had either not always been completed or lacked detail. One person had clear information about their end of life wishes and plans, but there was no detail in some other records. For example, in one person's care plan it detailed how their faith was important to them. However, their end of life plan did not refer to this. Having this information in place enables people to discuss and consider their choices and preferences around how they would like to be cared for at the end of their lives. In addition, the service had a separate end of life care plan to guide staff in caring for people in their last few days and hours of life. However, the plans we reviewed often were not fully completed or contained limited information. As some of the information was unable to be collected in the timeframe from when the plan commenced. We discussed the current plans with a senior staff member who acknowledged further development would be beneficial.

We recommend that the registered person researches available resources to support consistent practice in advanced care planning.

Care plans gave staff details of effective strategies to use when supporting people that may experience agitation. For example, one care plan explained what a person felt anxious about, how staff could reassure them and examples of how to respond positively to the person's questions. A relative told us how staff distracted their relative at the end of their visit. This enabled the relative to leave without upsetting the person. We observed this take place. The relative told us how much this meant to them and the person, to ensure they remained calm and happy. People were supported to be involved in reviews of their care and future plans. In some cases, people had signed to confirm their involvement. Relatives were often actively involved in care plan reviews.

Activities were displayed on the noticeboard in the entrance area to the service. These included religious services, hair and beauty salon, one to one activities and trips out in the mini bus. People were aware of the activities that were available but did not always wish to participate. One person said, "They try to organise things, but people don't join in." Another person said, "I know of the activities, but I choose not to join in. I like to be quiet." One staff member said, "The activities are good here. They are done really well." Photographs displayed showed the Easter celebrations the service had organised in conjunction with people from the local community. Around the service there were games, books, art and colouring materials and puzzles for people to use. Activity staff told us they needed to be flexible with the provision of activities to change things in order to engage people. Staff commented that people responded well to one to one engagement. One staff member said, "We need more staff to sit and talk with people."

People were supported and encouraged to engage in activities within the wider community. For example, we reviewed information about one person's ongoing lunch club and community group attendance. This included details about the activity, who would pick the person up, and how best to remind and reassure them about their ongoing activities. This meant that people were able to continue to engage in different activities which supported their wellbeing and maintained their interests.

A wishing tree was located in the foyer. This displayed people's wishes. For example on wish read, "I would like to visit an old English pub and visit the seaside." These ideas and wishes were facilitated by keyworkers or through the activity team. A staff photo board displayed who staff were for people and relatives. People and relatives said they could raise concerns and complaints and felt listened to. One person said, "I would tell a head nurse." Information regarding how to raise a complaint or concerns was displayed in the reception area of the service along with the complaints procedure. The service had received six complaints in 2018. Some complaints we reviewed were still in progress, these were in line with the provider's complaints timeframe. All closed complaints had been fully investigated and had clear correspondence about the outcome of the complaint. People told us how they had raised concerns about the temperature of food and the recording of food intake. Actions had been taken to make improvements.

Meetings with people occurred regularly. We reviewed recent minutes and areas such as housekeeping, activities and the food were discussed. People also decided to have an incubator so they could observe the eggs develop into chicks.

Is the service well-led?

Our findings

At our last two comprehensive inspections the service had failed to meet the regulations in regards to good governance. This was due to governance systems not being consistently used effectively and that records relating to people were not always accurate. Care plan audits were not effective in identifying inconsistencies and inaccuracies.

At this inspection we found improvements had been made but not all areas relating to the shortfalls in the management of records and feedback about the service had not been identified and/or actioned.

When we reviewed people's consent to care we found numerous capacity assessments that were completed in 2017 in relation to different aspects of people's care in a box within a staff area. For example, people's capacity had been assessed in relation to continence needs, personal care and living at the service. These showed how assessments had been conducted in a person centred way, considering the environment and the time of the discussion. However, where associated best interest meetings were documented as being conducted, these could not be always be located. It was unclear why these assessments were not in people's care files. This meant that staff would not have access to correct and accurate information when needed. After the inspection senior staff took immediate steps to address this and we were sent confirmation of the actions taken.

We received mixed feedback in regards to staffing levels at the service from people and staff. People told us, "Sometimes at weekends if the hostess isn't here and carers have to serve meals then there aren't enough staff to answer bells," Another person said, "Not enough carers on duty. Carers to residents not a good ratio at times," Another person commented, "Staff are always rushing. They want to be helpful but they haven't got the time."

Staff told us the staff sickness impacted on care and support. A staff member said, "There is a lot of staff sickness." Another staff member said, "It is a let down when someone rings in sick. Once you've lost a member of staff it does make a difference. It is not always possible to get another member of staff at short notice." Staff also commented that in one area of the service the kitchen hostess role was not always filled. This was highlighted as difficult for care staff to complete this role in addition to their care duties. However, one staff member said, "Like everywhere you could always do with more staff. If you get a good mix of staff it is no problem. I feel there is enough staff generally."

Since the last inspection a new governance system had been introduced. This had improved the auditing of different areas of the service. Audits monitored and reviewed areas of care such as care records, medicines, infection control and people's dining experience. Care plan reviews identified areas for improvement or when further details were required.

Where quality improvements were needed these were collated into a central plan. There were several ongoing actions. Where progress had been made this had not been dated so it was unclear when actions had been taken. Improvements required in capacity assessments and best interest decision recording had

been identified in October 2017 and March 2018 as had those in induction records in February 2018. Effective action had not been taken promptly to make the necessary improvements in these areas. However, the mismanagement of MCA records found during this inspection had not been identified. The provider had also not identified that further analysis of staffing was required. In order to explore and understand how people's experiences were affected by staffing provision and deployment.

Improvements at the service were noted by staff we spoke with. One staff member said, "We've been on a journey. Upstairs, the care plans have improved and we're now starting to do the same downstairs." Another staff member said, "We're turning things around, but it's a long process."

People and staff highlighted how unstable management in the past had impacted on the service. One person said, "The change of leadership has been very unsettling. Hopefully this will improve." A staff member said, "It's been really tough having so many managers, I hope the new one stays." The newly appointed registered manager said they had been well supported from the provider and senior managers in settling into the role.

Staff and people spoke positively about the team culture. One staff member said, "It is good working with the people I work with. Everyone gets along and helps each other out." Another said, "My care colleagues are brilliant. We want the best for people we care for." One person said, "The staff seem happy here, always cheerful." Another said, "The staff don't moan and groan, they are always ready to help." However we received one comment from a staff member that nursing and care staff could work together more effectively.

Positive feedback was received about the registered manager recently in post. One person said, "The manager is approachable." One staff member said in regards to the registered manager and senior staff, "They are all lovely and approachable." Another stated, "They are very thorough. I can go to them if I have any concerns."

Staff told us there were good systems in place to ensure information was communicated effectively. A handover took place at the beginning of each shift. The registered manager was usually present at the morning handover to be visible and approachable. Monthly nurses meetings were held where clinical issues were updated and discussed. In addition to these there were regular staff and departmental meetings such as health and safety.

The service had developed good links with the local community. Events and activities ensured there were opportunities for people to meet members of the community and for them to be welcomed at the service. For example, members of the emergency services were invited to have a break at Kingfisher Lodge if they were in the area. The service offered space and complimentary refreshments and appreciation to those staff for their work. Local professionals could utilise meeting space courtesy of the service. An open day was planned in June 2018 so local residents could come and see what the service did. The service had been highlighted in the local newspapers for events such as, fundraising to support dementia charities, a sports day and a member of staffs' achievement award.

Relatives said they received good communication from the service. One relative said, "They keep me updated and informed." In the foyer area of the service information and communications about the organisation and service were displayed. One relative said in regards to the relatives meetings minutes, "I have seen the meeting notes."

The service had a number of employee benefit and recognition schemes. Anyone could nominate a member

of staff for a monthly award. Forms were located in the entrance area. The previous month's recipient was displayed.

People, friends and family were encouraged to give feedback to the service in a variety of ways. Leaflets in the foyer detailed how ratings and reviews could be left on national websites. Regular relatives meetings occurred. Relatives had opportunities to raise questions and give their feedback. Areas discussed included the key working system, staffing, management structure, outings for people and the laundry. A survey had been conducted with people and relatives, which showed overall positive results. An analysis was conducted and a plan devised to address items raised. In the foyer area a, 'You said, we did' noticeboard displayed suggestions and comments that had been raised and the actions the service have taken in response.

The provider understood the legal obligations in relating to submitting notifications to the Commission and under what circumstances these were necessary. A notification is information about important events which affect people or the home. The provider had completed and returned the Provider Information Return (PIR) within the timeframe allocated and explained what the service was doing well and the areas it planned to improve upon.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not always ensured consent to care was sought in line with legislation and guidance.