Barchester Healthcare Homes Limited

Kingsland House

Inspection report

Kingsland Close, Off Middle Road,
Shoreham by Sea, West Sussex, BN3 6LT
Tel: 01273 440019
Website: www.barchester.com

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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

Overall summary

The inspection was unannounced and took place on 08 and 09 January 2015.

Kingsland House is a purpose built home that provides nursing care and accommodation for up to 71 older people with a physical disability, dementia and/or related mental health conditions. The home includes 'Memory Lane Community', a dedicated part of the home that accommodates people living with a dementia and 'Bluebell Community', part of the home where people with complex and general nursing needs reside. Services offered at the home include nursing care, end of life care, respite care and short breaks. At the time of this inspection, there were 60 people living at the home.

During our inspection the registered manager was present. 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 told us that they felt safe in the home. However, staffing levels did not ensure that people received all the support they required at the times they needed. People

Summary of findings

told us that at times, they had to wait for assistance to get up in the mornings. We observed that staff were rushed and had little time to spend with people outside of delivering care to them.

Due to the numbers of people who required medicines there was not a safe time gap between the morning and lunchtime medicines being given. This compromised people's wellbeing. During our inspection we observed that nurses were interrupted when giving people their medicines and when speaking with visiting healthcare professionals by care staff who required support and guidance.

Records were not in place that demonstrated two people were having their pressure wounds redressed at the frequency stated in their care plans. A nurse told us that at times it was difficult to ensure people were repositioned every two hours as part of their pressure area management.

Activity staff were on duty however, for most of time we did not observe them facilitating any activities. On the first day of our inspection we observed one of the activity staff conducting a crafts session with seven people. On the second day of our inspection we observed five people sitting at a table that had dominoes and jigsaw puzzles on it. Although people were sitting at the table they did not engage in the activity or with one another as there was no staff present to support them.

People were treated with kindness and compassion. Although we observed that staff at times appeared busy and rushed we saw no signs of impatience with people. Staff appeared dedicated and committed. We observed that care was given with respect and kindness but it was clear that some people had to wait for too long for the help they required.

Since the manager had been in post she had prioritised making sure shifts were covered as this had not previously been happening. Records confirmed that the number of shifts with a full staff compliment had increased since the manager had been in post. The manager had an action plan in place that collated findings from a range of quality assurance audits. Although they identified shortfalls in service provision that reflected our inspection findings they had not ensured prompt action had been taken. The manager explained that until December 2014 she had not had a deputy manager and that this had impacted on her being able to address issues in a timely manner. As a result, people had not received a consistently good quality service.

Kingsland House was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The manager informed us that 45 people who lived at Kingsland House required either urgent or standard DoLS applications and of these, she had submitted six. The manager said, this was, "Purely a time issue" as the reason why applications had not been made. This meant that people's rights were not protected.

Staff had not been receiving regular, formal, one to one meetings and appraisal that would support their development and allow the manager to formally monitor staff practice. The manager had devised a plan to address this. Staff told us that morale was low. The manager was aware of this. Joint handovers between shifts had been introduced which nursing, care staff and either the manager or deputy attended. Daily head of department meetings and interdepartmental meetings had also been introduced, all of which helped promote a whole team ethos and approach.

People had care plans and risk assessments in place for their individual needs. People's individual care and support needs were reviewed when incidents and accidents occurred to help keep them safe. The manager told us that she had not yet started to look at incidents as a whole and as a result trends or themes had not been identified or action taken where applicable. We did note that some people's care plans were not being reviewed at the frequency stated in the provider's policy.

Formal systems were not being used consistently to support people to express their views and to be involved in making decisions about their care and support. The manager was aware of this and had re-introduced residents meetings and was planning to invite people to participate in a six monthly care package review process.

Medicines, including controlled drugs were stored safely and audits had been introduced to monitor that systems were safe.

There was a core team of staff who knew people well and understood their needs and wishes. It was clear that they cared about the people. People had access to healthcare professionals, such as the GP, dentist and optician. We

Summary of findings

found examples of good care and a quick response to changes in people's needs. People's nutritional, health and personal care needs were assessed, planned for and met. When recommendations were made by external healthcare professionals these were acted upon to ensure people received the care and support they required. People were supported at the end of their lives to have a comfortable, dignified and pain free death. The home had links with a local hospice who offered support and advice when needed.

In the main, the home was clean and free from unpleasant odours. Regular audits were completed by kitchen and housekeeping staff that were checked by the manager and shared with representatives of the provider to ensure standards of cleanliness and infection control were maintained. Bathrooms and toilets were clean along with bedrooms, beds and carpets. We did note an unpleasant odour in one lounge and two people's bedrooms.

Checks and risk assessments had been undertaken on the home environment to ensure it was safe. Within the Memory Lane Community pictorial signs were displayed on toilets, bathrooms and bedrooms to help people living with dementia orientate independently. There were sensory and 'memory-jogging' pictures and ornaments on walls and shelves which helped give a sense of home to people living with dementia.

Staff said that the training provided was good and equipped them with information and the knowledge they needed to care for people effectively. One member of staff said, "It's one of the best places I've worked at for the training provided". Training was provided during induction and then on an on-going basis. A training programme was in place that included courses that were relevant to the needs of people who lived at Kingsland House. These included the 'So Kind' programme. This was a course for staff that supported people who lived with dementia provided by the providers learning and development department.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People told us that they felt safe in the home. However, staffing levels did not ensure that people received all the support they required at the times they needed. There was not a suitable time gap between medicines rounds which could affect people's wellbeing.

Generally, the home was clean systems were in place to reduce the risk of the spread of infection. The premises were safe and well maintained.

Staff knew how to recognise and report abuse correctly. Potential risks were identified and managed on an individual basis.

Is the service effective?

Requires Improvement

The service was not effective.

People were not supported by staff who received formal supervision and appraisal. A thorough training programme helped staff to gain the skills and knowledge needed to care for people.

Kingsland House was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) as applications to deprive people of their liberty had not been made. Therefore people's rights were not protected.

People were supported to maintain a healthy diet and told us that food at the home was good. People's health care needs were met.

Is the service caring?

Requires Improvement

The service was not caring.

People were not actively involved in making decisions about their care and treatment.

People were not consistently treated with dignity and respect.

People were supported at the end of their life to have comfortable, dignified and a pain free death.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive the care they required at the time they needed it.

People's needs were assessed and when recommendations were made by external professionals these were acted upon.

Summary of findings

People were not always supported to participate in activities available. Efforts had been made to make the environment physically stimulating for people who lived with dementia.

People felt able to express concerns and these were acted upon.

Is the service well-led?

The service was not well-led.

People received an inconsistent service. Quality assurance processes identified aspects of the service that required improvement however the manager had not ensured action had been taken to rectify issues in a timely way.

The manager was committed to providing a good service that benefited everyone and had introduced systems and meetings to involve staff and improve moral.

Requires Improvement

Kingsland House

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 checked 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 08 and 09 January 2015 and was unannounced. The inspection team consisted of three inspectors, a specialist nurse advisor and an expert by experience who had experience of dementia and nursing care. 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, we checked the information that we held about the home and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed complaints, whistleblowing and safeguarding information that we had received from relatives of people who received a service, staff who had worked at Kingsland House and West Sussex County Council Adult Services. We used all this information to decide which areas to focus on during our inspection.

We spoke with 17 people who lived at Kingsland House, four relatives and one friend of a person who lived there. We also spoke with three nurses on duty, eight care staff, one house keeper, the training co-ordinator, two activity staff, the deputy manager and the registered manager. We also spoke with a GP, a specialist psychiatrist in dementia and a speech and language therapist; all of whom were visiting the home during our inspection and consented share their views on the service.

We observed care and support being provided in the lounges and dining areas, and with people's consent, 12 people's bedrooms on the first day of our inspection. We also spent time observing the lunchtime experience people had. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. On both days of our inspection we also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included care records and medicine administration record (MAR) sheets for 12 people and other records relating to the management of the home. These included staff training, support and employment records, quality assurance audits, minutes of meetings with people and staff, menus, safeguarding reports and action plans and accident and incident reports.

Kingsland House was last inspected on 24 February 2014 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

People who lived at Kingsland House, relatives and staff told us that there were not enough staff on duty to support people at the times they wanted or needed. One relative said, "Agency staff tend to be on at the weekend, and no-one from management is present, all issues are referred to the nurse in charge, and that may not be enough, there's no-one responsible to consult". Another relative said, "They do need more staff at weekends, mum is pretty independent, but she can be difficult to handle, and it always takes two to shower her." A member of staff said, "Some people have to stay in bed and I have to say I'm sorry I can't get you out of bed yet". Another member of staff said, "The pressure on us, we don't have time to do showers and baths sometimes. Sometimes the tea trolley doesn't get done". Another member of staff also commented that people were not able to have evening drinks as staff were too busy completing other tasks.

Two people told us that they were worried that their personal care would not happen in time for lunch. At 10.30am we observed one person on their bed in their night clothes and that a strong smell of urine was apparent. This person was not supported with their personal care until 12.45pm. We spoke with another person just before 12.00 and they told us, "They are short of staff. I'm still waiting for my wash. It's usually about 10.00, I don't mind staying in bed, but today they're short." We observed two members of staff arrive at about 12.05 to help this person with their personal care. Another person told us that on occasions they had to wait 15 to 30 minutes for help to use the toilet due to staff being very busy.

We observed that staff were available most of the time when people needed assistance in communal areas such as the lounges. However, we did observe times when there was not a staff presence in a lounge where seven people who were living with dementia were sitting. We observed one person attempt to get up from a chair but they could not do this by themselves. On another occasion, a person approached us for assistance as they thought we were members of staff as none were present. The above evidence demonstrated that there were not always sufficient numbers of staff to safely support people's care needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager told us that staffing levels were decided on occupancy and dependency levels and that a staffing tool was not currently used. We were informed that the provider was going to introduce a tool for deciding safe staffing levels in the near future. The manager informed us that this was currently being trialled in other Barchester services.

The manager told us that staffing levels consisted of two nurses and eight care staff during the day in the Memory Lane Community (which was divided into two sections, A and B) and one nurse and four care staff during the day in the Bluebell Community. At certain times of the day the care staff levels altered. During the afternoon between four and six care staff and one nurse were allocation to section A and two care staff and one nurse to section B. In the Bluebell Community between 8pm and 10pm there were two care staff and one nurse. The manager told us that the provider was, "looking to increase the staff in Bluebell". During the night there were two nurses and five care staff on duty. Other staff employed at Kingsland House included housekeepers, catering staff, maintenance and administration. Records that we looked at confirmed that in the previous four months since the manager had been in post, in the main, unless short notice, staffing levels had been maintained to the numbers described by the manager. Although the numbers of staff planned to be on duty were delivered, we found this was not sufficient to ensure people's needs were met.

At the time of our inspection the home had staff vacancies that included 155 hours per week of nurse cover and five care posts. The manager informed us that these were being covered by agency staff and that permanent staff were offered regular overtime. The manager explained that where possible the same agency staff were used but that this was not always possible, particularly with nurses. Discussions with staff and examination of records confirmed that agency nurses were given information about people who lived at the home at the start of their shifts to ensure they were informed of the care and treatment people required.

Recruitment checks were completed to ensure staff were safe to support people. Three staff files confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. The home had used agency staff to cover shifts. The manager was

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Is the service safe?

able to produce documentary evidence for some agency staff that confirmed that their employer had completed checks to ensure they were safe to support people, but this was not the case for all agency staff.

Medicines were not always managed safely at Kingsland House due to the staffing levels. We observed parts of a medicine round on both days of our inspection and saw that the staff who administered people's medicine did this safely. However, we did note that the morning medicines round did not end until 10.50am and the lunchtime medicine round started at 12.45pm. One person was given paracetamol at 8.45am and then again at 1.05pm which was less than the six hourly intervals prescribed. Nurses informed us that it was the norm for the morning medicines round to take two and a half hours. This meant that people might not have had a suitable time gap between medicines which could affect their wellbeing. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that pain relief was offered and could also be asked for, and records that we looked at confirmed this. There were guidelines for the administration of medicines required as needed (PRN). Staff knew when PRN medicines should be given and why. There were up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. Staff were able to describe how they ordered people's medicines and how unwanted or out of date medicines were disposed of and records confirmed this. They also showed that staff had been trained in the administration of medicines and their competency assessed and staff confirmed this. We saw that medicines were stored safely in a locked trolley which was not left unattended when open.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971 - these medicines are called controlled drugs or medicines. Controlled medicines were stored safely and separate records maintained. The stock of controlled medicines reflected the amount recorded in the controlled drugs book.

In the main, the home was clean and free from unpleasant odours. We did note that one of the sluice rooms was used to store flower vases on shelves that were directly above the sluice machine which did not promote good infection control. Bathrooms and toilets were clean along with bedrooms, beds and carpets. We did note an unpleasant odour in one lounge and two people's bedrooms during the morning on the first day of our inspection. This was addressed during the day and no odours were noticed on the second day of our visit. Staff used personal protective equipment (PPE), including disposable gloves and aprons when they carried out personal care such as assisting with continence to help reduce the risk of the spread of infection. Alcoholic hand rub was available at the entrance of the home which people could use to help reduce the risk of the spread of infection. We noted that hand gels were not available for use in the corridors of the home. Cleaning records had been completed showing the daily cleaning that had taken place and monthly deep clean routines. Regular audits were completed by kitchen and housekeeping staff that were checked by the manager and shared with representatives of the provider to ensure standards of cleanliness and infection control were maintained. Infection control training was included in the induction programme at Kingsland House that all staff were required to complete when first employed.

People told us that they felt safe. One person, when asked, said, "Oh Lord, yes! My family were worried about me at home, I knew I couldn't cope. They saw this place, and brought me here."

Staff confirmed that they had received safeguarding training and were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. The manager was clear about when to report concerns. She was able to explain the processes to be followed to inform the local authority and the CQC.

Checks and risk assessments had been undertaken on the home environment to ensure it was safe. Equipment had also been checked to ensure it was safe for people. These included gas appliances, lift, and emergency lighting and fire alarm systems. Health and safety audits had been completed by the provider's quality assurance team and action taken to address any issues. Maintenance staff were employed and a system was in place to address repairs to the environment and equipment promptly that ensured facilities were safe for people.

Risk assessments were in people's care records on areas such as moving and handling, skin integrity including pressure sore risk assessments, malnutrition and mobility.

Requires Improvement

Is the service safe?

Accidents and incidents were looked at on an individual basis and action taken to reduce, where possible, reoccurrence. People's individual care and support needs were reviewed when incidents occurred to help keep them safe. For example, when people experienced falls that resulted in injuries, the manager reviewed the individual accident records and made changes to the care that they received. Reports were completed by the manager and shared with the provider that included statistical data about accidents, incidents and concerns. The manager confirmed that she had not completed an analysis that looked at overall trends or themes to identify what, if any action could be taken to prevent future occurrence at a service level.

Requires Improvement

Is the service effective?

Our findings

Staff had not received support to understand their roles and responsibilities through regular, formal supervision and an annual appraisal. Of the 86 staff employed 15 received an annual appraisal during 2014. The manager explained that a system had recently been introduced that identified named staff who would have responsibility for supervising other staff. This included nurses being responsible for supervising certain members of the care staff team. She told us that the system had not yet started as some named staff required training in order to undertake their new roles. Mentoring and coaching training had been arranged for February and March 2014. A nurse told us that there was not enough time to supervise staff due to other responsibilities they had that included administering medicines, liaising with visiting professionals and contacting GP's. During our inspection we observed this to be the case; the nurse was interrupted when speaking with visiting healthcare professionals about people who lived at the home by staff who required support and guidance. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff confirmed that formal support systems were not in place but said that since the manager and deputy had started working at the home this had started to improve. For example, a staff meeting had been held over two days in December 2014 in order that greater numbers of staff could attend and hand overs now took place between shifts.

Kingsland House was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. We saw that there was a coded lock on the door of the Memory Lane Community and that some people used bedrails. The code to unlock the door was discreetly displayed next to the door that allowed people who could read to leave this area of the home. The manager and staff confirmed that many people who lived at the home were unable to consent to the use of bedrails and a locked door due to them living with dementia. Individual assessments were in place for the use of the bedrails that included consideration of people's ability to consent to this equipment. Some people were not able to consent to the use of bedrails and/or the locked door. The manager had not ensured best interest decision making processes had been followed in line with the Mental Capacity Act. The manager informed us that 45 people who lived at Kingsland House required either urgent or standard applications and of these, she had submitted six. This demonstrated that people may have had their freedom of movement unnecessarily restricted without due consideration to their abilities to consent or whether this was in their best interest. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the time of our inspection the manager had not undertaken Mental Capacity Act or DoLS training. Training was due to take place for the manager and other key staff at Kingsland House at the end of January 2015. Other staff had received training on DoLS as part of the safeguarding adults training that they completed during induction.

Despite formal consent processes not being followed in full, we observed that that staff checked with people that they were happy with support being provided on a regular basis and attempted to gain their consent. During our inspection we observed staff seeking people's agreement before supporting them and then waiting for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions.

People's opinions of staff were mixed. People on the whole said that the permanent staff understood their needs and the support they required but that at times agency staff did not. Comments included, "I've got everything I want; the people here are all very nice, and the doctor and nurse take care of me every week", "Yes, it's OK here, they do us OK". A relative said, "Well, they're (staff) still very nice, but they seem a bit tired, and anxious about things, and there are more agency people lately, who the residents don't know."

Staff were sufficiently skilled and experienced to care and support people to have a good quality of life. All new staff completed an induction programme at the start of their employment that followed nationally recognised standards. This helped equip staff with information and

Is the service effective?

knowledge relevant to the care sector they were working in. The induction process included shadowing other staff and spending time with people before working independently. Training was provided during induction and then on an ongoing basis. We did note that none of the staff induction records that we viewed included evidence of review meetings between the new member of staff and their supervisor. This was not in line with the provider's induction procedure which said that three review meetings should take place and be recorded.

Staff were trained in areas that included health and safety, fire safety, food hygiene, and moving and handling. A training programme was in place that included courses that were relevant to the needs of people who lived at Kingsland House. These included the 'So Kind' programme. This was an eight module course for staff that supported people who lived with dementia provided by the providers learning and development department. Other training that staff had completed included managing nutrition, pain management and equality and diversity. Staff said that they were provided with training that enabled them to support people appropriately. Comments included, "The training is brilliant", "There is loads of training available" and "It's one of the best places I've worked at for the training provided".

People told us that they were happy with the support they received to eat and had a balanced diet that promoted healthy eating. One person said, "The food is lovely, very good, Christmas dinner was out of this world". At lunchtime people were observed enjoying a variety of meals of their choosing. Some people chose to sit in the dining rooms while others sat in the lounges or their bedrooms. The atmosphere was calm. There were clusters of tables that seated up to four people which helped people who lived with dementia experience a more intimate dining experience. The mood throughout lunch was relaxed and friendly and people were enjoying the food and each other's company. There was some conversation at the tables, and staff interactions with people were relaxed, helpful and cheerful. We did observe one person who had to wait for their lunch to be served. We were told this was due to the person needing their meal pureed and assistance to eat and that staff would do this when they had finished assisting those at the dining table.

People were offered snacks that included biscuits and sweets, whilst sitting in the lounges and these, along with a range of drinks, were available for people to access independently if they wished. Care records provided information to staff about people's food and nutrition that also included people's food preferences. Specialist diets were catered for that included pureed and fortified meals and thickened fluids.

People were supported to access healthcare services and to maintain good health. People told us that they were happy with the support they received to maintain good health. They told us that staff supported them to visit their GP, dentists and opticians. Kingsland House had an arrangement with a GP who visited at least once a week and a chiropodist who visited every six to eight weeks. Records confirmed that people were referred to dieticians, tissue viability nurses and the dementia crisis team when required. People's current health needs were recorded on their care records. Two external healthcare professionals expressed the view that staff turnover at the home affected communication. One said, about staff, "They don't seem to know why I'm here, every time you visit there are different staff and it is difficult to get feedback. Consistency of staff is definitely a problem, I feel frustrated that staff don't know the patient". Another said, "Communication has always been good. But the staff are very busy and there is not always someone to ask". However, they did go on to say that they felt people received good care.

Care records were updated to reflect any changes and to ensure people's most up-to-date care needs were identified and planned for. For example, one person's continence needs were recorded and the change in need documented when they needed to have a catheter removed. A clear plan for managing this change was in place. We did note that although the expectation was that care plans were reviewed on a monthly basis this person's plan was last reviewed in November 2014. Another person had a care plan in place for nutrition and hydration that had not been reviewed since October 2014.The manager was aware that some people's care records were not being reviewed or updated in line with the provider's policy and had allocated named staff to oversee that this took place. The manager told us, "This is a work in progress".

One person with a pressure wound had a care plan in place and other records that demonstrated this was being managed effectively. A referral to the tissue viability nurse had been made and a pressure relieving mattress was in place. The person told us that that they were happy with

Requires Improvement

Is the service effective?

the care they had received to manage the wound and that their needs had been met. However, we did note that the wound dressings had not been changed at the frequency stated in the care plan.

Within the Memory Lane Community pictorial signs were displayed on toilets, bathrooms and bedrooms to help people living with dementia orientate independently. People's bedrooms were personalised with possessions such as pictures, bedding and furniture. There were sensory and 'memory-jogging' pictures and ornaments on walls and shelves which helped give a sense of home to people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Two people told us that staff did not treat them with respect and dignity when providing personal care. They told us that they had to use continence pads when they needed to open their bowels rather than be assisted to the toilet with the use of a hoist. One person said that they did not want to use to continence pads but said that staff, "Expect me to do it in the pad". They went on to say that they were concerned about smelling unpleasantly when they had visitors. This was confirmed by a member of staff who said that they "Felt guilty" when they had to rush and that they knew of two people who had not had their continence pads changed in a timely way due to staff shortages. This demonstrated that the provider did not have suitable arrangements to ensure people were treated with dignity and that their independence with continence was encouraged. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Formal systems were not being used consistently to support people to express their views and to be involved in making decisions about their care and support. The manager explained that prior to, and when first moving into the home, people and their representatives were asked for their views and these were incorporated into their care plans. The manager had identified that people were not routinely involved in their care plan reviews. She explained that it was her intention to write to people and their representatives, to invite them to participate in the six monthly review process. Residents' meetings had been introduced, with the first held in December 2014. During this meeting, people were asked for their views on staffing, care and the environment.

People told us they were treated with kindness and compassion in their day to day care. Visitors of one person said, "She's happier here than in her last place; the staff are kind and polite too. When we took her for a walk along the corridor the other day, each carer stopped and greeted her by name and touched her hand, it was lovely to see."

Although we observed that staff at times appeared busy and rushed we saw no signs of impatience with people. Staff patiently informed people of the support they offered and waited for their response before carrying out any planned interventions. The atmosphere was relaxed with laughter and banter heard between staff and people. We observed people smiling and choosing to spend time with staff. Staff knew what people could do for themselves and areas where support was needed. Staff appeared dedicated and committed. They knew people's individual needs, traits and personalities. They were able to talk about these without referring to people's care records.

The manager told us that she spent time "On the floor" with people in order to build relationships of trust and to monitor how staff treated people. She gave examples of when she had done this and spoke to staff as a result. For example, when she observed staff had not helped a person to remove a stained serviette from around their neck and on another occasion when they had not ensured a females skirt did not expose the top of their legs. The manager explained, "Part of my role is reinforcing and reiterating the importance of these types of things to staff". We observed people approaching the manager and vice versa. It was apparent that people felt relaxed in the manager's company.

When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. Attention to detail had been given with people's appearance with many ladies wearing items of jewellery that complemented their co-ordinated outfits and gentlemen were freshly shaved. Double rooms were available so that couples could continue to live together and maintain their relationships. A quiet lounge was also available for people to have meals with relatives in private if they wished. We observed that care was given with respect and kindness but it was clear that some people had to wait for too long for the help they required.

Staff were able to explain how they treated people with dignity and respect and promoted privacy; however, they did say that staffing levels sometimes affected this. One explained, "Even if you know someone cannot answer you because of their dementia you should always knock on their door and introduce yourself before entering".

Systems were in place that helped ensure people were supported at the end of their life to have a comfortable, dignified and pain free death. The home had links with a local hospice who offered support and advice when needed. Nurses had received training in the use of syringe drivers. Syringe drivers are battery operated pumps used to give medication continuously under the skin for a period of time if a person cannot take medication by mouth. This helped people manage symptoms, including pain, an

Requires Improvement

Is the service caring?

important part of end of life care. People confirmed that they had received adequate pain relief and we observed a nurse offering this when completing the medicine round. Care records for one person showed that they were receiving good end of life care. Assessments and care plans were in place for symptom control, pain management, mouth care, involvement of the family and spiritual needs.

Completed Do Not Attempt Resuscitation (DNR) forms, along with an advanced care planning documents, were in place along with evidence of monthly evaluations having been completed. A nurse on duty demonstrated knowledge of pain and symptom control and the needs of the person and their family.

Requires Improvement

Is the service responsive?

Our findings

Staffing impacted on people receiving personalised care that was responsive to their needs. The manager explained that, where possible, staff were based in particular parts of the service such as the Memory Lane Community so that they got to know people's individual needs. However, people living at Kingsland House, visitors and staff said that at times they had not received the care they wanted and needed in a timely way.

On the first day of our inspection a nurse informed us that three people had wounds that required dressing. These had not been undertaken by 3.45pm due to the nurse having to complete other tasks. Records confirmed that for two people, their dressings had not been changed at the frequency stated in their care plan. For one of these people, their care plan stated that their dressing required changing daily but there was no record of this happening for seven days. Some people required repositioning every two hours as part of their pressure area management. A nurse told us that at times this was difficult to achieve due to staffing levels. This demonstrated that the provider had not taken proper steps to plan and deliver wound care treatment based on people's individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Despite an activity programme being in place and specific staff employed to support people with activities people did not consistently receive stimulation that met their needs. Two activity staff were employed who were responsible for planning and ensuring activities took place. During both days of our inspection the activity staff were on duty; however, for most of time we did not observe them facilitating any activities. They were seen completing administration work and staff rotas and assisting nurses and care staff. One of the activity staff confirmed that as well as arranging activity programmes they were also responsible for staff rotas and updating the home's website.

On the first day of our inspection we observed one of the activity staff conducting a crafts session with seven people. The people involved appeared to enjoy the social event and were heard laughing and talking to one another. On the second day of our inspection we observed five people sitting at a table that had dominoes and jigsaw puzzles on it. Although people were sitting at the table they did not engage in the activity or with one another as there was no staff present to support them. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Daily newspapers were available and people were seen choosing their preferred ones and reading at their leisure. Within the Memory Lane Community textured surfaces were in place and interactive tactile activities such as scarfs and balls of wool were located at various points. These helped provide physical stimulation for people who lived with dementia when organised activities were not happening. An activity programme was in place that offered everyday opportunities for manicures, reminiscences sessions, knitting and crochet, crosswords, word games and crafts. On occasions external entertainers visited the home and provided music to involve people and encourage mental stimulation. One person told us of a recent activity that their family member had arranged, "Staff came and collected me from my room and said there was a surprise for me, and it was my daughter, who'd arranged a concert here for me and the others, and it was lovely! Now she volunteers, and sings here." However, this did not effectively compensate for the lack of activities initiated by staff on a daily basis.

People's needs were assessed prior to admission to the home and relatives confirmed this. The manager told us they would talk with potential residents and their families so that they had a comprehensive picture of the person, their health and care needs, personal preferences and cultural needs. They said that people's preferences with regard to gender preference of staff who assisted them with personal care was sought but that there was no one who currently lived at the home who had requested a specific gender of staff. A Deacon provided non denomination religious services at the home that people could attend if they wished.

Care records gave descriptions of people's needs and the support staff should give to meet these. Staff completed daily records of the care and support that had been given to people. These detailed activities such as assistance with personal care, moving and handling and eating. Relatives told us that they had been involved in the formulation of some care records relevant to people's needs such as advanced care plans but none of the people that we spoke with who lived at the home were able to recall being involved in any such activity.

Requires Improvement

Is the service responsive?

Referrals had been made to external health care professionals when changes occurred to people's health and mental wellbeing and assessments completed. These included speech and language therapists, GP's, diabetes nurse specialists and tissue viability nurses. The findings from these assessments were then incorporated into people's care packages and changes made to the delivery of care so that people could receive the care and support they needed. An external healthcare professional told us, "They are very good at referring directly and will ring us if they are concerned".

There were no restrictions when relatives or friends could visit the home. Relatives felt welcomed by staff when they came to visit. There were small, enclosed courtyard garden areas that people could access and Kingsland House also had its own transport that people could use to access local towns.

People said they felt able to express concerns or would complain without hesitation if they were worried about anything. One person said, "I haven't needed to complain, but I wouldn't hesitate if I did!" Another person said that they did not know how to raise a complaint with management but would speak to a member of the care team. A relative said, "I would be happy to go to the deputy with a concern".

The home's complaints procedure was displayed at prominent points throughout the building in order that people could refer to this if needed. Information about how to make a complaint was also included in the home brochure which was given to each person when they moved into Kingsland House. At the entrance of the home, we saw that there was information displayed regarding the fees, service user guides and contact details for the Commission so that people could make contact if they wished to share information about the service they received. Recommendation cards were also available in the reception that people could complete. The findings from these were then published on Care UK website. Records were in place that showed that where concerns or complaints had been raised, the manager had responded to these on an individual basis, either by email or letter.

The manager was unable to tell us how many complaints had been received in the last six months as these had not been recorded on the provider's complaints logging system. She explained that she had not yet been trained to use this and as a result, systems were not being used to identify themes or trends. At the end of our inspection the manager was able to provide us with a list of complaints and evidence of actions taken to address each.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since 23 June 2014 and said that she was aware of areas of the service that required improvement. She explained, "When I came I knew it was a troubled home. I was told at interview. There was an overarching safeguarding investigation that had identified issues with quality of care, staffing levels, morale, records and a lack of understanding and awareness of clinical issues". The manager explained that due to the amount of issues she had prioritised actions based on risk. She said that the first thing she had addressed was to ensure shifts were covered as this had not happened previously. The manager said that in almost every case shifts were now covered unless staff rang in sick at very short notice and agency staff could not be found. Records confirmed that the number of shifts with a full staff compliment had increased since the manager had been in post. In October 2014, as a part of another safeguarding concern the manager had been asked by the local authority to complete an investigation within 14 days. When we asked to view the investigation report the manager informed us that she had not completed this and that it had been "Overlooked". This meant that the manager had not had regard to the views and comments made by those acting on behalf of people who received a service at Kingsland House.

Accidents and incidents were included in the electronic quality governance system at the home. This captured information about each individual incident, the severity, staff involvement and where in the home the incident occurred. The quality governance system included the ability for data to be analysed as a whole in order that trends and themes could be identified and action taken if required. This had not taken place and the manager informed us that this was due to her not being familiar with the system. This meant that systems were not being used to ensure that the findings from accidents and incidents resulted in changes to the care and treatment people received.

A range of quality assurance audits were completed by the manager and the members of the provider's quality assurance team to help ensure quality standards were maintained and legislation complied with. These included audits of medication, care records, staff records and health and safety. The format for capturing information included a form that was structured on CQC methodology of safe, effective, caring, responsive and well led. All audits completed then filtered into an electronic, central action plan that could be viewed by the provider and other relevant people within the organisation. However, these had not ensured that people received a consistent and good quality service. The manager agreed with our inspection findings when we gave feedback at the end of our visit. She said that nothing that we had identified was not already known to her. She was aware of staffing level issues, DoLS applications required, the lack of formal supervision of staff, gaps in record keeping and the need for activities to be developed. However, to date these had not been addressed. The manager explained that until December 2014 she had not had a deputy manager and that this had impacted on her being able to address issues in a timely manner. All of the above demonstrated that the service did not have an effective system to assess, monitor and improve quality of care for people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's views of management of the home varied. One relative said that the manager was, "Nice". Most commented that the manager was not visible enough. Everyone said that the deputy manager was more "Hands-on". A member of staff said that management was improving, "I think it's taking time, and it feels like a work in progress". Another member of staff said, "Morale is down at the moment due to the staffing situation".

The manager was aware of the need to create a positive culture at Kingsland House and had started to take steps to ensure this was inclusive and empowering. She explained that when she first started working at the home she found a clear divide between the nursing and care staff that had a negative impact on the service provided to people. To address this, joint handovers between shifts had been introduced which nursing, care staff and either the manager or deputy attended. Daily head of department meetings and interdepartmental meetings had also been introduced, all of which helped promote a whole team ethos and approach. A general staff meeting had also taken place in December 2014 and a schedule had been devised for regular meetings to take place in the future. At the time of our inspection the minutes of the staff meeting had not been shared with staff. The manager said that action would be taken so that in future, people received timely information.

Requires Improvement

Is the service well-led?

The manager had also introduced a schedule for residents and relatives meetings to encourage people to be involved in making decisions about the service provided at Kingsland House. The first meeting was held in December 2014 and the next was planned for March 2015.

Barchester Healthcare Homes Limited have a clear vision and a set of values which are included in staff job descriptions, training literature and in the employee handbook. The manager said, and records confirmed, that these had been discussed with staff during their induction. She said that due to other areas of the service that required attention she had not focused on monitoring if staff understood and displayed the required values but that this would be covered when staff started to receive regular, formal supervision. Staff that we spoke with were not able to describe the provider's vision and values.

There were clear whistle blowing procedures in place which staff were aware of when we spoke with them. Information that guided staff how to report concerns and bad practice was displayed on the staff noticeboard so that information was easily accessible. This included a dedicated telephone number that the provider had in place that supported staff to report concerns anonymously.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9(1)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and welfare of service users.** **The registered person had not taken proper steps to ensure each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the planning and delivery of care and treatment in such a way as to meet service user's individual needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 (1)(a)(b)(2)(b)(i)(c)(i)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** **The registered person had not protected service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to –** **Regularly assess and monitor the quality of services provided and identify, assess and manage risks relating to the health, welfare and safety of service users.** **The registered person had not had regard to the complaints and comments made and views expressed by those acting on behalf of service users.**

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not where necessary, made changes to the treatment or care provided relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines.** **The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the safe administrations of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Respecting and involving service users.** **The registered person had not, so far as reasonably practicable, made suitable arrangements to ensure the dignity of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulation 18(1)(a)(b)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Consent to care and treatment.** **The registered person had not ensured suitable arrangements were in place for obtaining and acting in**

This section is primarily information for the provider

Action we have told the provider to take

accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing. The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers. The registered person had not ensured suitable arrangements were in place in order to ensure that persons employed are appropriately supported by receiving appropriate supervision and appraisal.