Care UK Community Partnerships Ltd

Kingsleigh

Inspection report

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10 October 2017

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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?	**Inadequate**

Summary of findings

Overall summary

Kingsleigh is owned and operated by Care UK Community Partnerships Ltd. It provides accommodation and personal care for up to 67 older people, who may also be living with dementia. The facilities are purpose built and organised into five, ground floor units with level access from the car park. On the day of our inspection 57 people were living at the service.

This inspection was carried out over two dates, both of which were unannounced. The first inspection was undertaken in the early hours of 28 September 2017. We then returned to the service on 10 October 2017.

The home had a registered manager. 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.

We last carried out a comprehensive inspection of this service on 3 November 2016 when we rated the service as Good.

This inspection was brought forward in response to concerns we had received about the care being provided at Kingsleigh. Due to the nature of the concerns that were raised, we inspected the service in the early hours of the morning. Following the first inspection date, we made contact with the provider to discuss our findings, in particular the concerns we had about staffing levels at night. As a result of the issues we shared with them, the provider sent us an initial action plan which outlined the immediate steps taken to improve the safety of the service. The second inspection visit was to assess the impact of the action plan and to review the overall rating of the service.

The findings from this inspection highlighted significant concerns about the leadership of the service. The management team had failed to respond to concerns repeatedly highlighted by staff that staffing levels were not sufficient and that people's needs were not being met. Internal auditing and monitoring had further failed to identify that the service was not providing good outcomes to people. Complaints made by relatives had not been listened to and acted on. As a result of our findings we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Until very recently, staffing levels at Kingsleigh were so insufficient that the service was not safe. In response to the concerns raised, the provider allocated a management support team to the service and took immediate steps to increase the number of staff on duty. Staffing levels were raised and agency staff were brought in whilst permanent staff were being recruited. On our second inspection day, staff reported that staffing levels had significantly improved and that consequently they now felt able to support people safely. Due to the current reliance on agency staff, the provider is sending us weekly rotas to demonstrate that safe levels continue to be maintained.

Risks to people were not always managed safely. The management team had failed to appropriately respond to incidents that were occurring and consequently a service was being offered to some people whose needs were unable to be met. Staff were not sufficiently trained or supported to manage these people's specialist needs. The escalating behaviours of some people and the poor management of this placed people at risk of harm. Following our inspection, urgent steps were taken to find more suitable placements for some of the people who were living at Kingsleigh.

The environment was not used effectively to support people living with dementia. There were little points of reference to orientate and engage people in their surroundings and consequently this further increased people's anxiety and behaviours. Bedrooms were not easily identifiable and people spend time in rooms that did not belong to them.

The management support team had recognised that care had been provided in a task based way and had taken immediate and effective steps to enable staff to deliver a more personalised approach to care. Care plans were being updated and reviewed to ensure they accurately reflected the support people required. Group activities were enjoyed by those who participated. Opportunities were however missed to deliver meaningful activities and engagement to people on a one to one basis throughout the day.

The management support team were working closely with other professionals to ensure people's health care needs were being met. Staff understanding of the Mental Capacity Act was varied and assessments of people's capacity were not always completed in a person-centred way. Staff did however understand the principle of providing support to people in the least restrictive way.

Staff had a good understanding of their personal roles and responsibilities in safeguarding people from abuse. Staff advocated strongly on behalf of people and took steps to ensure any concerns about abuse were reported and dealt with quickly. Appropriate recruitment checks were carried out to ensure suitable new staff were employed. Staff received regular supervision and appraisal, but these were not always effective in furthering their professional development.

Medicines were managed safely and people received their medicines as prescribed. Our first inspection highlighted that some people did not have appropriate guidelines in place to support the administration of occasional medicines, such as pain relief. By our second inspection date, many of these guidelines had been implemented and team leaders had a good knowledge of people, so they received their medicines when needed.

People had choice over their meals and appropriate action had begun to ensure people were effectively supported to maintain a healthy and balanced diet. A staff member had recently been appointed as a designated champion for nutrition. This meant that they were starting to have a better oversight of people's weights and nutrition risks. Food and fluid charts were being used to monitor those people identified as being at high risk of malnutrition or dehydration.

Staff remained caring and compassionate towards people, despite working in very difficult conditions themselves. Staff had a good knowledge of people's lives and used this information to support people with empathy and understanding. End of life care was provided with dignity and humility with staff supporting people to live their last days peacefully and in the presence of their loved ones.

The provider was open and transparent about the shortfalls within the service and committed to taking swift action to improve the service. Staff felt motivated and well supported by the management support team and they were all working together to move the service forwards.

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.

Staffing levels had not been sufficient to meet people's needs safely. Appropriate recruitment checks were carried out to ensure suitable new staff were employed.

Risks to people were not always appropriately assessed and managed.

Staff understood their roles and responsibilities in safeguarding people and advocated strongly on their behalf.

Medicines were managed safely and staff knowledge of people helped ensure they received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not sufficiently trained or supported to manage people's specialist needs.

Staff understanding of the Mental Capacity Act was varied and capacity assessments had not always been completed in a personalised way.

People had choice over their meals and were now being more effectively supported to maintain a healthy and balanced diet.

Partnership with other healthcare professionals had improved. People were better supported to access the other healthcare services they required.

The environment was not used effectively to support people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

People had warm and positive relationships with the staff who

supported them, but the leadership of the service was not caring. Staff treated people with dignity and respect, but the management of people's behaviours did not uphold the privacy of people's rooms and belongings.

People were involved in making decisions about their care and staff understood the importance of respecting people's choices and individual preferences.

End of life care was provided with empathy and humility, with staff supporting the whole family during people's last days.

Is the service responsive?

Requires Improvement

The service was not responsive.

Until very recently, staffing shortages had meant that support was provided in a very task-based way. Developments to care plans were on-going.

Not all people had access to activities and engagement that were meaningful to them.

Complaints had not always been handled in a way that made people feel valued and listened to.

Is the service well-led?

Inadequate

The service had not been well-led.

The management team had failed to assure the delivery of high quality support. Internal auditing and monitoring had not identified that the service was no longer providing good outcomes to people.

The provider had recently allocated additional resources to strengthen the leadership of the service and this was starting to positively impact on the care being delivered.

Kingsleigh

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 was a re-inspection of this service to check whether the provider was 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 an updated rating for the service under the Care Act 2014.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. In the planning of this inspection, we gathered feedback from other health and social care professionals who have recently been involved with the service.

On this occasion we did not request a Provider Information Return (PIR) before our inspection. 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. This was because the inspection was brought forward due to concerns we had received.

This inspection took place over two dates on 28 September 2017 and 10 October 2017, both of which were unannounced. The first inspection commenced at 04:30am and was carried out by three inspectors. This was because we had concerns about the care provided at night. During this visit we spoke with four people and eight members of staff. We also looked at the welfare checks for eight people and the medicine administration records for each person.

The second inspection took place during the day and we arrived at 7:45am. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

On the second inspection day we spoke individually with five people who lived at the service, two relatives, ten staff and a member of the provider's quality team. We observed interactions between people and staff throughout the day and joined people across the service at lunchtime to gain a view of the dining experience. We also reviewed a variety of documents which included the care records for five people, four

staff files, medicines records and other documentation relevant to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People told us that there were enough staff to look after them. For example, one person said, "I use the bell if I need to and they usually come within a few minutes. They come quickly at night too." Similarly, another person commented, "I wait for them usually to come along, but if I really need to I will use the bell. You don't wait too long, day or night." A relative also stated, "They do help and offer all the time, they are often busy and you do wait a little while for them to come back to help. They tell Dad they know he is waiting though and if it's the toilet they take him very quickly."

This feedback however was not reflective of the how the home had been staffed until recent weeks. Prior to our inspection, it was clear that staffing levels had not been sufficient to meet people's needs safely. One relative had contacted us to express concern that their family member had been incontinent unnecessarily, because staff were too busy to take them to the toilet. We also received information that alleged people were being made to get up very early due to staffing issues. Rotas showed that some staff had been working excessive hours as the service was so short staffed. Prior to the inspection, these issues were discussed with the provider who informed us that they had increased staffing levels during the day.

During our night inspection, staff told us that there were not enough of them to support people. For example, one staff member said, "Personally I don't feel there are enough staff. It's a difficult job as not every resident goes to sleep. People need reassurance and it can take some time to calm people down." Likewise, another staff member told us, "I think we have quite a few high needs. There needs to be someone in the lounge and there are not enough staff for this to happen."

The lack of care staff impacted on the lives of people that lived there. Staff did not have enough time to support people with their continence care. There was a strong smell of urine in one of the lounges where most people that were awake were sat. We asked one person who was awake when we arrived if they had been offered a drink. They told us they had not and said, "Staff will get around to it eventually." Another person told us they were, "Parched." We noted that people who were up at 4.30am were not offered a drink until 7am. Throughout the night inspection we noticed that people were repeatedly left without support from staff who were busy supporting other people in their bedrooms.

Following the first inspection date, we highlighted our concerns about staffing levels at night to the provider. This was immediately responded to and an additional member of staff was allocated to work each night. When we returned for our second day of inspection, there were more staff on duty, both at night and during the day. One staff member told us, "There has been a lot more staff recently and things have been made things a lot easier." Likewise, another staff member said, "Staffing levels are amazing now, but they have been awful." Rotas showed that significant numbers of agency staff had been used to increase staffing levels.

Despite the increase of staff numbers, the deployment of staff across the service was not always effective. We observed that some units were well staffed, whilst in others, staff were rushing around, with little time to support people in a meaningful way. We also noticed that one staff member had worked the night duty until

8am and then returned at 2pm for a late shift. Staff cannot be effective when they work long hours without sufficient breaks.

People living at Kingsleigh had high needs and as such the impact of low staffing was significant, not only in respect of the quality of care, but also the safety of the service.

The failure deploy sufficient suitably qualified, competent and skilled staff to support people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to the heavy reliance on agency staff, the provider was requested to submit weekly rotas to the CQC, so we can continue to monitor compliance.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who used care and support services. There were also copies of other relevant documentation, including employment history and professional and character references in staff files to show that staff were suitable to work in the service. The provider had systems in place to ensure that DBS and training checks were undertaken on all staff supplied by external agencies.

People told us that they felt safe with staff. One person said, "Oh yes I feel safe, never felt unsafe here" and another commented, "I don't doubt the safety here at all." Whilst people said they felt they were safe, they also raised concerns about other people entering their bedroom. One person talked to us at length about how they worried about other people coming into to their room and taking their belongings. This person was very angry and upset by this. During the inspection we saw the reality of this as one person repeatedly took items belonging to others. The items taken included clothing, handbags and people's walking frames. The impact on those affected was variable, but the risk of harm for those whose walking frames were removed was high. We also both observed and read about multiple incidents in which a person had thrown items or touched other people in either an aggressive or inappropriate way. The provider was taking action to manage this situation.

Staff spoken with were frustrated that the management team had previously not responded to people's increased needs. They told us that they had repeatedly raised concerns about the escalating behaviours and incidents occurring between people, but that nothing had been done. Senior managers were clear that some people were no longer appropriately placed at Kingsleigh and were actively working with the Local Authority to resolve this. Following our inspection, urgent action was taken to find more suitable placements for some of the people who had been living at the service.

Whilst staff were aware of the risks associated with people, these were not always accurately reflected in their care plans. This was significant, because of the high number of temporary staff working in the service. For example, one person made inappropriate comments to one of the inspection team and whilst this risk was known by staff, it was not in their care records.

The failure to provide care in a safe way and mitigate risk of harm was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health were mostly identified and managed. Care records documented the risks that had been assessed in respect of areas such as skin care, dehydration and malnutrition. Where a risk had been identified there was a clear plan in place to manage it. Staff on duty knew the risks associated with the people they supported and followed the guidelines in place to manage the risks. For example, permanent staff talked to us about the people at risk of falls, pressure wounds or weight loss and the things they were

doing to mitigate the risks.

Environmental risks had been considered and mitigated. Records were kept of health and safety checks that were carried out. A daily checklist was completed that looked at environmental and fire safety, along with the security of the building. This also included visual checks of electrical devices and equipment. Where risks had been identified, appropriate remedial action had been taken.

People told us that staff were kind to them and that staff treated them well. Staff understood their roles and responsibilities in safeguarding people and advocated strongly on their behalf. Staff were clear about the need to report any safeguarding concerns and told us they would report abuse to outside agencies if necessary and knew where to find the contact details for these. The management team referred safeguarding matters to the local authority and CQC in a timely way.

There were systems in place to manage medicines safely and people told us they received their medicines as prescribed. For example, one person said, "They bring me my tablets in the morning while I'm having breakfast so I always get them. They watch me take them and write it down. I know what they are for." Similarly, another person commented, "They bring them round in a cup and watch me take them. We talk about what they are for and ask me if I need painkillers. I can ask for them anytime and they give them to me."

At the time of our first inspection, protocols for occasional medicines (PRN), such as painkillers were not in place for each person. These guidelines are important for people living with dementia as they may be unable to communicate that they require pain relief. We also noticed that some medicines had been given to people, but Medication Administration Records (MAR charts) had not been signed. Following the first inspection, these findings were shared with the provider. On the second inspection date, we found that the majority of people now had PRN protocols in place and there was a plan in place to complete those that were outstanding.
Staff who administered medicines had received training and followed guidance from the Royal Pharmaceutical Society. For example, medicines were dispensed and administered to people on an individual basis and they did not sign Medication Administration Records (MAR charts) until medicines had been taken by the person. Staff washed their hands in between each person they administered medicines to.

All medicines were delivered and disposed of by an external provider. Medicines were stored safely. There were lockable rooms for the storage of medicines. Medicines trollies were locked when left unattended. Medicines that required refrigeration were stored in fridges, which were not used for any other purpose. The temperature of the fridges and the rooms in which they were housed were monitored daily to ensure the safety of medicines. The medicines trolley was organised and creams and bottles had opening dates on them.

Requires Improvement

Is the service effective?

Our findings

People told us that staff were good and supported them well. For example, one person said, "They do a good job looking after so many" and another commented, "Yes they are quite good". Likewise a relative told us that they felt confident that staff knew what they were doing.

Despite positive feedback from people using the service, not all staff had the skills and experience to support people effectively. In particular, staff expressed concern about some people's specialist support needs. Not all staff had completed training in supporting people with dementia or positive behaviour support. We asked staff whether they felt confident in providing care to people with behaviours that were challenging. One member of staff said, "I personally do feel confident but I feel some staff are not as confident. We haven't had training here." Another member of staff said, "I've only had manual handling training. I feel I can deal with people but I haven't had any training." A third told us, "We try to discourage people by reassuring them. Sometimes it's calm here in the mornings, but it's the incontinence that we find hard to manage."

There was a high usage of agency staff at the service. On the night shift there were agency staff that had never worked at the service before. One member of staff told us that this was their first night there and was waiting for the team leader to let them know what they needed to do. Another member of staff said, "There are too many agency at night that don't know people."

Staff were allocated to work with people without the necessary skills or coaching to support them effectively. One person had a designated 1-1 staff member, but because the staff member did not know how to manage the person's behaviours they ended up just following them around and witnessing incidents, rather than preventing them.

Staff told us that they had regular supervision sessions, but that the issues they raised were not acted upon. For example, staff said that they had repeatedly told their supervisors that they were not coping, but that nothing ever changed. The provider was taking active steps to improve the training, support and mentoring provided to staff.

The failure to provide appropriate support, training and supervision to enable staff to carry out their duties was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment was not used effectively to support people living with dementia. Despite being a service specialising in the care of people living with dementia, there were little points of reference to orientate and engage people in their surroundings. Bedroom doors were fitted with display boxes, but most of these did not include any form of meaningful memorabilia to support people in identifying the room as their own. Lack of thought about the environmental factors further increased people's anxiety and behaviours. The management support team had also recognised prior to the inspection that the environment was not being used appropriately and therefore staff from another of the provider's dementia services were being brought in to support some changes.

The provider had an induction programme for new staff which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. We saw that new staff were given time to shadow other staff in order to get to know people and their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People and their relatives told us that staff involved them in making decisions about their care and support and were aware of the care plans in place. Staff understood the importance of gaining consent from people, but some were not familiar with the principles of the MCA or which people may be being deprived of their liberty.

The documentation regarding people's capacity was varied and incomplete. DoLS referrals had been requested for some people who actually had capacity and were therefore not needed. In other cases, best interests decisions around people's care had been completed without capacity assessments having been undertaken first. The management support team had already highlighted these concerns and a deputy manager from another service had been brought in to review the MCA processes at Kingsleigh and support staff in this area.

Due to the nature of the services provided at Kingsleigh, it is recommended that the provider ensures the improvements to MCA processes implemented without delay.

People had choice over their meals and were effectively supported to maintain a healthy and balanced diet. One person told us, "It's quite good, I choose in the morning and then they remind me before lunch and you can change your mind. There is reasonable choice." Another person commented, "It's okay and always hot which is good. I choose from a few things and you get dessert. You have tea and biscuits, fruit, crisps during the day. They keep an eye on what I'm eating. I have my own snacks in my room." Relatives spoke positively of their experiences of mealtimes, with one family member saying, "It's good from what the residents say during lunch. We sit with them when we are here. It always smells nice."

People could choose where to take their meals and we saw some people eating together in communal areas, whilst the choice of others to eat in their room was respected. People who needed assistance to eat and drink received appropriate support. For example, we saw staff sitting at eye level with people and talking to them as they offered each mouthful slowly.

Portion sizes were appropriate and people were offered a choice of drinks with their meal. With the exception of our findings during the night visit, drinks were located next to people, with assistance and prompts offered as necessary. One person told us, "I have a jug in my room and they get a new one when they help me in my room, it's next to the bed. You get drinks in the morning and afternoon and you can have whatever you like, hot drinks, squashes, and juice. I can always reach one."

The chef maintained a list of people's dietary requirements from allergies to likes and dislikes and food consistency. Where there were concerns about the food or fluid intake for a person, we saw that this was

being recorded and monitored alongside the person's weight. The chef told us they had fortified foods for people losing weight and also encouraged them to eat more small meals throughout the day.

A staff member had recently been appointed as a designated champion for nutrition. This meant that they were starting to have proper oversight of people's weights and nutrition risks. Food and fluid charts were being used to monitor those people identified as being at high risk of malnutrition or dehydration.

People were supported to maintain good health and access external healthcare support as necessary. People told us that staff arranged for them to see professionals such as the doctor, dentist or optician as necessary. For example, one person said, "They arrange my hospital appointments and someone to go with me in the transport if my daughter cannot make it." Likewise, another person commented, "I've seen the dentist and optician here and someone for my feet."

People had care plans in place for specific health care needs. For example, one person had a care plan which outlined the support they required to manage their diabetes, including a description of the symptoms that staff should look out for in the event of changes to their blood sugar levels. District nurses visited regularly to support staff with the management of people's diabetes, wound care or end of life pain relief.

Requires Improvement

Is the service caring?

Our findings

Whilst people had warm and positive relationships with the staff who supported them, the leadership of the service was not caring. Due to low staffing levels staff had not been given the time or support to care for people in a personalised way. As a consequence, people had been looked after in a way that was task orientated and not reflective of their individual needs or preferred routines.

Concerns raised with the management team had not been acted upon and as such some people and their relatives did not feel the management team cared about them. In particular, the poor management of continence meant that some people had been left uncomfortable and everyone lived in a service that smelt unpleasant. Some staff told us that they felt let down by the management team when they failed to acknowledge and address the concerns that were being highlighted. For example, one staff member told us that when they had told the registered manager how the behaviours of some people were negatively impacting on others, they were just told, "There's no harm done."

People were upset that their bedrooms and belongings were not always protected. The poor management of people's behaviours and failure to respond appropriately to people's specialist needs meant that little regard was shown towards the privacy of people's rooms and personal items. During the inspection we observed that one person was fully clothed and asleep in another person's bed. Staff were aware of this fact, but was unsure how to prevent it from happening. Similarly, another person repeatedly took things that belonged to other people and again staff were unable to manage this situation effectively.

Despite the pressures that staff were under, it was clear that people had warm and caring relationships with those who supported them. People repeatedly told us how lovely staff were to them and praised the kindness they were shown. One person said, "All the staff are so lovely, they are so busy, but they treat us all so well." Similarly a relative expressed, "The staff have been great. They are all so caring; it's because of them that I would recommend this place to anyone." Even relatives who had complained about other aspects of the service, told us "I can't fault the care staff, they are amazing."

Staff were attentive and caring in the way they supported people. We noticed that staff crouched down when they spoke with people to enable eye contact. Staff were tactile in the support they provided. For example, we saw a staff member walking around the service with one person, chatting to them throughout. As they approached a doorway, the staff member put their arm around the person avoid them hitting themselves on the architrave. Another staff member talked to a person about their foot being swollen and offered to get them a blanket to keep them warm.

People were involved in making decisions about their care and staff understood the importance of respecting people's choices and individual preferences. One person told us, "They ask me what I think I need help with and then write it down in my folder." Similarly a relative said, "They ask me to come in for a chat when we visit sometimes and we all look at the plan and chat about things in it or things that could be in it. They ask Dad about what he thinks too."

Staff involved people in daily events. For example, we noticed one staff member showing a person how to fold napkins into a fan shape ahead of the lunchtime meal. The person copied and the staff member praised them and thanked them for their help. Menus were displayed on tables with printed information on one side and photographs on the other. This enabled people to make meaningful choices about the food they ate. One person did not communicate in English and as such we saw that key information in their unit was written in their own language and we heard staff conversing in the same.

Care was provided in a way that promoted people's privacy. People told us that staff routinely knocked on their door before entering and we observed this to be the case. One person commented, "I can go to my room if I feel like it and they ask if I want to go in with my husband in the evening and we watch television together. I have a lock on my door if I want it." Likewise a relative said, "They always discuss things in the room so others can't hear and seem quite discreet when we are here."

End of life care was provided with empathy and humility, with staff supporting the whole family during people's last days. One relative talked of the palliative care their family member was receiving. They said, "All the staff are so caring. I can honestly say they are all brilliant." We saw that staff took active steps to ensure people were kept comfortable, by turning them regularly and refreshing their mouth. Another family member told us, "They are very reassuring to them if they are worried or feeling unwell as they are to me."

Requires Improvement

Is the service responsive?

Our findings

Until very recently, staffing shortages had meant that support was provided in a very task-based way. Prior to the inspection, concerns had been raised with senior managers that people were being made to get up earlier than they would like. In response to this, senior managers did a spot check at the service and found that some people were being woken up in the morning. Clear instructions were issued to staff that this must stop and people told us it had. One person said, "I get up later now and they don't mind that at all. They just let you choose now but when they are short staffed you get up quite early." Likewise another person said, "Sometimes I get up early because they help me but recently I have been staying in bed and even having breakfast in bed which is nice." Similarly one staff member told us that they used to come on duty at 7:30am and find most people were up and dressed. They said that this made them feel uncomfortable because they knew it was not done for the benefit of people using the service.

It was not clear why night staff had been getting people up so early, but the feedback from everyone that we spoke with was that this was no longer the case. We arrived at the service unannounced and early on both inspection days and it was clear that people were now waking up naturally.

People's continence needs were not always managed effectively. On both inspection days we noticed a strong smell of urine across the service. Both visitors and staff expressed their concerns about the way continence needs had been managed. One staff member told us, "There's a delay in getting the continence aids and as such the urine soaks into the carpets and furniture." Similarly, another staff member said, "There are not enough pads. We don't want to have to wake people to see if they need the toilet." A third staff member also told us that people were just not receiving the right continence support. There was evidence that these concerns had been brought to the registered manager's attention at the start of the year, but nothing had been done. The management support team were now actively seeking appropriate support.

Care records did not always provide current guidance about how to support people with difficult or challenging needs. For example, we found a person asleep in the wrong bedroom. Whilst staff were aware that this happened, there was no plan in place to manage it. Similarly, another person made inappropriate sexualised comments to people and yet their care plan only made reference to their 'aggressive behaviour.' It was evident that staff were aware of people's individual needs, but due to staff shortages, they had not had the time to update care plans accordingly. Team leaders told us that they had been working in a care worker capacity, but now staffing levels were improving, they expected to be able to deliver their roles better and update the records.

Not all people had access to activities and engagement that were meaningful to them. The structured group activities were well led and stimulating. People who attended these were visibly enjoying the sessions and spoke positively about them. For those people who were either unable or not willing to join these activities, there was very little opportunity for social activity. We observed that whilst there were items, such as books, fidget blankets and games appropriate for people to use, these were rarely offered to people. Two people spent the whole of the second inspection day in the same chairs without any meaningful engagement from staff. One person told us, "I like to read the paper every day but don't always get one. I would like to go to the

shop to get it but don't, I don't go out unless my children come."

Feedback from people followed a theme that they would like to see more activities and outings being organised. When asked what could be improved about the service, most people highlighted activities as their main issue. For example, one person told us, "I would like to do more activities, choose what to do like sewing, gardening, trips." Likewise, another person said, "I would like to go outside in the garden more or to the shops."

The failure to provide person-centred care that met people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints had not always been handled in a way that made people feel valued and listened to. Whilst people told us that they felt able to talk to staff about their concerns, information received from relatives indicated that their complaints had not always been treated seriously by the management team. It was not possible to view other complaints as the registered manager was on leave and the documentation could not be located. The concerns shared with us were highlighted to senior managers who agreed that the responses provided were not satisfactory or in line with the provider's policy. These issues are now being addressed.

The failure to operate an effective system for the handling of complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Despite having a registered manager in post, Kingsleigh lacked the visibility of strong leadership and oversight. The management team had not ensured the safe delivery of the service's statement of purpose by failing to adequately staff the service and effectively manage the needs of the people who lived there.

People were unfamiliar with the management arrangements for the service and repeatedly referred to the registered manager as being 'office based'. For example, one person told us, "She is always in the office." Similarly, another commented, "I don't know her name" and a further said, "She is always busy." Relatives also echoed that they did not have much contact from the registered manager. One family member told us, "We don't really see her. I find the team leader chats far better, informative and reliable." Likewise, another said, "A bit more organisation from above would be good and to see the managers helping out."

The management team had failed to effectively engage with people and their relatives regarding the ongoing concerns. Family members who had complained had not received a satisfactory response from doing so. Other relatives said that they had previously been invited to attend meetings at the service, but these rarely happened now. People and their relatives were disengaged from how the service was being run. Similarly, whilst staff meetings had been undertaken, the issues raised by staff had not been acted upon.

Where surveys had highlighted areas of dissatisfaction, appropriate action had not been taken. For example, the relatives' survey for 2017 found that 29% of respondents were not happy with the security of people's belongings. Similarly, 28% were unhappy with the smell of the home and 45% of people were not happy with the activities provided. These themes have all been highlighted as areas of significant concern in this report, which means that feedback was not acted upon.

Staff told us that whilst the managers were nice and had been personally supportive of them, that the management of the service was not always effective. One staff member told us that they had repeatedly reported that staffing levels were unsafe, but said "Nothing changes, so we just gave up." Likewise, another staff member said that they felt very angry that when staffing levels were so low, that the management team sat in the office and did not help staff.

Internal auditing by the management team had not identified that the service was no longer providing good outcomes to people. Despite various audits and reports, the systems in place had failed to efficiently inform the provider that the service was no longer providing a good service to people. The management team had failed to effectively monitor the accidents and incidents in the service, which if they had would have identified that staffing levels were insufficient and that they continued to support people whose needs they could not meet.

The failure to assess, monitor and improve the quality of the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A few weeks prior to our first inspection date, the provider had completed a full governance audit of

Kingsleigh. This review of the service had identified many of the areas of concern that are highlighted in this report. Two senior managers had also completed an unannounced night visit in response to issues raised with them about the culture of support provided at night.

In view of their own concerns and ours, the provider had recently allocated additional resources to strengthen the management and leadership of the service and this was starting to positively impact on the care being delivered. One staff member said that since the management support team had been in the service, managers were supporting staff. They also went on to say that staff were now being encouraged to spend quality time talking with people, where before this had not been allowed.

The provider had implemented a Duty of Candour policy. Duty of candour came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. The provider had demonstrated the principles of this regulation by sharing openly acknowledging and addressing the shortfalls of the service.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to provide person-centred care that met people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to provide care in a safe way that mitigated the risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had failed to operate an effective system for the handling of complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to deploy sufficient suitably qualified, competent and skilled staff to support people's needs. The registered person had failed to provide appropriate support, training and supervision to enable staff to carry out their duties.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to assess, monitor and improve the quality of the services provided.

The enforcement action we took:

We issued a Warning Notice.