Caring Homes Healthcare Group Limited

Kingsclear

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 7 March 2018 and was unannounced. This was our first inspection of the service since its registration in October 2017.

Kingsclear is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Kingsclear accommodates up to 97 people in a new adapted building. Part of the service specialises in providing care to people living with dementia. At the time of our inspection there were 27 people living at Kingsclear.

There was a registered manager in post who supported us to access information during the inspection. 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.

Prior to the inspection we received concerns regarding the clinical competency of nursing staff and staffing levels within the service. We found sufficient staff were not consistently deployed to meet people's needs. Staff told us they struggled with the workload and did not have time to spend with people socially. Following the inspection senior managers told us they had reviewed the allocation of duties to support staff in their roles. We found that clinical training had not always been provided in line with the needs of people living at Kingsclear. This meant that pressure was being put on community nursing services and that people were at risk of not receiving healthcare in a timely manner. The provider assured us that training was booked for clinical staff and this would be completed within six weeks. We have made a recommendation regarding this. In other areas we found that staff had received the training they required for their roles and that a full induction into the service and organisation had been provided.

Risks to people's safety were not always managed consistently and there was a lack of guidance for staff on how to support people when they became anxious. Care records available to staff lacked detail and guidance regarding people's individual needs and preferences. Staff were unable to tell us about people's personal histories, their likes and dislikes in detail. There was a lack of person centred activities available to people. This meant staff were unable to provide person centred, responsive care to people. People told us

they were regularly bored and staff told us they felt people needed more stimulation. People's legal right were not always respected as the principles of the Mental Capacity Act 2005 were not consistently followed. Assessments to determine people's capacity to make decisions were not decision specific and best interest decisions were not recorded.

Staff did always feel valued and listened to. There was a lack of consistency in approach and ethos within the service and staff did not work together as a team. Although quality assurance systems were in place these did not always identify shortfalls in the service provided. Where concerns were identified these were not always acted upon effectively.

Staff supported people in a kind and friendly manner. However, although interactions were pleasant they were not always focussed on the individual as staff did not know people as well as they could. On occasions staff did not use terminology which was respectful to the people they supported and were heard to discuss people's care in communal areas. We have made a recommendation regarding this. With the above exceptions we observed staff respected people's privacy and supported them in a dignified way. People were offered choices and supported to maintain their independence. People told us that they generally enjoyed the food and choices were available to them. Meal surveys were regularly distributed to monitor people's satisfaction. People had the opportunity to comment on the quality of the overall service they received through surveys, residents meetings and a comments box placed in the communal entrance. The provider had a complaints policy in place and complaints were responded to in line with this policy.

People's medicines were stored and administered safely and access to healthcare professionals was arranged as required. Staff were aware of their safeguarding responsibilities and received training in this area. All staff had undergone robust recruitment checks to ensure they were of suitable character to work in this type of service.

People lived in a safe, clean and well maintained environment which was designed to meet their needs. Regular health and safety checks were completed and equipment was checked to ensure it was safe for use. The provider had developed a contingency plan which gave guidance to staff on the action to take in the event of an emergency. Infection control procedures were in place and followed by staff. Accidents and incidents were recorded and monitored for any emerging trends to prevent them from happening again.

During the inspection we identified 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Sufficient staff were not always deployed across the service.

Risks to people's safety were not always adequately addressed and monitored.

Accidents and incidents were recorded and monitored to minimise on-going risks.

Staff had received safeguarding training and were aware of reporting procedures should they have concerns.

People's medicines were stored and managed safely.

Safe recruitment processes were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People's legal rights were not protected as the requirements of the Mental Capacity Act were not being met.

Clinical staff did not always receive the training they required to meet people's needs. We have made a recommendation regarding this. In other areas training was provided and monitored to support staff in their roles.

Assessments were completed prior to people moving into the service

People had a choice of food and their nutrition and hydration needs were met.

People lived in an environment which was safe and designed around their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff treated people with kindness but did not always know people as well as they could. On occasions staff spoke about people's care needs in communal areas. We have made a recommendation regarding this.

People's privacy and dignity were maintained.

People were supported to maintain their independence.

Visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of activities for people to be involved in.

Staff were not fully aware of people's life histories, preferences and needs to support them in providing person centred care.

Complaints were responded to in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff did not work together as a cohesive team. The ethos of the service was not embedded and staff did not always feel supported.

Quality assurance systems were not always effective in identifying and addressing concerns.

People and staff had the opportunity to give feedback on the service through regular meetings and meetings for relatives were planned.

Kingsclear

Detailed findings

Background to this inspection

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

The inspection was prompted in part by concerns received by the Care Quality Commission (CQC) relating to staffing levels, staff skills and people's nutritional needs not being adequately monitored. Prior to our inspection we discussed these concerns with the Clinical Commissioning Group and the local authority.

The inspection took place on 7 March 2018 and was unannounced. The inspection was carried out by three inspectors, a nurse specialist and an expert by experience. The nurse advisor specialised in the care of older people. 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 reviewed records held by the Care Quality Commission which included notifications, complaints and any 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. On this occasion we did not ask the provider complete a Provider Information Return (PIR) as we inspected the service sooner than we planned. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with eleven people who lived at Kingsclear and observed the care and support provided to them. We spoke with four relatives, ten staff members, the registered manager and regional manager. Following the inspection we met with the registered manager and senior operations director.

We reviewed a variety of documents which included the care records for seven people, five staff files, medicines records, complaints and compliments, quality audits and various other documentation relevant to the management of the service.

Requires Improvement

Our findings

People told us that although they felt safe living at Kingsclear they had concerns regarding the number of staff available to support them. They told us that staff were often rushed and didn't have time to get to know them. One person told us, "There always seem to be lots of management about but not enough staff. They are always flying around and you can't always find anyone." Another person told us that although staff were kind and pleasant they didn't have time to talk to them.

Prior to our inspection we had received concerns from the local authority and anonymous sources that there were not sufficient staff available to support people's needs. During the inspection staff told us they found the workload demanding and that they did not have time to spend with people.

We spoke to eight staff who told us that staffing levels impacted on the care people received. One staff member told us, "Quite often there are just two of us (on one floor of the service). At breakfast people are unsupervised. When there is just the two of us it's hard to manage." They added, "There are too many high dependency people for this many staff. If I give up my break I can then sit down and chat to people." Another staff member told us, "We have three carers here today but it's often only two. It's just the demand on staff. It's about assistance with food that they (people) need. People won't get their drinks all of the time. There is a pressure on staff and we sometimes don't even get our breaks. People are in their rooms and in the lounge and its hard keeping an eye on everyone. When we have two carers people will have to wait until after lunch before they have a wash." During the inspection we also reviewed staff meeting minutes and staff nurse minutes. Both expressed concerns relating to staffing levels within the service which were impacting on people's care and the staff's ability to complete administration tasks.

The registered manager told us that in addition to care staff a minimum of one nurse was required to be on duty at any time to support the whole service. They told us that the clinical lead was also available to support when required. Staff told us that they did not believe this was sufficient to support all the people with nursing needs. One staff member told us, "One nurse isn't enough. It's just hectic. You have to keep going up and down the stairs. When we are short on carers we have to work harder to help them. Personal care is delayed and rushed."

The registered manager told us that the staffing numbers required to cover the service were six care staff in the mornings and five care staff in the afternoons. We asked for copies of the rotas for the past six weeks. The documents that were originally provided to us showed that the service was regularly falling below these levels. Following the inspection the registered manager stated the wrong rotas had been supplied and

provided additional documentation. The registered manager told us that this was the information that was most up to date. This information showed that staffing levels assessed as being required by the provider were normally met, with the exception of covering occasional staff sickness.

Following the inspection we met with the registered manager and the senior operations director for the provider. They told us that staffing levels were determined by the use of a dependency tool which assessed people's care needs in relation to the number of staff required. They assured us that these numbers had been met and that going forward additional staff had already been recruited. This would ensure that as the number of people living at Kingsclear increased staff would already be in post and have completed the induction process. In addition, they said they had also reviewed the allocation of staff duties on each shift to ensure staff were effectively deployed. They added that as there were 24 people at the home they had closed a number of wings to enable staff to reach people more easily. The senior operations director told us they had spoken to staff who said they did not believe the staffing levels affected the care they were able to provide. This was in direct contrast to the comments we had received from staff.

On the day of our inspection we found that the required staffing numbers, as determined by the provider, were available. However, due to the numbers of people who required support from two staff members during personal care, there were times when people who required staff supervision to keep everyone safe were left unattended. We observed one person regularly walked into other people's rooms throughout the day without staff knowledge. One person told us, "I'm fed up of (name) coming in here. The staff should stop them." One relative also told us they found this very worrying and upsetting. We observed staff were busy throughout the day completing tasks and did not have time to sit and engage with people.

Failing to ensure sufficient staff were deployed to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's well-being were not always thoroughly assessed and monitored. One person had been assessed as being at risk of de-hydration which may affect their health and skin integrity. There was no guidance for staff on how much fluid the person should ideally be consuming each day. Records for a one week period showed that the person was offered below 500mls of fluid per day on three occasions. The registered manager and clinical lead told us they believed that this was a recording issue and that staff were offering more frequent drinks. Although the amounts offered and consumed were totalled at the end of each day, no action was taken when low fluid levels were noted. This meant that staff could not assure themselves that the risk of de-hydration was being effectively managed. Following the inspection the registered manager informed us that the needs of people requiring fluid monitoring had been reviewed and target amounts set. Where it was identified these were not being met this would be passed on at handover and where required people would be referred to their GP.

People's anxiety and behaviours were not routinely monitored and guidance for staff in minimising these risks lacked detail. One person who had recently moved to the service had an assessment completed whilst in hospital. This stated that behavioural forms were being completed and the person 'Can be resistant to personal care, becomes agitated and aggressive.' The person's care plan did not give detailed guidance to staff on how best to support them. Although it was documented that they became anxious during personal care, their care plan for this area was not completed. Records showed that it had been agreed with professionals involved that the person's behaviour would be monitored. However, there were no systems in place to ensure that this was done in an effective manner. One staff member told us, "We have asked about how we can document (person's) behaviours and we just get told to enter the information on their care notes. There is no ABC chart (monitoring chart) and I don't think behaviours are analysed. We need a solution to see why (person) is behaving that way." Although the person's behaviours were recorded on daily

notes this did not guide staff on the information required to identify patterns or triggers for behaviour and how the person responded to different approaches. Records within daily notes regularly stated the person 'was unhappy' but gave no explanation as to how they had had displayed this or how they were supported. This meant there was a risk the person was not being appropriately supported with their anxiety.

Following the inspection the registered manager told us that they felt staff knew the person well and understood how to support them to minimise their anxiety. They also provided evidence that behavioural monitoring had been started in relation to the person. However, the recording was not always fully completed and therefore lacked detail to enable a full analysis to be completed.

People did not always have access to a call bell in order to summon assistance. Each person had a call bell in their room although these were not always long enough to reach people's chairs. We observed this was the case for three people on the ground floor. A staff member confirmed that some of the call bells were only just long enough to reach people's chairs so when they lifted them to press them they could become unplugged. We spoke to the registered manager regarding this. Immediate action was taken to purchase both extension leads and pendant alarms to ensure people would be able to call for staff when required.

The lack of effective risk management systems was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were recorded by staff and analysed to identify any trends or emerging themes. Records showed that each accident and incident form was reviewed by the registered manager or a senior staff member to ensure that any required actions were identified. All accidents, incidents, safeguarding concerns and complaints were also assessed and monitored centrally through the provider's Clinical Management Trending system. This meant that the risk of the accident or incident happening again was reduced. For example, one person had fallen when getting out of bed. Action had been taken to ensure the person's bed was lowered to the lowest level to minimise the risk of injury should they fall again. Bed sensors were also in place to ensure staff would be alerted should the person not return to bed within a set time.

Where concerns were identified there was evidence that action was taken to minimise the risk of re-occurrence. Concerns were raised regarding a delay in one person receiving their prescription for urgent medicines. The registered manager had implemented a different ordering system to ensure that should the same situation arise again the pharmacy would be aware that the medicines being ordered were urgent. We spoke with clinical staff responsible for the ordering of medicines and found they were aware of the new procedures.

Prior to the inspection we received concerns that prompt action was not being taken when people lost weight. During the inspection we found the provider had implemented systems to ensure that people were weighed regularly and that any significant changes were reported to relevant healthcare professionals including the GP, dietician and speech and language therapy (SALT). Information regarding people's weights was shared with catering staff to ensure that they were aware of people's nutritional needs. We observed staff encouraging people to eat and offering fortified foods and drinks such as milkshakes.

People were protected from the risk of abuse as systems were in place to ensure that concerns were identified and reported. Records showed that staff had received safeguarding training. Staff were able to describe to us the different types of potential abuse and the signs which may alert them. One staff member told us, "I would report to the line manager and if I wasn't happy I would whistle-blow. I would feel confident to whistle-blow as it may be the only way to get things done." Another staff member said, "I would tell my

line manager if there was anything wrong or any injury on a person. We have been told we can speak up on these things." Records showed that the service had made appropriate referrals to the local authority safeguarding team where required.

Robust recruitment checks were completed prior to staff starting their employment. Staff recruitment files contained application forms, evidence of face to face interviews and written references from past employers. Evidence was also available to show that Disclosure and Barring System (DBS) checks had been completed. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff we spoke to also confirmed that they had undergone recruitment checks prior to starting work at the service.

There were safe medicines administration systems in place and people received their medicines when required. Each person had a medicines administration record (MAR) which contained an up to date photograph, details of each prescribed medicines and any known allergies. MAR charts were completed fully by staff and no gaps in recording were noted. We observed medicines being administered and found that best practice guidance was followed. Medicines were stored safely and staff responsible for the administration of medicines had completed training and undergone competency assessments. Were people were prescribed PRN medicines (as and when required) protocols were in place to guide staff on how and when to administer the medicines.

Procedures were in place to protect people from the spread of infection. The environment was clean and well-maintained. We observed that staff wore gloves and aprons when supporting people with personal care. The laundry area was organised and ensured that clean and dirty laundry was stored separately. Staff had received training in infection control and were aware of the systems used to prevent the spread of infection. One staff member told us, "Soiled items come in red bags and we wash these items on a high temperature. I use gloves when handling these items and always wash my hands in between. It's to reduce the risk of infection to stop people becoming unwell."

People were kept safe from the risk of their care being disrupted during an emergency. All required health and safety checks were completed in relation to fire safety, risk of Legionella and the servicing of equipment within the home. The provider had developed a business continuity plan to ensure that people's care would continue in the event of an emergency. For example, if the premises were damaged and it was necessary to evacuate, plans were in place to ensure that the disruption to people's care was kept to a minimum.

Requires Improvement

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

People's rights were not always protected as staff did not always follow the correct processes as outlined in the MCA. Capacity assessments within people's care files were generic and did not highlight the specific decision to be made. There were no decision specific capacity assessments relating to locked doors within the service or for one person who was receiving their medicines covertly (without their knowledge or agreement). The provider's policy clearly stated decision specific capacity assessments should be completed, 'The (Mental Capacity) Act sets out a clear test for assessing whether a person lacks capacity to make a particular decision at a particular time. It is a decision specific test. No one can be regarded as lacking capacity to make decisions in general.' We found this policy was not being followed. There were no records available to evidence that decisions had been taken in people's best interest or in the least restrictive way.

Failing to ensure that the principles of the MCA were consistently followed is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

DoLS applications had been submitted for individuals where restrictions were in place. The registered manager maintained a DoLS tracker which stated the date that application had been submitted and any contact received from the relevant authority.

People and relatives we spoke to did not express any concerns regarding the competency of staff. One person told us, "They do help me and seem to know what they're doing."

Prior to the inspection we received concerns from the local authority and clinical commissioning group

regarding the training and competency of clinical staff in their role. Training including catheter care, compression dressings and syringe driver training had not been provided in a timely manner. Despite the awareness that clinical staff were not trained in the above areas the service had admitted a number of people who required this care. This meant that people were at risk of not receiving the care they required in a timely manner and that community nursing teams were being called upon to provide clinical support to the service. The registered manager told us that there had initially been confusion regarding accessing the training required. They provided evidence that training in these areas had been booked and would be completed within the next four to six weeks.

We recommend that the provider ensures that clinical staff receive all training required within six weeks of the inspection taking place.

Staff received an induction into the service and on-going training plans were in place. As part of the induction programme training had been provided to staff in all mandatory areas including safeguarding, moving and handling, health and safety and emergency first aid. In addition staff had received training in supporting people living with dementia. Staff told us the training they had received had supported them in their roles and given them a greater understanding of people's needs. One staff member told us, "We had a really good induction. The training was good and we had time to learn about the company. It was good to be in a new place where we were all learning together." All staff new to care were required to complete the Care Certificate. The Care Certificate is a set of agreed standards that health and social care staff should demonstrate in their daily working lives. The registered manager told us they had access to the provider's training department to ensure that on-going and refresher training was monitored.

The registered manager had taken action to ensure that staff received regular supervision to support them in their roles. During our inspection supervision records showed that one third of staff had not received supervision with their line manager. One staff member who had been employed at the service for over five months told us, "The training is good but I haven't had a one to one since I joined here." Following the inspection the registered manager provided evidence to show that supervisions had taken place and monitoring forms had been updated. We will review this practice during our next inspection to ensure staff continue to receive supervision in line with the provider's policy.

Records showed that assessments were completed by senior staff members prior to people moving into the service. However, as previously reported there were some instances where clinical staff did not always have the skills to meet people's assessed needs. The registered manager told us that they had learnt from these concerns and were now checking all assessments completed. Evidence was provided to show that a number of people who had been assessed for the service were not accepted as their needs could not be met at the present time. With the above exceptions we found that assessments were completed in a detailed manner. Clear information was available regarding people's medical conditions, care needs and any specific support they required. Assessments showed that people and their relatives had been fully involved in the process.

People told us they were provided with a choice of food which on the whole was to their liking. Comments received included, "It's nice, it's particularly nice to have it all done for you." Another person told us, "They always try to get you what you want." A third person said, "I certainly wouldn't complain about it." We spoke with two people who told us that they felt there could be more variety in what was provided and that the quality varied depending on the chef. The registered manager told us they were in the process of completing meal surveys to gain people's opinions regarding the food and any further options they would like to be included in the menu. Following the inspection we were sent the results of the survey which reflected the comments we had received.

People were asked what they would prefer to eat from the menu. However, no visual choice was offered to people which may benefit people who are living with dementia. Where people required support to eat this was provided in a timely way and at a pace of the person's choosing. Tables were nicely laid and adapted crockery was available to enable people to to eat independently. The chef was aware of people's dietary needs and preferences and ensured adjustments were made for people with allergies or specific diets. Where people had been assessed as requiring their food to be of a soft or pureed consistency this was provided and staff were aware of their needs. We observed the chef took time to chat with people at lunchtime and gain their views on the food provided. People were offered a range of drinks with their meal and throughout the day.

People were supported to access health care professionals where required. People told us they were confident that their health care needs would be addressed and that the GP visited the service regularly. Care records evidenced that people were supported to see the GP regarding any health concerns. There was also evidence of involvement from the district nursing team, community mental health team, optician and dietician. Clinical staff we spoke with were confident they had access to contact details for health care professionals and were building links with services. Where people experienced specific health care needs such as diabetes or daily catheter care, detailed care plans were in place. Wound care plans were completed where required and were regularly reviewed and monitored.

People lived in an environment which was furnished and decorated to a high standard. People and their relatives told us they liked the environment and found it clean and comfortable. The use of technology had been incorporated into the design of the building. For example, bed sensors were available which monitored the average time people were out of bed when they got up during the night. An alarm would then alert staff if the person was out of their bed for longer than expected. This technology helped people to remain safe whilst causing minimal intrusion. The area for people who were living with dementia had been designed to minimise the use of colours and conflicting patterns in the communal corridors. Memory boxes were available outside of people's rooms and contained personal items to help the person recognise their room. Most mirrors had been removed as these may cause people confusion and distress and bedding was arranged in contrasting colours. However, we did note that the majority of bedroom doors did not have people's names on which would be of benefit in helping people identify their own room. In addition we discussed small changes which could be of benefit and add interest for people such as having clocks in communal areas and creating personalised destination points for people who enjoy walking around communal corridors. The regional operations manager who attended a meeting following the inspection discussed how they had applied dementia research and best practice in the home but that they will continue to review any improvements that could be made.

Requires Improvement

Our findings

People told us that staff were kind and helpful and relatives we spoke to were complimentary about the care provided to people. One relative told us, "The carers are always good with residents and helping people. Staff are kind and polite to him (family member) even when they don't know I'm listening at the door. They give him choices. They are really lovely. Nothing is too much trouble." Another visitor to the service told us, "From what I see staff are kind and caring. If I felt there was something wrong I would raise it with the managers."

The approach of staff was on the whole caring, respectful and kind. However, we observed that interactions were generic and passive rather than engaging people in areas that may be of particular interest to them. Staff checked if people needed anything and spent time asking them if they were comfortable. However, the majority of conversations we witnessed did not go beyond this. We did observe one staff member spending time sitting and talking with someone during the inspection which the person clearly enjoyed.

On occasions we heard staff use terminology which was not always respectful. For example, we heard staff referring to people who required support as, "still needing to be done". On another occasion we observed a staff member who was supporting someone to eat shout across the dining area to a colleague. The conversation was regarding another person's dietary needs. These discussions were held in front of others in communal areas which meant people's privacy and confidentiality was not always respected.

We recommend that the provider supports staff in developing their understanding of confidentiality and effective communication.

On other occasions we observed staff supported people in a respectful manner. Staff addressed people by their preferred names and spoke to people in a calm tone. We observed one person was anxious about sitting down in the lounge. The staff member reassured the person to let them know they were in a safe place and showed patience in supporting them until they took their seat. They then ensured the person was comfortable and brought them a drink. We observed staff encouraging people with their drinks and food in a gentle way which people responded well to. One relative told us they had been upset that their wife's appearance had changed during their illness. Staff had suggested that they brought a photograph of how their wife had liked to wear her hair so the hairdresser could give her the same style.

People's dignity was respected by staff. When entering people's room's staff knocked on doors and greeted the person. Staff ensured that doors where closed when supporting people with their personal care needs.

Staff were able to describe to us how they supported people to ensure their privacy was respected when being supported to wash or shower. Staff told us that they encouraged people to be as involved in their care as possible. One staff member told us, "We always offer choice to them. They can decide what they want to wear, when they get up, go to bed, where they sit, who they want to talk to. It's all up to them and we will help them get there."

People were supported to maintain their independence. We observed people were able to move freely around the communal areas. Tea and coffee making facilities available in the bistro area for people to make drinks for themselves and their visitors. Furniture was of a height and design which enabled people to stand easily with minimum support. Where people required specialist crockery to drink independently this was provided.

Visitors to the service were made to feel welcome. Staff told us there were no restrictions on the times people could visit and they always made an effort to ensure guests were welcomed into the home. One visitor told us, "I'm always greeted warmly. I enjoy my visits." We observed one person sat in the communal bistro area with a group of their visitors holding a small book group. The registered manager told us the person also had visitors from a local church group they belonged to and other people had been invited to join them. Other local churches had also been contacted and visits arranged. The registered manager had obtained a directory of local places of worship which could be accessed by people.

Requires Improvement

Our findings

People we spoke with told us they would like more opportunities to take part in different activities. One person told us they had been a keen gardener but had not had the opportunity to go out into the garden. Another person told us, "It's like living in a hotel, it's very nicely done but there's nothing to do." A third person told us, "It is easy to get bored here' They added they would like to go out more and would like to go out to the shops with assistance. Another person said that although they enjoyed some of the activities, particularly Tai Chi, they often went back to their room as there were no activities in the lounge area.

There was no activity worker in post at the time of our inspection. The registered manager told us that a member of the care team had taken responsibility for running some activities with people. During the morning of the inspection the scheduled activity was the on-site hairdresser. People who did not wish to have their hair styled spent time sitting in the lounge area. There was little interaction between people and we did not observe this being encouraged by staff. In the upstairs lounge the television was on throughout the day although no one was observed to watch it. Although there was a staff member present in the lounge throughout the day they did not prompt any activities for people. The afternoon session was scheduled as flower arranging but this did not take place. A visiting therapist spent time with people giving hand massages which people appeared to enjoy. There were few items of interest within communal areas for people to pick up and use such as books, sensory items, puzzles or games.

Although an activities programme was in place staff told us that these activities did not always happen and that they felt there were not enough activities to occupy people. One staff member told us, "There isn't enough for people to do. They get bored. I would like something to motivate them. More activities would give people a purpose and motivate them. It helps them (people) feel valued." Another staff member said, "They (people) need more sensory things to do, it would be great. They get bored and sleep. It's really stressful. No one goes out and we don't have time to take them." A third staff member told us, "There could me more for people to do. People go back to their rooms because they are bored and there isn't enough for them to do." We spoke with five people who told us they would like to be able to go out more. Minutes from the residents meeting in December 2017 confirmed people had made suggestions about outings and day trips they may enjoy. The registered manager told us that although trips out had not regularly taken place this was something which was planned for the summer months. Following the inspection the registered manager held a residents meeting where suggestions for activities were again discussed to help ensure people's preferences were taken into account.

Staff did not always have a good knowledge of people's needs, preferences and life histories. When asked

about people's family lives, past occupations, likes and dislikes staff were unable to provide us with details. We asked one staff member what they knew about the person they were supporting. They told us, "Nothing. It would be helpful as it helps you look after them well. More person centred care can be given." Another staff member told us they had not been provided with information relating to one person who had recently moved to the service. They told us, "I didn't know enough about (person's) background or behaviours. We weren't told about that." They went on to say they had since gained some basic information from the person's family. Information relating to people's life histories varied. We found some records did not contain detailed information whilst others were more comprehensively completed. However, as staff did not always access this information it was not being used to support them in providing person centred care.

Care plans were completed on an electronic system with care staff having access to hand held devices which gave a summary of people's care needs and enabled them to record when care had been provided. Staff told us that the summary information did not provide them with enough detail to enable them to provide care in a person centred manner. One staff member told us, "We only read the summary care on the phone but it's not detailed. We get basic information but we don't get access to the main care plan." Another staff member said, "It would be really good if we had more information about people. It would be a conversation starter. Information is limited on the summary care plan." The registered manager told us that staff were able to access full care plans in the various offices and that summary care plans were used as a prompt to staff. However, staff we spoke to told us that they had not been provided with access to the full system and were not allocated time to read people's plans in full. This meant staff did not have access to the information required to provide people with person centred care which reflected their preferences.

People's needs were not always responded to. We observed one person who walked around throughout the day, on occasions appearing anxious. Staff spoke to the person when they entered the room but did not try to engage them in any activity or conversation. The person's care records stated, 'To ensure that life biography is completed to allow a total understanding of (name) and (their) life, behaviours and activities that would support staff in understanding the reasons for behaviours and characteristics'. This had not been completed by staff and staff spoken to knew little about the person. One person told us they would like to go outside to the patio area and to have the patio door in their room open sometimes. They said they felt claustrophobic not being able to open their door as, "the key has been removed". They told us they believed they were being prevented from going outside. We explained the person's concerns to the registered manager. They were unaware that not all doors had keys available to people and ensured the person was provided with a key to their door.

The failure to ensure that people were provided with person centred care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy in place which was made available to people and relatives. The registered manager maintained a complaints log which showed that complaints had been responded to in full within the expected timescales. Complaints were also reviewed as part of the audit process to ensure that any trends could be identified and acted upon. An overview of complaints was also reviewed by senior managers to further check that all appropriate action had been taken. One person told us that when they had raised a complaint about the food not being very hot. They told us the chef had come to see them right away and their food had always been hot since they had raised this. The registered manager also maintained a record of compliments received. One person had written, 'Many thanks for being so kind and helpful during our stay at Kingsclear. It has been enjoyable and beneficial. You all deserve a medal!'

Plans regarding how people wished to be cared for when nearing the end of their life were in place to support staff. We found that plans contained basic information and instructions for staff in how people

should be cared for but lacked personalised information regarding people's preferences. However, the service had received a number of compliments regarding how they had cared for people at the end of their life and for their families. One relative had written, 'It was a very difficult time for us all and your kindness and thoughtfulness was very much appreciated.' Another person wrote, 'Throughout this difficult period, we felt welcomed and looked after by Kingsclear staff, who really made Kingsclear a second home for us all and did everything possible to make things bearable for us.'

Requires Improvement

Our findings

Staff told us that although they were pleased to be working for the organisation they did not always feel valued in their roles or listened to by the provider. Their concerns centred around not feeling listened to regarding staffing levels within the service. One staff member told us, "I don't feel listened to. We mention it (staffing levels) in meetings but I don't see the minutes of the meetings. I don't feel valued. It's all work, work, work. They don't want to hear we are short staffed." Another staff member said, "I don't feel valued. We express our views about staffing but are told the ratio is what it should be." A third staff member told us, "I feel supported 50/50. I get support from the managers. They are sometimes listening but options are limited." As previously reported under safe, staff meeting minutes confirmed that concerns regarding staffing levels had been raised on a number of occasions.

Both staff and the management team were able to describe the aims of the service in providing people with person centred care in a caring and homely environment. However, our discussions with the staff team and managers showed a clear difference of opinion as to whether this was being achieved. As detailed through the report staff told us they did not feel the systems were in place to enable them to provide person centred care, to enable them to get to know people and their families well and to monitor people's well-being effectively. One staff member told us, "It's a beautiful home but it's not fit for its purpose. There should be more staff, more going out and more involvement."

We spoke with the registered manager, regional manager and senior operations director regarding our concerns. They told us that as an organisation they placed great value on supporting and involving staff. The registered manager said that many staff had been in post since before the service had opened and had been involved in setting up the service and welcoming people as they moved in. They provided evidence of different schemes to build team work and promote good practice within the staff team. These included monthly staff social meetings, surprise gifts for staff who had gone above the call of duty and awarding 'Caring Stars' to staff nominated by their colleagues, people or families. In addition to staff meetings, staff welfare council meetings had been established. Minutes of the January meeting described the purpose of the meeting was, 'To improve the service we offer to residents and the working environment of staff'. Despite these initiatives it was clear from the staff we spoke to during the inspection that there was not a feeling of the team working collectively to achieve the aims of the service.

Quality assurance processes were not always effective in identifying concerns. The provider had a number of systems in place to monitor the quality of the service provided. These included regular audits, the clinical management trending system, management reviews and feedback from key stakeholders. Audits conducted

by the service included infection control, housekeeping, medicines, care plans, night care and health and safety. The registered manager told us that due to issues with a key staff member's role in the service some audits had not been completed on a regular basis. For example, monthly care plan audits had not been completed since January. In addition the registered manager told us this audit had not been completed to the standard and detail that was expected. This meant the gaps in care plans we had found during the inspection had not been identified by the audit system. The provider had recognised these concerns and had employed a peripatetic manager to support the registered manager in embedding these systems.

The regional manager also completed a full audit of the service on a regular basis. An action plan was developed following this which showed that actions had been implemented to address the shortfalls identified. However, where systems had been changed as a result of concerns being identified these were not always monitored to ensure they were working effectively. For example, a full audit completed in January 2018 identified gaps in the recording of food and fluid charts. The decision was taken to stop using paper forms and record all entries on the electronic system. Fluid levels would then be totalled by night staff and any shortfalls or risks discussed at handover the following day. We found this system was not proving effective as low recording of fluids was not being identified and discussed. Following the inspection we were informed additional changes had been made to the system which was being closely monitored. Audits had not been effective in identifying some areas which required improvement such as concerns regarding the activities available, risks arising from people's anxiety and behaviours, call bell access and the lack of decision specific mental capacity assessments. In other areas we found that the audit and action planning process had been effective in identifying concerns and implementing change. The regional manager's audit identified that wound care plans were not in place for five people. This had been actioned and the care plans now contained the relevant information and detail required.

The lack of effective quality assurance systems and the failure to embed a positive ethos and culture was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our discussions with the senior management team there was a clear commitment to ensuring the service continued to develop in a positive manner. Following our feedback the provider gave us evidence that a number of concerns identified had been addressed immediately. These included extension leads and pendants for call bells, daily call bell audits, a residents meeting to discuss activities and hospitality arrangements and meetings with staff to adjust the way in which tasks were allocated. They told us there had been specific, on-going issues which had created difficulties across the service. These concerns had now been resolved. Additional management support was in place to support the registered manager in ensuring that going forward the service could grow and develop in a positive and proactive manner. The registered manager told us the provider had been very supportive of them in addressing any barriers faced. They told us, "They are just a brilliant organisation to work for. I can pick up the phone anytime. They really have given me and the staff so much support here."

At the time of our inspection the service had only been open for a relatively short time. The provider had systems in place across the organisation to gain feedback on the service provided at Kingsclear and these were in the process of being compiled. The senior operations director told us that surveys distributed included residents, relatives, staff, other stakeholders and hospitality and meals. Once the data had been analysed an action plan would be implemented with an expectation it would be completed within six weeks. In addition a residents meeting was held every three months and a relatives meeting was planned. There was also a comments box available to people which meant that any concerns could be raised anonymously.

People's confidential records were stored securely. All care records were electronically stored and could

only be accessed by the use of individual passwords. Paper records were stored securely in locked cupboards in the office. The CQC had been notified of all significant events that happened in the service in a timely way. This meant we were able to check that the provider took appropriate action when necessary.

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
Treatment of disease, disorder or injury	The provider failed to ensure people received person-centred care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider failed to ensure that the principles of the MCA were consistently followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure that effective risk management systems were in place

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to implement effective quality assurance systems and to embed a positive ethos and culture

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient staff were deployed to meet people's needs.