Barchester Healthcare Homes Limited

Kingsland House

Inspection report

Kingsland Close
Off Middle Road
Shoreham By Sea
West Sussex
BN43 6LT

Tel: 01273440019
Website: www.barchester.com

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

This comprehensive inspection took place on 13 August 2017 and 7 September 2017 and was unannounced. At the last comprehensive inspection on 27 September 2016, the service was rated as 'Good' overall. This comprehensive inspection was undertaken in response to information of concern we received, which included allegations that people were not always provided with safe care and treatment.

Kingsland House is registered to provide nursing and residential care for up to 71 people with a range of healthcare needs, including people living with dementia and chronic conditions. On the first day of our inspection, there were 66 people living at the service. On the second day of our inspection, there were 62 people living at the service, as some people were in hospital, or had sadly passed away. Kingsland House is a purpose-built care home which is divided into two units: Memory Lane, which accommodates people living with dementia and Bluebell, which accommodates people with a range of health and nursing needs.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We were told that staffing levels had been assessed based on people's care and support needs. However, people, relatives and staff felt that there were insufficient numbers of staff on duty at certain times of the day and night to ensure people's safety. Our own observations supported this.

Certain aspects of the management of medicines required improvement and we saw that safe procedures for the giving people their medicines were not routinely being followed.

Several people commented they were well looked after by care staff. However, care was not always personalised to the individual. For example, people did not always get up or spend their day how they wished. It was recognised that staff had a good understanding of person centred care and knew people's routines well. However, staffing levels at the service did not allow staff to routinely meet people's preferences in relation to how their care was delivered.

There was a range of quality assurance systems to help ensure a good level of quality of care was maintained. However, these systems had not fully ensured that people received a consistent and good quality service that met individual need, specifically in relation to the assessment of staffing levels.

Unpleasant odours and the smell of urine were evident in Memory Lane at the time of our inspection and cleanliness was not of a high standard.

People were complimentary about the food and drink on offer. There was a varied daily choice of meals, special dietary requirements were met, and people's weight was monitored. However, improvements were

needed to the mealtime experience, and people's food preferences being met in some parts of the service.

Care plans were accurate, however three out of the 10 we looked at lacked information to guide staff when people's needs had changed.

Although some staff spoke positively of the culture and how they all worked together as a team, feedback from other staff was mixed and indicated that there was a lack of cohesion, support and a negative culture in the service. We received mixed feedback from people, relatives and staff in relation to the service being well led.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service. Staff had received both one-to-one and group supervision meetings, and formal personal development plans, such as annual appraisals were in place. However, some improvement was required in relation to the induction provided for agency staff.

When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People took part in activities in the service and outside the service. They told us they enjoyed the activities, which included singing, films, arts and crafts and themed events, such as reminiscence sessions and visits from external entertainers. People were also encouraged to stay in touch with their families and receive visitors.

People told us that friendly and genuine relationships had developed between them and staff. They also said they felt listened to and confident that they could raise any concerns or issues. Health care was accessible for people and appointments were made for regular check-ups as needed.

We found several 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 this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staffing levels were determined through the regular assessment of people's care and support needs, using a Dependency Indicated Care Equation. However, despite the dependency tool stating the calculated number of staff required, this did not ensure that care was delivered safely and people's needs were met. People spoke negatively of their care and commented that staffing levels could impact on them receiving the support they required at the times they needed.

Safe procedures for the administration of the medication were not routinely being followed.

Some areas of the home required attention in relation to housekeeping concerns.

Risks to people were managed safely. Safe recruitment processes were in place. Staff had been trained to recognise the signs of potential abuse and knew what action to take if they had any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to maintain their hydration and nutritional needs. However, improvements were required to the mealtime experience and people's preferences to food being met in some parts of the service.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision. Their health was monitored and staff responded when health needs changed.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care practices did not always respect people's privacy and dignity and people were not consistently treated with respect.

People were not actively involved and supported in making day to day choices about their care and treatment.

People were supported by kind and caring staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were on the whole accurate, however some lacked information in respect to when people's needs changed. People did not always receive the care they required at the time they needed it.

People were supported to take part in meaningful activities.

Forums were in place to gain feedback from staff and people. There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to.

Is the service well-led?

Inadequate

The service was not well led.

Systems of audit and quality monitoring did not always identify areas that required improvement.

The registered manager had failed to send us notifications relating to incidents as required under their conditions of registration.

People, relatives and staff gave mixed feedback in relation to the service being well led. Feedback indicated issues in relation to staff morale, support and a negative culture at the service.

Staff were aware of their responsibilities in relation to whistleblowing and told us that there were systems of communication to give feedback about the service.

Kingsland House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 took place on 13 August 2017 and 7 September 2017 and was unannounced. On the first day, the inspection was undertaken by one inspector and in light of the evidence gathered, a decision was made to return for a second day of inspection. On the second day, the inspection was undertaken by four inspectors, a specialist adviser in nursing care, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience for this inspection was an expert in care for older people.

Before the inspection, we checked the information that we held about the service and the service provider. This included previous inspection reports and some statutory notifications sent to us by the registered manager. A notification is information about important events which the service is required to send to us by law. We looked at concerns we had received from people who had contacted the Commission and brought this inspection forward in light of them. We used all this information to decide which areas to focus on during our inspection. Due to bringing the inspection forward, on this occasion, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the first day of our inspection, we spoke with three people living at the service and four relatives. We observed them as they engaged with their day-to-day tasks and activities in Memory Lane. We spoke with the registered manager, the deputy manager/clinical lead, the regional director, a registered nurse and three senior care assistants. We observed care and spoke with people and staff. We spent time looking at records including 10 care records, three staff files, medication administration record (MAR) sheets, staff rotas and other records relating to the management of the service. At the time of the inspection, we asked the registered manager to send us information in relation to staff safeguarding training, the pharmacist's report and notifications relating to allegations of abuse, Deprivation of Liberty Safeguards and serious injury. We have received this information and it forms part of our judgement on how the service is managed.

On the second day of our inspection we spoke with nine people living at the service and four relatives. We spoke with the registered manager, the regional director, two registered nurses, six care staff, the activities co-ordinator, the chef, the maintenance worker and a member of housekeeping staff. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including nine people's care records, medication administration record (MAR) sheets and other records relating to the management of the service, such as policies and procedures, accident/incident recording and audit documentation. We also 'pathway tracked' the care for some people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

The service was last inspected on 27 September 2016. The service was rated 'Good' following that inspection.

Inadequate

Is the service safe?

Our findings

Before this inspection, we had received information of concern that there were insufficient numbers of staff on duty, especially at weekends. People, relatives and staff told us there were not enough staff on duty to support people at the times they wanted or needed. One person told us, "There's definitely not enough staff. This is a lovely place to live, but there's just not enough". A relative said, "There's not enough [staff]. Weekends are particularly bad. I look around and wonder where the staff are. You can be in the dining room [in Memory Lane] and look around and there are no staff, but patients are shouting out wanting someone". A further relative added, "There's not enough people around in the other side [Memory Lane] to keep an eye on everyone". A member of staff told us, "One hundred percent the issue is staffing, there just isn't enough".

We looked at staffing and staff deployment at the service, and asked staff about the staffing levels. All but one stated they felt rushed and under a lot of pressure. One member of staff told us, "It's quite stressful working here and there are better paid jobs. I wouldn't work at night because of the stress levels, especially on this unit [Memory Lane]. I would say it's unsafe, there are a lot of falls". Care staff, with the exception of one, all felt that staffing levels were insufficient to meet people's needs safely. One member of staff told us, "It's chaos. It's stressful and busy all the time". Another member of staff said, "Staffing levels are the worst issue. Sometimes we can have two staff to a unit with 26 residents". A further member of staff added, "Memory Lane is more physically demanding, they need more staff. There isn't time to spend with people, but those people need more of our time. We are told all the time not to say we are short staffed. I want to give people the time they deserve, I don't want to leave a person without thinking I've done my job".

Our own observations supported the feedback we had received. During our visit we viewed care delivery at different times throughout the service. For example, at 10:25am we spoke with one person in their room. It was clear this person had a soiled incontinence pad. They told us, "I wish the staff would come more often, and it's nice for someone stay and have a talk with me, not many of them do". We returned to this person's room at 11:30am. They were still sitting in the soiled incontinence pad, and stated they were thirsty. They added, "It's nice for someone to come in, nobody comes". We informed a member of staff and saw that the person was attended to at 11:55am, approximately 90 minutes later. Additionally, one member of care staff was needed to ensure people's safety in the communal areas in Memory Lane. A member of staff in Memory Lane said, "When people are sitting in the lounge, someone needs to be there. They're not safe otherwise". We observed that staff were present most of the time, however we did observe times when there was not a staff presence in the lounge. We saw one person attempt to open the door from the corridor to the lounge. They were holding on to a Zimmer frame and spent over a minute struggling with the door. There were no members of staff present, therefore a member of the inspection team assisted this person, as they were at risk of falling.

At the time of our inspection, we observed that people's call bells were responded to promptly by staff. However, feedback from people indicated that this was not always the case. One person told us, "When I press the bell they don't come very quickly. I have waited sometimes for up to 20 minutes. I don't like to be rushed as I'm a bit slow on my bowels, so they have to leave me and come back. I can sometimes wait for quite a while". Another person said, "I've got a catheter, so I don't need to wait for someone in that regard,

but for other personal care, when I press my bell I can wait up to 25 minutes for someone to come. Most times someone will pop their head round and say I'll be with you soon, but they sometimes forget". A further person added, "Someone might come quite quickly and pop their head round the door, realise they need another carer and then go off to find someone. I've found myself waiting 20 minutes or so".

The service relied heavily on agency staff to fill any gaps within shifts, which was having an impact on the quality of care delivered. One person said, "It's worse when its agency staff. I don't feel safe on the hoist when it's people that don't know me, because there's been two mishaps. The doorway into the bathroom is only just wide enough for the hoist to go through and you have to have it straight on. I tell them, but they're not familiar and I've twice been bumped into the frame. I've not been hurt, only a bruise or two, but I am nervous when it's someone new. It's also partly because they want to get things done quickly, because they have to get on to someone else". A further person added, "Some of the staff are very overworked. They get agency people in who don't know what they're doing. The regulars tell them this wants doing or that, then have to show where and how. So much time is wasted showing the agency staff where things are and what to do, sometimes it's quicker to just get on with it themselves, because they don't have the time. The agency staff are very willing, but I sometimes think they're making up numbers and not much use". Staff we spoke with felt that if new agency staff worked at the service then they required more support from permanent staff, which took up their time. One member of staff said, "We talk to the manager and she does the best she can. It would be nice to have permanent staff. It's been pressurised recently". The registered manager told us they were in the process of recruiting new permanent staff, which would mean less reliability placed on the use of agency staff.

We fed back the above concerns to the regional director and registered manager. They told us they felt the service had enough staff to provide safe and person centred care. However, our own observations showed that staffing levels were not sufficient to ensure people's needs could be met safely.

The above evidence demonstrated that there were not always sufficient numbers of staff to safely support people's care needs. We found the staffing levels to be inadequate and placed people at risk. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a registered nurse giving medicines to people on both days of our inspection. We discussed the administration of medicines with a registered nurse. They told us that it could easily take two hours to give people's medicines in the morning. The registered manager told us that people living with Parkinson's disease always took priority when giving medicines, as it was crucial they receive their medicines at a set time. However, on the second day of our inspection, the medicines round did not start until 10:25am. A registered nurse told us this frequently happened, due to staffing levels at the service, meaning that the registered nurse had to deal with other tasks and priorities before the medicine round could begin. We asked about the medicine being prescribed for people that should be taken at 9am. Again we were told that it can take up to two hours to complete the medicine round, so people would not always receive their medicine on time. The medicine round finished at 11:30am and we were told the next one would start at 2pm. Therefore, people who required further medicine, may not have had enough time elapsed to safely take their next dose.

We saw that one person's record stated they self-administered medication. We raised this with the registered nurse, who agreed this was an error and it was changed immediately. However, this had placed this person at risk of not receiving their prescribed medicine. One person was receiving covert medicine. Covert medicine is the administration of any medical treatment in disguised form. This usually involves disguising medicine by administering it in food and drink. As a result, the person is unknowingly taking medication. There was signed documentation within their medication record, however we saw that this had

not been reviewed since 2015. Good practice would be that any use of covert medication should be reviewed on a six-monthly basis. Additionally, we observed a large stock of medicines prescribed for one person in the refrigerator. Eighty vials had been stored dating back to February 2017. The registered nurse, deputy manager and registered manager agreed these should have been disposed of, as they were no longer required. We also found eye drops, prescribed for another person on 2 February 2017. The expiry date of these was 5 July 2017. However, the eye drops had not been disposed of as needed at the time of our inspection on 13 August 2017. We looked at the Medication Administration Records (MAR) for people living in Memory Lane. Where medicines had been given as required (PRN) we saw that the outcome of giving the medicine had not been recorded on the reverse of the MAR, in line with good practice. When we checked the MAR for the person who had received some medicine PRN earlier in the day, the outcome had not been recorded by the registered nurse who administered the medicine.

The registered manager told us that an audit had been completed by the prescribing pharmacy and the results were available to us after the inspection when we requested them. The temperature of the medicines room was recorded daily and was found to be within safe limits.

However, the above evidence demonstrated that safe procedures for the administration of the medication were not routinely being followed, which placed people at potential risk of receiving their medicines incorrectly. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection we had received information of concern in relation to the cleanliness of the service. Some areas of the service were clean and well presented, and we saw that there were systems in place to manage cleanliness and infection control. However, not all areas were clean and hygienic. On the first day of our inspection, in the entrance to Memory Lane, there was a strong smell of urine. The registered manager told us they were aware of this, as it was known that certain residents could urinate on the carpet. The registered manager said the carpet was due to be cleaned the next day and that the, "Smell had been bad for two or three weeks". They told us new carpet was on order for this part of the service. We observed that the carpet in the lounge area of Memory Lane was stained and there was an unpleasant odour in this part of the service too. The registered manager told us that Memory Lane was being refurbished in the near future. It is acknowledged that when we returned for the second day of our inspection 25 days later, work had begun to re-paint Memory Lane. However, the offensive smell of urine remained, the carpet was still dirty and the lounge/dining area was not clean. A relative told us, "It smells so bad round there [Memory Lane], which is why we bring our [relative] round to this side [Bluebell]. It's like a different place entirely here". A member of staff added, "If there's a bad spillage or accident at 4:30pm, it won't be properly cleaned until the next morning. It's not good for infection control and however hard we try, some smells get ingrained, so it's not right for people's dignity". We raised this with regional director and registered manager, who told us that the carpet was due to be replaced imminently and we saw documentation to support this. However, this has been identified as an area of practice that needs improvement.

People told us they felt safe living at Kingsland House and were protected from abuse and harm. One person told us, "I like the people here they make me feel safe, they help me". Another person added, "I do feel safe here, I have my own room which I've made into my home with personal stuff, it's a lovely place to live". Staff we spoke with told us they had completed safeguarding training. When asked how they would respond to any potential abuse one member of staff said, "If I see something I don't like, I will report it straight away". A second staff member confirmed they had received safeguarding training and added, "We have all the resources we need". We saw documentation that confirmed staff had received safeguarding training and this had been refreshed as needed.

Safe recruitment practices were in place. Staff files showed that new staff had completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting. The registered manager told us that when agency staff came to work at the service, the agency would send them details of the individual which confirmed all necessary checks relating to their suitability to work at the service had been completed.

Risk assessments were in place for people, which considered the identified risks and the measures required to minimise any harm whilst empowering the person to undertake the activity. Risks associated with the safety of the environment and equipment were identified and managed appropriately. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan. Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a reoccurrence. Any subsequent action was shared and analysed to look for any trends or patterns.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. A relative told us, "One of us comes in most days, I agree the staff are very good at what they do, they're kind and well trained". A person said, "They go out of their way to make sure people are comfortable. It's not an easy task to be at everyone's beck and call. They're very good". Another person added, "I have a catheter and it's really important they change it properly otherwise it will painful for me, or I could end up with an infection, touch wood I've never had any trouble, they are superb with that". However, despite the positive feedback, we saw areas of practice that need improvement.

We observed lunch in the dining area of both units in the service. People were supported to move to the dining areas, or could choose to eat in their room. In the Bluebell unit, we saw that the atmosphere was enjoyable for people. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or additional choices. However, some people were still waiting to be served more than 20 minutes after they had sat down, whilst others were eating, or had finished their meal. Our observation of the lunch service in the Memory Lane unit was not positive. People were seated for extended periods in the dining area waiting for their meal. We observed six people waiting upwards of 20 minutes to be served their food. Once again others around them were in the process of eating their meal, or had finished it before they were served. It was clear that some people required encouragement and assistance to eat their food. Staff worked tirelessly to ensure that people enjoyed and ate their meal, however, they were too stretched to ensure that this took place effectively. One member of staff told us, "Lunch is supposed to be at 12:30pm, but it's more like 1pm usually. It takes ages to get people to the table, it's bedlam usually". A person added, "Sometimes I get to dinner and the grub is cold".

Furthermore, for some people, their preferences around food were not met. For example, one person was given a bowl of soup at 12:40pm. They were asleep and did not wake up until 1:01pm. They ate three spoonfuls' of soup and then stopped eating as it was clearly cold. They were not offered another bowl of hot soup and at 1:20pm were given a hot plate of food. The person did not eat any of the food given to them and the plate was taken away at 1:40pm and replaced with a bowl of pudding. Again the person ate none of their pudding and at 1:55pm a member of staff took the bowl away. The member of staff stated that they hadn't eaten much, and would they like a sandwich or omelette. However, by this point the mealtime was coming to an end and the person had lost interest in eating. We looked at this persons care plan which stated they did not like big meals and preferred salads, fruit and a Mediterranean style diet, none of which was offered. We observed another person who for the entire lunch ate only two pieces of potato and two mouthfuls of pudding. It was clear that they were struggling with their meal, but they were not offered assistance. At the end of the meal they asked a member of staff if they could have some biscuits. The member of staff said they would get them, but they did not. We looked at this persons care plan, which stated they preferred finger foods and should be verbally prompted to eat. Our observations showed that the person chose to eat with their fingers. The food they were given was not appropriate to eat with fingers, nor did they receive verbal prompts, which therefore contributed to the amount of food the person ate. We spoke with a relative who told us that their relative was being offered sandwiches for lunch. They said, "[My relative] hates sandwiches. She likes toast, sausages, bacon and egg". Records we saw supported these preferences, however we could

see no evidence in the person's food charts for the previous 10 days that they had been offered these choices.

Other people at the service were complimentary about the food and drink, and were on the whole involved in making their own decisions about the food they ate. One person told us, "Very good food, you get a proper meal". Another said, "There's nothing to complain about the food, it's first class. There's as much as you want and we get a choice. I sit at the table, I don't need anyone to help me". Special diets were catered for, such as pureed and fortified. For breakfast, lunch and supper, people were provided with options of what they would like to eat. The chef confirmed that people could have an alternative meal if the person did not want what was on offer.

Due to their health conditions, many people were at risk of malnutrition and dehydration. Staff understood the importance of monitoring people's food and drink intake and monitored for any signs of dehydration or weight loss. Where people had been identified at risk of weight loss, food and fluid charts were in place which enabled staff to monitor people's nutritional intake. People's weights were recorded monthly, and where people had lost weight, we saw that advice was sought from the GP.

People were not put at risk and they were supported to have their nutrition and hydration needs met, for example weight documentation reflected that most people were of a stable weight. However, in light of the evidence above, in relation to people's preferences being met, the mealtime experience and people being appropriately supported and encouraged to eat, we have identified as an area of practice that needs improvement.

When new staff started employment they underwent an induction and shadowed more experienced staff until they felt confident to carry out tasks unsupervised. The training plan and training files we examined demonstrated that all staff attended essential training and regular updates. Training included moving and handling, food hygiene, infection control and health and safety. Where training was due or overdue, the registered manager took action to ensure the training was completed. Staff we spoke with all confirmed that they received high quality training and regular supervision. Registered nurses told us that they received ongoing development and were supported to revalidate their skills. However, we received negative feedback in relation to the competency of agency staff and the induction they received when starting at the service. A relative told us, "The staff are very good indeed, they are kind and helpful, but they are rushed off their feet. The trouble is the agency staff. Take last week for instance, there was a new agency person in on their own. He said to me, 'I'm on my own and I don't know where anything is'. I'm not happy about that, anybody new shouldn't be left on their own. They should be shadowing someone on their first day and have someone showing them the ropes". We were told that agency staff received an induction to the service, however in light of the feedback we have received, we have identified this as an area of practice that needs improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions. Staff had knowledge and understanding of the Mental Capacity Act (MCA) and had received training in this area.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority. The manager understood when an application should be made and the process of submitting one. Care plans reflected people who were under a DoLS with information and guidance for staff to follow. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information.

People received support from specialised healthcare professionals when required, such as GP's and social workers. Access was also provided to more specialist services, such as chiropodists and dieticians if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. One person told us, "I'm an insulin dependent diabetic and have to be injected twice a day. The nurses here do it, they're good and I'm confident that they won't ever forget a dose. The doctor comes in every week, she's always willing".

Requires Improvement

Is the service caring?

Our findings

People told us they were supported with kindness and compassion, and that caring relationships had developed with staff. Most people thought they were well cared for. One person told us, "The staff are good, I have no complaints". Another person said, "I get on very well with the staff. You can have a good laugh and joke with them". A further person added, "Oh, yes, they're wonderful, they do their very best in the time they have, but they can't be everywhere, there's just not enough of them and that's not fair on them or us". However, some people expressed concerns in relation to their choices being adhered to, and we saw areas of practice that need improvement.

During the inspection people were not routinely offered day to day choices around their care, for example how and where they wished to spend their day. They did not always have their independence promoted, and some had their dignity compromised.

In relation to choice, feedback we received was mixed. One person told us, "I can get up when I want, it is my own free will". Another person said, "We can make our own choices. No one has told me when I need to go to bed or get up. I'm never late going to bed, sometimes I even like to go to bed before supper and eat in bed". A further person added, "I choose to have breakfast in my room. Breakfast is usually brought in to me at around 8:30am. I can ask for a bath or shower, there's no problem, it's just a case of waiting for someone to be able to do it, as there's usually nothing important filling my day, it makes no difference to fit in". However, one person told us, "They can't always be here to move me, so I end up sitting here all day and I get frustrated. They are short of staff and I have to wait my turn. I have a hoist that needs two people and it takes time to get two people". A further person added, "There's plenty going on here [activities], I sometimes have gone down and joined in. I might go more often if there was more staff, but because it takes two to get me down there and back again, and what happens if I want to use the loo? I need to be put in the hoist and if there's no one available and I have an accident, it's too embarrassing".

In relation to people privacy and dignity being upheld, we saw areas of good practice. For example, care staff always knocked before entering someone's bedroom. Some of the feedback we received from people was very positive around the care staff and comments included, "I have complete confidence in the staff here. They make my life bearable". Staff discussed people's care needs in a respectful and compassionate way and they were able to describe how they maintained people's privacy and dignity. However, we found that due to staffing levels, the principles of privacy and dignity were not embedded into every day care delivery. For example, one person told us that they had recently left the service for the day and returned tired in the afternoon. They said, "I got back at around 4pm, I was exhausted. I was put to bed with my clothes on and told someone will be round shortly to undress me and put my nightie on. It was 10:30pm before anyone come back". A further person added, "Recently they've been very short staffed indeed. I need two carers to help me and sometimes my calls of nature aren't at convenient times for the staff. I know how busy they get at mealtimes, because they have to get people up into their wheelchairs, or frames and walk them to the dining room, that takes time and I'm happy to wait. I wear pads, so if I have an accident I will just sit and wait until the busy time has passed and then I'll press my bell".

We asked staff whether they felt they had time to sit and chat with people and deliver personalised care. One member of staff said, "Absolutely not enough staff, I would say throughout. I've raised this with the manager and deputy manager. We don't have time to sit and chat. We don't always get time to take people into the garden". They added, "We are very stretched as staff. I love my job on this unit, but we can only really spend time with people when we are giving them care. It's a case of non-stop hourly rounds". Another member of staff said, "We don't get time to just sit and talk to people. We talk when we give care, but there's no time to talk normally". A further member of staff added, "All the staff are really caring and supportive to the residents, but we are running around really hectic. I can't do my job 100% and I feel guilty". On the first day of our inspection, whilst it was a sunny day, people in Memory Lane did not make use of the outside courtyard areas or the gardens surrounding the service. Staff were busy supporting people with their personal care in their rooms, or supporting people in the communal area. A fundamental part of providing people with dignity in care is ensuring that as far as possible, they have choice and control in what they do and where they would like to spend their time. When a person enters a residential care setting, this service effectively becomes their 'home'. Unless a risk was too great, people within their own home would not be restricted in respects to when, where and how they could enjoy their day.

The above evidence demonstrated that people's care and treatment was not delivered in a way that supported their independence, ensured their dignity and treated them with respect at all times. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that needs improvement.

Despite the concerns identified above, it was clear that staff demonstrated a commitment to providing compassionate care. When interactions took place between people and staff they were positive. From talking with staff, it was clear that they knew people well and had a good understanding of how to support them. Staff gave us examples of people's individual personalities and character traits. One person told us, "I think staff understand their responsibilities, but they get frustrated. Some are very kind. Overall they are good". We saw that visitors were welcomed to the service. One person told us, "My daughter can come to see me whenever she wants. Staff encourage visitors".

Requires Improvement

Is the service responsive?

Our findings

On the whole, people and their relatives told us that staff were responsive to their needs and aware of their preferences. One person told us, "I find this is a good home and staff will listen to me if I speak to them. I find the staff very responsive". Another person said, "In the main they are responsive". A further person added, "I'd have no hesitation speaking to the manager and have done". However, despite the positive feedback, we saw areas of practice that need improvement.

Several people commented they were well looked after by care staff and that the service responded to their needs. However, care was not routinely personalised to the individual, and we saw several examples of people's preferences not being met. We saw examples of people not being supported to get up when they wished to, and not being provided with their preferences in relation to food. One person told us, "I like to go to bed very early, 3pm or 4pm and like to get up early, otherwise I'd be in bed for a very long time, so I have to remember to book for someone to get me up early and help me get washed and dressed. If I forget, I can wait until lunchtime until they get to me. I know of others who sometimes don't get washed until 2pm or 2:30pm, even later. There just isn't enough staff in my opinion". Another person said, "I choose to have breakfast in my room, but because of that I'm not high on their list for them to help get me up, washed and dressed. One day last month it was 2pm before they had me up. Today it was 12:30pm". Furthermore, in Memory Lane, we saw that at 12:05pm, seven people had still not received their morning personal care. A member of staff told us, "We really struggle with personal care. It's very rare that we can get people up by 12pm". Staff felt that the care delivery was reactive and task based, meaning that care was given when it fitted in with the staff's routine rather than the person. One member of staff told us, "We don't have time to do anything, other than react to the needs arising". Another member of staff said, "I love my job and my only issue is the level of staffing. There's not enough carers for me to feel I've done a good job. I feel like I'm chasing my tail. People on Bluebell have a routine and we can plan for that. I feel bad if we keep people waiting, especially on a Sunday, if people want to go to the church service at 11am. It can be difficult and stressful". One person added, "Staff don't communicate very well. They don't explain why there is a delay".

We saw that some people were cared for in bed. One member of staff said that, where people wore continence pads, these could not always be changed at regular four hourly intervals, because staffing levels at night were insufficient to meet people's needs in a timely manner. Furthermore, some people required hourly checks to be completed during the day and night. For example, people who were cared for in bed, were at risk of pressure damage and required repositioning, and the support of two care staff. A member of staff said, "We don't always have time to reposition people. I couldn't guarantee it always gets done when it's supposed to". We further checked that people who were at risk of pressure damage had their care and treatment managed appropriately, and saw this was the case, and we looked at documentation used to record this. Documentation in Bluebell was accurate, however documentation for three people in Memory Lane contained several gaps and omissions and it was not possible to determine exactly when people had been checked on or repositioned.

We saw the staff undertook an assessment of people's care and support needs before they began using the service. The pre-assessments were used to develop a more detailed care plan for each person which

detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people or their relatives were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews. The planning of peoples care was accurate and staff tried their best to provide people with person centred care. Care plans were reviewed regularly, however in three care plans information had not been updated to guide staff on how to deliver care. For example, in one care plan the person was assessed as being at low risk of falls. It was detailed that they had fallen 12 times from the 21 July 2017 to 2 September 2017. As is correct, their risk of falls had been updated to reflect this, but no guidance or actions had been added to the care plan to guide staff on what to do now that the risk had increased. Two more care plans showed that people were at high risk of malnutrition. We saw that advice had been sought from professional in respect to this, but again no guidance or actions had been updated to the care plan to guide staff.

The above evidence demonstrated that we could not fully determine that people always received the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. We have identified this as an area of practice that needs improvement.

People told us they were listened to and the service responded to their needs and concerns. Meetings were held and people were also aware of how to make a complaint and all felt they would have no problem raising any issues. One person told us, "They do seek feedback and I can send a message to the senior nurse". Another person said, "There are meetings, they don't give you a rollicking if you don't turn up". A further person added, "If I needed to complain I would have no problem doing it. It would depend what my complaint was, if it was one of the nurses I'd speak to the senior nurse, if it was something else I'd speak to the manager". The complaints procedure and policy were accessible and displayed around the service. Complaints made were recorded and addressed in line with the policy with a detailed response.

The provision of meaningful activities was good and staff undertook activities with people both at the service and outside of the service. Activities on offer included, arts and crafts, reminiscence quizzes, music lessons, residents choice sessions, exercise, games and singing and music. There was a mobile bar and a DVD projector that had been provided through fundraising, which enabled activities to be taken to people's rooms. The service had use of a minibus and this was used for regular outings. Feedback from people was gained to gather their ideas, personal choices and preferences on which activities they enjoyed. On the day of the inspection, we saw people joining in with a visit from a mother and toddler group, and in the afternoon an entertainer led a popular singing session. It was clear that people were enjoying joining in and those that didn't get involved with the singing were appreciating the music and atmosphere it created. Other people chose to watch television or spend time in their rooms. A relative told us, "[Activities co-ordinator] is brilliant. She deserves a medal. She makes everyone feel special and I have to say it is because of people like her that balances my opinion on this place". One person said, "I'm happy enough here. They do have a mini bus and I have been out in it, but there is only one space for a wheelchair, so if you want to go you have to get in quick to book". A further person added, "I very rarely take part, I like to sit and watch TV, that's my choice". The service also catered for people's faiths. One person told us, "I receive Holy Communion here in my room, that is a great comfort to me". Staff also published details which informed people of when certain activities would be taking place.

Inadequate

Is the service well-led?

Our findings

In respect to the whether the service was well led, comments we received from people, relatives and staff were mixed. We also found areas of practice which need improvement.

Quality assurance systems were in place to monitor the running and overall quality of the service and to identify any shortfalls and improvements necessary. The registered manager completed daily management reports, and the regional director carried out a regular 'Quality First Visit'. Outcomes from these visits were fed into a centralised system of tracking quality, which in turn created a Central Action Plan. Any concerns identified were then escalated to senior management. However, these systems of quality assurance had not fully ensured that people received a consistent and good quality service that met individual need. For example, staffing levels were not correctly assessed and implemented. Staffing levels were calculated using a dependency tool called the dependency indicator care equation (DICE) to monitor the workforce numbers, and that this tool looked at each person's level of dependency (care needs) and calculated the required staffing numbers. The information to aid the DICE tool was based on individual care plans and the assessed level of need documented. The regional director told us that, "Barchester have introduced an initiative where all the registered managers have endeavoured to speak to all staff members to get their views on staffing". They stated that according to the DICE tool, the service was "over-staffed". However, feedback from people, their relatives, staff and our own observations showed that staffing levels were not calculated appropriately, and staffing levels were not sufficient to ensure people's needs could be met safely. Furthermore, systems of governance had not picked up or addressed other areas of concerns at the service, such as people's preferences and choices being respected, issues with the administration of medicines and required notifications being sent to the CQC.

The above evidence demonstrated that people were placed at risk as the provider did not have effective systems to monitor and improve the service, specifically in relation to the assessment and implementation of appropriate staffing levels. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have identified this as an area of practice that needs improvement.

The registered manager had not submitted notifications in line with the Commission's registration requirements. Apart from notifications relating to deaths, the Commission had not received any statutory notifications in 2017 to date from the provider. We had not received any notifications of serious injury since June 2016, or notifications relating to abuse or allegation of abuse since October 2016. We discussed this issue with the registered manager, who told us there had been some safeguarding incidents and people who had sustained some serious injuries during this time. The registered manager told us they had notified the provider of any accidents or incidents and had assumed that, in notifying the provider, the Commission was automatically included. This was not the case. Following the first day of our inspection, we sent the provider a formal request to submit specified information under Section 64 of the Health and Social Care Act 2008. This was the required information relating to medicines audits, accidents and incidents, and of any Deprivation of Liberty Safeguards authorisations or refusals, for the time period in question. We have received this information and it forms part of our judgement on how the service is managed.

The above evidence shows that the registered manager/provider did not notify the Commission of incidents as required under the Care Quality Commission this is a breach of Regulation 18 (Registration) Regulations 2009.

We asked people and their relatives whether they felt that the service was well led and if they were happy with the service. The feedback we received was mixed. One person told us, "I wouldn't know how the service is managed, but it's working for me, so it must be effective. I wouldn't change anything". Another person said, "I'm perfectly happy here. Got to take things as they come these days". A further person added, "The home is very nice and they're all very friendly. Very kind to residents. [Registered manager] has always been very pleasant with me". Other comments included, "There's a good atmosphere here in general" - "I'd complain to [registered manger] if I was unhappy. I have spoken to her about the amount of agency people and I understand what she says, so what can she do", and "If I was unhappy I'd speak to [the registered manager], but I'm happy enough, the only thing that would improve things for me would be to have more carers". However, one person told us, "I think management are oblivious to some of the problems. They are too busy. I think they have too many people in the home for the staff they have". A relative said, "The place is really going downhill again". Another relative said, "I'm not sure my [relative] is getting the level of care that she's paying a lot of money for". A further relative added, "I think the full time staff really know what they're doing, but I get frustrated, because when I phone up to ask for an update there's either no-one available to be put through to, or I speak to someone, but get told I'll have to be called back by someone who knows what's going on".

We asked staff about the culture of the service, how they communicated and worked together as a team, and whether they felt supported within their roles. The feedback we received was mixed. One member of staff said, "I like how the home is organised, it's good team work and we feel supported". A further member of staff added, "The support here is incredible. I have a team leader as my mentor, it means a lot, but I can talk to anyone if I've got a question. On the whole there is a good atmosphere". However, feedback from staff was not always positive about the culture and support of the service. One member of staff told us, "I hate coming to work. I don't feel there is a lot of respect for us from the management. We often all feel so negative and end up blaming each other. I think the support is c**p and there is a massive lack of communication with the management. We have to work as a team, because we're always going through this c**p every day. We're just rushing around all the time". A further member of staff added, "There are some very good staff and the agency staff that are used come back, so that there is continuity of care, but it is very challenging working on the unit due to staff shortages". In respect to culture and morale, the regional director told us, "I have met with every member of staff to get their views on staffing". We were told that exit interviews were held with staff, so that reasons for leaving were reviewed. Staff were offered incentives to improve culture, performance and to improve retention. For example, bonuses were offered should the service achieve a good or outstanding rating from CQC. There were systems to make staff a 'champion', a refer a friend scheme and employee of the month. The regional director told us, "The company recognises success". We were told about systems of communication, such as staff meetings and handovers between shifts, which were thorough and staff discussed matters relating to the previous shift. These meetings were seen an opportunity to discuss and analyse any issues with the service. One member of staff told us, "We have staff meeting every month and things do get answered".

However, the culture of a service directly affects the quality of life of residents. A positive culture has the ethos of care built around the resident, and acknowledges the importance of fostering positive relationships between residents, relatives and staff as the foundation to quality of life. Staff working as an effective team, with mutual appreciation and some blurring of roles, improves team performance and will impact positively on the quality of life for people and the wellbeing of staff. The lack of a fully supportive, positive culture and dissatisfaction with the service had impacted on the ability of staff to deliver care. This was reflected in the

quality of care that some people received and in the feedback that people gave us. We have identified the above as an area of practice that needs improvement.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They stated they were willing to disclose any incidents of poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of incidents in line with the Commission's registration requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were treated with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that they had systems and processes to ensure that they were able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).Systems and processes did not robustly assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff had been deployed to make sure they can meet people's care and treatment needs.

The enforcement action we took:

We have issued a Warning Notice in relation to Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff had been deployed to make sure they can meet people's care and treatment needs.