Kimberley Home Ltd

Kimberley Nursing Home

Inspection report

51-53 The Avenue
Surbiton
KT5 8JW
Tel: 0208 390 4372

Date of inspection visit: 10 and 11 February 2015
Date of publication: 11/06/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection took place on 10 and 11 February 2015. Kimberley Nursing Home provides accommodation and nursing care for up to 38 older people. There were 18 people living at the home when we visited. The home was based on three floors. There were bedrooms and bathrooms on each floor. Although 10 of the rooms were designated for double occupancy, on the day of our visit each person had their own room.

Although the care home has been in existence for many years it has been re-registered on 16 December 2014 to the current provider, Kimberley Home Ltd.

Staff, people and relatives did not fully understand the new registration of Kimberley Nursing Home and were not aware how the changes may affect them. When we spoke with people and relatives, they appeared unclear about who the manager of the home was and staff referred to the nominated person and the administrator as the owners of the home. A nominated individual is employed as a director, manager or secretary of the organisation with responsibility for supervising the management of the regulated activity. The administrator explained to us the policies and procedures for the new limited company were not in place during this inspection and staff had not yet been given new contracts. The lack of up to date information and processes meant that staff, people and relatives had not been kept informed of changes within the service.

Summary of findings

The home had a registered manager at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The provider did not always ensure that the premises were safe. The communal bathrooms were congested with equipment, including hoists, walking frames, laundry bins and wheelchairs. Emergency pull cords in the bathrooms and toilets were not all within reach, some of the cords had been tied up. This meant that where they were able to, people could not use the bathrooms independently or safely.

We saw several radiator covers had broken fret work with jagged edges and were not securely attached to the walls. One of the handrails on the stairs were loose We saw occupied bedrooms, which contained broken furniture, a broken chest of drawers and bedframe. Two unlocked rooms housed numerous items stored up to ceiling height. People were therefore not always protected against the risks associated with a lack of maintenance of the premises and adequate risk assessments.

The provider did not carry out adequate health and safety risk assessments in relation to the premises. Regular checks of maintenance and service records were not conducted. We saw that the doors to the sluice rooms were open and inside were bottles that contained cleaning fluids. This meant that the risks of people accessing these areas had not been mitigated by keeping doors locked and ensuring people were protected against faulty equipment or inadequate maintenance.

A gas safety inspection was conducted with recommendations for gas safety work to be carried out. We did not see any evidence that the works needed had been scheduled.

There were individual risks assessments in place to ensure the safety of people using the service; however these had not always been updated as required to reflect people's changing needs. We saw that daily records were not kept confidentially. There was a book of accident and incident forms completed correctly however no summary or analysis of the records had been undertaken although the majority of the incidents related to two people.

We observed there were enough staff on duty to attend to people's needs. The home did not employ an activities coordinator and the registered manager told us that a member of staff was allocated each day to engage people in activities: we did not see this effectively managed. An activities company came to the home for two hours twice a week and the quiz we observed appeared to be enjoyed by people.

Staff recruitment procedures were not sufficient to ensure that people were kept safe. Not all the files we looked at had a current criminal records check and none of the files contained a health declaration. We saw that two overseas staff had outstayed their 'leave to stay' permit.

We found that not all medicines were stored safely. The medicines fridge had recorded temperatures of between 10.1 and 18.4 degrees Celsius, recommended temperatures should be between two and eight degrees centigrade. Unused or old medicines were not stored securely.

We saw the kitchen was clean, ordered and clear of clutter and daily hygiene checks were all up to date. The laundry room housed suitable cleaning equipment. Soiled linen was put into separate coloured bags and washed separately. But the provider did not ensure that all parts of the premises were cleaned to an adequate standard. We saw the décor of the whole house was poor, which made it difficult to maintain good hygiene standards. Some bathrooms and toilet facilities were unclean and had broken tiles and lime scale on pipework. Some of the chairs and carpets throughout the home were stained and dirty. This lack of cleanliness did not help to ensure people were protected from the risks of the spread of infection.

Records showed there was an annual training programme in place, but more than half of staff had not received yearly updated training. Staff we spoke with confirmed they had received an induction, but did not always receive regular one to one supervision. The lack of training and consistent supervision meant that staff were not as well supported as they could be.

Summary of findings

We found the provider had not always taken the correct actions to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were met. These safeguards ensure a service only deprives someone of their liberty in a safe and correct way, when it was in their best interests and there was no other way to look after them.

People's nutritional needs were assessed and a record of this was kept in the care plans we reviewed. We saw records of weight monitoring in care plans but records were not consistent or clear. Food preferences and dietary requirements such as soft food and food allergies were recorded but not shared effectively with kitchen staff. The menu we looked at appeared balanced and nutritious, although it did not reflect what was served on the two days of our inspection. We observed during the lunchtime on the first day that most interactions between staff and people were positive. However people were not encouraged to eat more when they had only eaten a small amount, their plate and the remaining food was taken away. The issues we identified meant that there were risks that people's nutritional needs were not being met.

Records showed that people received visits from health care professionals such as the GP, chiropodists, the tissue viability nurse or other specialist nurses. These visits by specialist professionals helped to keep people well.

People were not always looked after by staff who were caring. Relatives we spoke with were fairly complimentary about the home, but people using the services were less complimentary. During our inspection we heard two call bells that went unanswered for 15 minutes, and found another person sitting in a cold room with the outside door open, which they were unable to close. This lack of attention by staff meant that people's needs were not attended to in a timely manner.

None of the people who used the service could recall seeing their care plan or giving agreement to their care and treatment and none could recall taking part in any review of their care. This meant that people were not involved in the care planning to meet their specific needs.

We observed that bedroom and bathroom doors were closed when delivering personal care and that most staff knocked on bedroom doors before entering, but we observed a few instances where people's privacy and dignity were not being appropriately promoted. For example screens used in communal areas were insufficient to protect people's privacy. Staff did not engage with people while delivering personal care and people's clothes were marked with the person's room number and not their name.

People's files were not ordered in a consistent fashion and were difficult to navigate and were often lacking in detail. The care plans we looked at were not always detailed enough to describe how to meet a person's individual needs, their background, life style, wishes and preferences of how they would like to be cared for.

The provider had some quality assurance systems in place but people were not always protected against the risks of poor care and treatment because these systems were not always effective in identifying areas for improvement and for ensuring that prompt remedial action was taken to make improvements.

From our discussions with the registered manager, it was clear they had some understanding of their management role and responsibilities, but they had not always notified CQC of incidents as required by law. The provider had not sent a notification when the lift was out of order for three days.

People, relatives and staff were asked for their opinion of the service through an annual survey; the last was conducted in April 2014 under the previous registration. A new survey was being conducted at the time of the inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can find the action we have asked the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe. Hazardous chemicals and some medicines were not stored securely which meant people and others could have access to these.

Some areas of the home were dirty. This meant that people's health and wellbeing were put at risk.

Individual risks assessments for people were not updated to reflect people's changing needs, this may mean people did not receive the care they needed.

Regular checks of maintenance and service records were not conducted. This did not help to ensure services and equipment were safe for people, staff or visitors to the home.

Is the service effective?

Inadequate 

The service was not effective.

Staff had not had training and supervision which meant they were not supported to gain the skills and competencies they required to care for people effectively.

People were not supported to be healthy through an effective assessment of their nutritional needs. Dietary information about a person was not passed on to the cook or kitchen staff. This disparity of information posed a potential risk to people's health and safety

The service had not taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards(DoLS) were followed.

Where a person may have been subjected to restrictions of their liberty we did not see that they had given their consent or that their relatives had been involved in any decisions taken.

Is the service caring?

Requires Improvement 

The service was not always caring. People were not always looked after by staff who were caring and respectful. Their independence was not always promoted.

Call bells were not always within reach of people and answered within a reasonable time.

The provider did not have suitable arrangements to support people and where appropriate relatives in making decisions about the care people received.

Staff did not always respect people's privacy and dignity.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst people's needs were assessed prior to admission to the home, care plans were not comprehensive and had not considered the person's preferences, likes and dislikes and how their individual needs were to be met.

Some of the care plans had not been reviewed often enough to ensure these appropriately reflected people's needs.

People did not always benefit from activities that met their individual needs. Activities were organised twice a week for four hours. During the inspection we saw staff engage people in one activity for a short length of time.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have adequate systems to assess the quality of the service provided.

The provider did not ensure that staff, people and relatives were kept fully informed about the services being provided and by whom. They were unsure who the manager was and were unaware who the owner of the home was.

Kimberley Nursing Home

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.

This inspection took place on 10 and 11 February 2015 and was unannounced. It was carried out by two inspectors and a specialist advisor who was a qualified nurse. Before the inspection, we reviewed information we had about the service such as notifications the service were required to send to the Care Quality Commission (CQC).

During this inspection we spoke with nine people living at the home, three relatives, two nurses, four care staff, two visiting nursing professionals, the registered manager and the nominated person. We also spoke with the senior nurse from the local nursing impact team before the inspection. We observed care and support in communal areas. To do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for eight people and the care three of these people received more closely. We reviewed the medicines records for all the people living at the home, the training and staff supervision records for all staff employed at the home and looked at seven staff files. We also looked at other records that related to how the home was managed including the quality assurance audits.

Inadequate

Is the service safe?

Our findings

The provider did not always ensure people were protected from the risks associated with the premises. The communal bathrooms we looked at were congested with equipment, including hoists, walking frames, laundry bins and wheelchairs. Emergency pull cords in the bathrooms and toilets were not all within reach, some of the cords had been tied up. We saw that these bathrooms were in use by people. This meant that people who were able to could not use the bathrooms independently and safely.

We saw that some areas of the home were not adequately maintained and could pose risks to people. At least five radiator covers had broken wooden fret work with jagged edges and were not securely attached to the walls. We saw that one of the handrails on the stairs was loose. There were two sluice rooms, neither room was lockable, there was a hole in the door to the first floor sluice room and a broken window in the second floor sluice room. We saw occupied bedrooms on the first floor which contained broken furniture, a broken chest of drawers and bedframe. The lift had been inspected on the 16 October 2014 with recommendations for repairs that needed to be carried out. We saw evidence that this had been carried out. The stair lift was inspected on the 16 October 2014 with a recommendation that the arm of the chair which was broken be repaired. We saw that the arm was still broken. People's safety was at risk should they come into contact with the broken furniture and equipment.

In a communal bathroom, the light switch inside the room was not a pull cord type and could cause an electrical shock if touched with damp or wet hands. One of the ground floor bathrooms was seen to have electrical equipment stored next to the bath and sink, although this equipment was not plugged in, if it became wet and was later used this may cause serious injury to a person or staff. The certificate for the portable appliance testing (PAT) was not available during the inspection. The provider has since sent us the PAT testing record showing all but two items had passed the electrical testing.

A gas safety inspection was carried out on 23 April 2014 with recommendations for gas safety work to be carried out, including three boilers that were not to current standards. A warning notice was issued by British Gas but the boiler was left on due to the nature of the business. The cooking range and gas meter were not to current standards and there was also no permanent ventilation in the kitchen. We did not see any evidence that the works needed had been scheduled.

Two unoccupied bedrooms were congested with numerous items stored up to ceiling height. It was not possible for the automatic fire door to the dining room to close as the door jammed on the flooring tiles. We informed the London Fire and Emergency Planning Authority (LFEPA) about these concerns. The paragraphs above demonstrate that the provider did not always ensure the premises were safe and people were cared for in a safe environment. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure that all parts of the premises were cleaned to an adequate standard to ensure people were protected from the risks of the spread of infection. Some areas of the home had not been decorated for some time and appeared old and in need of decoration. We saw paint and wallpaper were peeling off walls; this made it difficult to maintain good hygiene standards. Some bathrooms and toilet facilities we looked at were unclean and had broken tiles and limescale on pipework. Various items had been left in some bathrooms, for example a used commode lid in one toilet and a used mop and bucket in another. One of the unlocked sluice rooms contained bedpans and commode pans, including one half full of a liquid, which did not look like it had been emptied and cleaned. This had not been removed when we visited on the second day. Floor tiles in the dining area were broken and could not be cleaned adequately. A kettle and microwave oven for use by staff and people in the dining room were dirty. Some of the chairs and carpets throughout the home were stained and dirty. We spoke with one of the cleaners who said the carpets were deep cleaned. This lack of attention to safety, cleanliness and infection control could put people's health at risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not carried out appropriate risk assessments, including health and safety risk assessments

in relation to the premises. There was no evidence that regular checks of maintenance and other services were conducted. We saw that the door to the sluice room was open and inside was an open cupboard that contained cleaning products, which come under the Control of Substances Hazardous to Health Regulations 2002 (COSHH). This meant the risks of people accessing these areas had not been assessed and mitigated for example by restricting access to these areas by keeping the sluice doors locked.

All of the occupied bedrooms we looked at had portable heaters and some rooms had two heaters. This was because the main heating system had on occasions broken down. In one bedroom where a person was sitting there was a portable heater and a portable fan, both of which were on and the electrical wire belonging to the fan was trailing across the bedroom floor. This could pose a trip hazard to people and visitors. In one room there were two extension sockets attached to each other (with multiple sockets) which could represent an electrical safety risk. As the provider had not carried out appropriate health and safety checks, these issues were not identified so could be addressed.

The outside door in a ground floor bedroom was not lockable but connected to the call bell system which should alarm if the door was opened. On the first day of our inspection we opened the door and the door handle fell off in our hands. On the second day of the inspection we found the door open in the same bedroom. We tried to close the door but the handle fell off. The provider stated that to comply with fire safety regulations the door must be capable of being opened from the inside of the room and was not operable from the outside. They stated the door was alarmed and this was activated when the door was opened so staff would know if the person living in the room had opened the door. We did not hear an alarm on either day that this door was opened and no staff came to investigate the open door. This meant that the person was not protected against the risks that could arise if they leave the home unnoticed. The provider checked the handle and the call bell system and told us these issues had been resolved after our inspection.

The provider did not have effective arrangements to protect people from the risks of Legionella (a water borne infection). There was no Legionella risk assessment in place, no evidence that the quality and temperature of the water was being monitored and no certificate that the water system had been tested and was safe to use.

There were individual risks assessments in place to ensure the safety of people using the service; however these had not always been updated to reflect people's changing needs. Within the eight care plans we reviewed there were risk assessments for falls, Waterlow and MUST scores, and body maps if pressure areas were identified. The MUST and pressure sore assessments were not always filed within the care plans so were not easy to find and were often mixed in with wound care monitoring although this was often not referenced in the care plan. For example one person was scored as being at risk of malnutrition which should have triggered a referral to a dietician but there was no evidence of this and no record in the Multi-Disciplinary Team (MDT) notes to confirm if this had taken place.

An open stair gate at the top of a flight of stairs had a one inch lip on the floor; this was part of the frame of the stair gate and was a serious trip hazard. We spoke to the provider about this and they agreed to remove the stair gate immediately.

There was a book of accident and incident forms completed correctly and signed to record the date, time, location and detail of the incident, who was involved and whether any follow up action was required. However no summary or analysis of the records had been undertaken although the majority of the incidents related to two people. The lack of detailed information and checks did not help to ensure services and equipment were safe and could prove a danger to people, staff or visitors to the home. The above shows that there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment procedures were not sufficient to ensure that people were kept safe. We looked at seven staff files and saw that before a person started work two references were requested, one from a former employer, the other a character reference. The character references often referred to the staff member as a 'friend' but no further details were available. Not all the files we looked at had a current criminal records check, some were five or more years old

Inadequate

Is the service safe?

and had not been updated. We did not see a completed health declaration form or evidence that further checks were made to ensure staff employed were fit and in good health to work.

We saw that two staff had outstayed their 'leave to stay' permit, one staff by 18 months and the other by 30 months. We asked the administrator and the nominated individual about this, we also spoke to one of the staff members involved. They told us that applications had been made to extend the work permits. We asked to see records to show that these members of staff could work in the UK, but none was available on the day. We asked the provider to send this information to us but no information had been received. We have referred this matter to the UK Visa and Immigration Service. The lack of effective recruitment processes meant that people were not appropriately vetted so they could work with people who use the service. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have suitable arrangements to protect people against the risks associated with medicines. We found not all medicines were stored safely. The medicines fridge which was located in the manager's office had recorded temperatures of between 10.1 and 18.4 degrees centigrade, recommended temperatures should be between two and eight degrees. We checked the temperature on the day of the inspection with the manager and it was consistently high. Unused or old medicines waiting to be returned to the pharmacy were store in an unlockable crate in the manager's office.

We observed a nurse administering the morning medicines. The nurse checked the medicines with the medicines administration record (MAR) chart and signed immediately after the medicines were taken. The MAR charts had the person's photo and allergies recorded. We saw that one MAR chart did not provide adequate information about the medicines that a person had refused on one occasion at night. The record stated that night time medicines had been refused but did not state the specific medicine. Where one person was prescribed a variable dose of medicines to be given when required (PRN), the numbers of tablets administered were not recorded. Therefore it was not possible to monitor the effectiveness of the medicines in managing the person's condition. We checked the controlled drugs and found they these were being managed appropriately. The lack of care over the storage and recording of medicines meant that people's health and wellbeing were put at risk. There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the kitchen was clean, ordered and clear of clutter and daily hygiene checks were all up to date. The laundry room housed suitable cleaning equipment and laundry was being managed appropriately to reduce the risk of the spread of infection. Soiled linen was separated and put into separate coloured bags and washed separately to reduce cross contamination.

We spoke with six staff about what they would do if they witnessed abuse or events likely to cause abuse. Staff stated they would report such matters to the manager, but some staff needed prompting when asked about which external agencies to report safeguarding issues to. Staff stated they had received information on safeguarding either through their induction at Kimberley or through their other employment.

We observed there was enough care staff on duty to attend to people's needs, there was also a team of domestic and catering staff. Although there was sufficient staff on duty they were all very busy and did not have enough time to talk to people or engage with them in an activity.

Inadequate

Is the service effective?

Our findings

People were cared for by staff who did not always receive appropriate training and support. We asked staff about on-going training and one nurse said they would like training in wound care and care planning but had not been supported to access this. Records sent to us after the inspection showed that five staff had received care planning training on 17 February 2015. Another nurse stated they had received mandatory updates although on asking further questions it appeared these had been provided in their other employment and not at Kimberley Nursing Home. Another staff member said they had never received any training although they had been employed for over a year. Training records showed less than half of staff had received training in safeguarding adults at risk in 2014. The lack of training could mean that people were cared for by staff who did not have the skills to do so effectively.

Staff we spoke with confirmed that they had received an induction, but the length of time varied between three and four days with one member of staff who told us their induction was only over two shifts. Staff confirmed their induction covered manual handling, fire awareness, safeguarding adults, health and safety as well as other mandatory topics, which they were unable to name. The apparent inconsistency in the induction process could mean that people were placed at risk of not receiving effective care.

Records showed there was an annual training programme in place, but this also evidenced that more than half of the staff had not received this yearly update training. We reviewed these records and the updated records that the provider sent us after the inspection.

These records showed of the 34 listed staff, seven had received training in dementia awareness in 2014 and six in 2013, 11 staff had completed moving and handling in 2014 and two in 2013. 12 staff had completed training in safeguarding adults in 2014 and eight in 2013 and 14 staff had completed training in fire awareness in 2014 and five in 2013.

Other training such as control of substances hazardous to health (COSHH) had been provided to 20 staff in 2014 and four staff had received medicines handling training through the supplying pharmacy in 2014. Records also showed that four or five staff had received training on various subjects at their other places of employment but the dates of this training was not given.

The nurses stated they had received medicines training although they were unclear if they had undergone a medicines competency assessment. On asking the manager about medicines competency assessments she was unclear as to what this was. We explained this is an assessment to ensure that staff who administer medicines are assessed as competent to do so. The National Institute for Health and Care Excellence (NICE) in its guidance 'Managing medicines in care homes' states on page 35 that "Care home providers must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as "Competent." The manager confirmed this had not been carried out.

The manager told us that staff received one to one supervision twice a year but staff said it was every four to six weeks. Of the 20 records we looked at only nine staff had received regular supervision, every three to six months. Two supervision records, one dated September 2014 and the other December 2014 showed areas of concerns with the staff members care practices but we could not find any follow up action plans of how this would be monitored and addressed. The lack of training, inconsistent induction processes and supervision meant that staff were not well supported to fulfil their roles. This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider had not always taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were met. This was because they had not ensured staff received training in these areas to understand the relevant requirements. DoLS are safeguards to ensure that a service only deprives someone of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. We asked staff what their understanding was about mental capacity, best interests and deprivation of liberty. They had some knowledge of these concepts. One staff member stated, "They [people who use the service] cannot make a decision, they are confused and unable to answer and we

Is the service effective?

(staff) can take a best interests decision." Another said when asked about mental capacity, "It means you give them respect as they do not have the capacity to make decisions as a normal person." Records showed that 13 staff had received training on MCA and DoLS in 2012.

We saw that bed rails were in use and the assessment form for bed rail use stated that a mental capacity assessment should be present if the person was unable to sign. In the eight files we looked at only one was signed by the person or their representative, the other forms were signed by staff. There was no evidence that best interests decisions had been made for the other seven people.

The manager has a duty to inform CQC of any incidents that may stop the running of the service. They had not informed CQC when the lift was out of order for three days. The issues summarised above were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported to be healthy through an effective assessment of their nutritional needs. People's nutritional needs were assessed using a risk assessment tool called the Malnutrition Universal Screening Tool (MUST) and a record of this was kept in the care plans we reviewed. However, the records were not maintained consistently to clearly demonstrate that people's nutritional state was being carefully monitored. In one case a person was identified as at risk of malnutrition/weight loss but had not been weighed since the beginning of Dec 2014.

Food preferences and dietary requirements such as soft food and food allergies were recorded in care plans but this information was not passed on to the cook or kitchen staff. We saw a handwritten board in the dining room referencing people dietary requirements which was incomplete and not up to date and one handwritten note on the wall in the kitchen concerning one person's needs. When asked how kitchen staff knew about special dietary requirements or allergies the cook informed us this was communicated verbally by the registered manager. The registered manager told us people who were using the service at the time of the inspection did not have any allergies although one of the care plans viewed clearly stated the person had an allergy to a particular food. This disparity of information posed a potential risk to people's health and safety.

Food and fluid charts were seen in some people's daily records where nutritional status was poor and these records were completed. However, food charts were not fully completed as staff did not always record how much of the meals offered the person had consumed. This meant that staff might not have had all the necessary information to fully assess people's nutritional intake to decide whether this amount was adequate.

Our use of the Short Observational Framework for Inspection (SOFI) tool during the lunch period on the first day found that most interactions between staff and people were positive. People were asked if they were enjoying the food, if they needed any help and what they would like for desert. However we saw that all people had a clothes protector put on them without being asked and people were not encouraged to eat more when they had only eaten a small amount, but rather their plate was taken away without the person being asked if they had finished. We saw one person struggling to eat a desert that their care plan stated they could not manage independently. Their care plan did state what dessert the person liked to eat to be able to maintain their independence but this was not offered. The above show that there was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed people received visits from health care professionals such as GP's, chiropodists, the tissue viability nurse or other specialist nurses. There was a separate section in a person's care file for multi-disciplinary team visits and notes and a communication section. However these visits did not appear to be recorded in the same location in all the care files. This could mean staff were unable to locate the most up to date notes about a person's care and people may not receive the care they required.

Requires Improvement

Is the service caring?

Our findings

Some relatives and people were complimentary about the home and said staff were attentive and kind to people and welcoming to visitors. One relative mentioned that female residents could have their hair done regularly and always looked clean and tidy. One visitor said "The staff are always kind as far as I can tell though they seem to change a lot." One person said "Staff are very kind, I'm so well looked after, they [staff] really do care but are overworked." Another said "It's alright some staff are more friendly than others."

However, our findings and feedback from other people showed that people were not always looked after by staff who were caring. Two people said that staff were not attentive enough and they often had to wait for their call bell to be answered. We received a number of negative comments from people about staff including "They're rough, always so rough and always hurt me when they move me", "I don't use the call bell at night because they never come" and "The care here is very variable I often don't get breakfast till after 10am, because they are so busy." One person said staff called them "rude names". A healthcare professional said "I don't know if the staff have received dementia training but they don't always speak to the residents appropriately or with the respect that they should." On day one of our visit we heard two call bells that went unanswered for 15 minutes.

We asked the manager what action they would take for allegations of rough handling, which several people had spoken to us about. They replied they would investigate, gain statements from those involved and raise a concern with the local authority safeguarding team if they thought a person was at risk. The manager added that in their daily work they observe staff and if incorrect practices were seen these would be corrected. The manager stated that regular manual handling training was conducted, but records showed that 26 of the 35 staff had not received recent training. This may mean that people were at risk of injury by staff who were not suitably trained in manual handling.

On the second day of the inspection we saw a person in their bedroom was very cold and wrapped in blankets, they had a portable heater beside them but the room was very cold. We checked if the door in their room that led to the garden was closed and found it open, we tried to shut the door and the handle came off in our hands, as it had the previous day. We managed to shut the door and we spoke to a member of staff who went in to check on the person. This lack of care meant that people did not receive the level care they required.

We observed care being delivered in the main lounge for the majority of the morning of the first day, where staff appeared patient and attentive towards people. But the lounge was a large L shaped room and chairs were lined up against the walls, which did not help facilitate communication or interaction between people. There were two televisions in the separate areas of the lounge and these were both turned on to different channels. One person told us "The television is on all day and I miss music dreadfully."

There was a service user's guide in all bedrooms but these were from the former provider and had not been updated to the new provider. It contained daily menus although these were incomplete and did not reflect those seen in the kitchen. There was an activity schedule but again this did not reflect events seen on the days we visited. This lack of up to date information meant that people were not enabled to make decisions about what they would like to do or eat.

We observed that bedroom and bathroom doors were closed when delivering personal care and that most staff knocked on bedroom doors before entering. However we observed a staff member entering an occupied bedroom without knocking. The staff member spoke in a quiet voice and did not introduce themselves, or advised the person of what they were doing. The person's visitor who was present stated this was a common practice, especially at weekends when they had observed staff becoming frustrated with the person. The person told us "Staff are rough and they treat me like a piece of meat." The person's care plan gave some information on how to approach the person but when the staff member involved was asked they stated they were aware of the need for safety, but said little else on the way to approach or how to engage with the person.

We observed when people were being transferred from wheelchairs to lounge chairs staff used old screens around the person but these were insufficient to protect people's privacy. We also saw staff in the corridors speaking to one another in loud voices, in front of the people they were providing personal care for, about which person should use which toilet dependent on what the person wanted to do. This did not help to maintain people's dignity.

Requires Improvement

Is the service caring?

We saw people's clothes were marked with a marker pen indicating the person's room number and not their name. The above shows that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

The care plans we looked at were not always detailed enough to describe how to meet a person's individual needs. There were therefore risks that people might not receive the care they needed. We also found that care files were not organised in a consistent way to ensure information about people's needs was recorded comprehensively and staff could locate this promptly when required.

The care plans had not fully considered the person's background, life style, wishes and preferences of how they would like to be cared for. Some care plans had been generated within the last year others as long ago as 2012. There was little evidence that people or their relatives had been involved in developing and reviewing their care plans. These were not signed by the person or their relative to show they had agreed with what was written.

We asked people and their relatives if they had been involved in planning their care or making decisions on the support they received. One relative said they had seen the care plan when their family member first came to the home but couldn't recall signing it or attending any reviews. None of the people who used the service could recall seeing their care plan or signing these to agree and consent to their care and treatment and none could recall taking part in any reviews of their care.

The care plans included a monthly review of people's care although these gave little information on the evaluation of the care that was planned for people and whether their needs were being met adequately. Many of the handwritten updates were often unclear. An example of this in one person's plan we inspected was: 'Good effect. She uses commode in need. Care plan continues.' The reviews did not include relevant information such as Waterlow scores, skin integrity reviews, weight loss or gain. In two care plans on the Malnutrition Universal Screening Tool (MUST) form, it indicated a significant weight loss in the last month. One chart showed on a weight loss of 6.4 kilos in six weeks and another chart a loss of 4.8 kilos in four weeks. We could not find a referral to a dietician, GP or of an action plan to increase the monitoring of the nutritional state of the person.

People's conditions were not appropriately monitored to ensure their safety and welfare. We viewed the wound care records for one person. There were up to date wound assessment charts and photographs of the wound, but these were unclear and without dimensions so could not give an accurate picture of the progress of the wound. The Tissue Viability Nurse (TVN) and the GP was aware of the wound and the person had received a pain review. However the wound had significantly changed and deteriorated, but the care plan did not reflect these changes. The care plan also noted the person had challenging behaviours although their behaviour chart showed no entries since April 2014. The care plan review in January 2015 stated 'the resident continued to express challenging behaviour.'

Care reviews were held with healthcare professionals and social workers and of the eight plans we looked at two reviews had included a relative. The reviews did not show any details of what actually took place, outcomes or impact of the care plan or if any changes were required to the care plan. The registered manager told us that the social workers produced a report and should send the home a copy. However these reports had not yet been received by the home.

We saw three people were engaged in an activity of their own but other people were sitting dis–engaged in any activity. We noticed one person who showed good signs of engagement at first between staff and visitors, initiating conversation, smiling and making light hearted comments. However staff did not try to bring this person into the conversation and after a while the person stopped speaking. The home did not employ an activities coordinator and the registered manager told us that a member of staff was allocated each day to engage people in activities; we did not see this effectively managed. During the morning two members of staff tried to engage people in a game of soft ball darts, the game lasted less than 10 minutes. Staff did not initiate any other activity. On the second day an external activities provider came into the home for two hours and held a quiz in the lounge which people appeared to enjoy and engage with. This activities provider came to the home twice a week for a total of four hours. One person told us that the local church came in to conduct a service once a fortnight and they enjoyed that. People's daily records did not reflect if people had engaged in an activity but typically recorded 'Watched TV or 'she was sleeping' repeated for every day of the month in one case.

Requires Improvement

Is the service responsive?

The above showed that there were risks that people might not receive the care they needed according to their preferences and wishes because these have not been accounted for when the care plans were developed and reviewed and people or their relatives had not been fully involved in their development. There was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated activities) Regulations 2014 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the complaints book and noted that where complaints had been lodged, these appeared to have been resolved appropriately. We saw a copy of the complaints procedure in the service user guide found in each person's bedroom. These were from the previous provider and not for Kimberley Home Ltd. None of the people or relatives we spoke with could recall seeing the complaints procedure but said they would raise a complaint with the head nurse who was the registered manager. Staff said they would also talk to the registered manager if they had a complaint.

Requires Improvement

Is the service well-led?

Our findings

People were not protected against the risks of poor care and treatment because the provider did not operate an effective system to monitor and assess the quality of the service, so areas for improvement were identified and promptly addressed. The findings in this report and the number of breaches of regulation we found showed that the quality assurance and governance systems were not effective in identifying areas where people might have been at risk so that the provider could take the appropriate action to protect people.

The provider did not ensure that daily, weekly or monthly checks of the building and of maintenance certificates, housekeeping and complaints were carried out as required. The administrator told us the checks they conducted of the building and maintenance were noted in their office diary. After the inspection they sent us extracts from their office diary that noted where items in the home were seen as needing repair. An example of this was 'Ask X (maintenance man) call bells rooms x and x' and 'Lock in staff toilet to be replaced.' But there were no records to show if all the call bells or other aspects of the home were checked on a regular basis. This did not tell us if all the calls bells in the home had been checked or if all the locks on bathroom doors checked.

This lack of oversight of the provider meant that people were not always protected against the risks of poor care and treatment because the quality assurance systems were not always effective in identifying areas for improvement and for ensuring that prompt remedial action was taken to make improvements. The above shows that the provider was in breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure that records were completed in a consistent way to provide clear information about people's needs and the care they received. This meant that appropriate and accurate records could not be located promptly if required. Records were also not kept securely to protect people's confidentiality. For example we saw records of weight monitoring in care plans and in a note book but weights for individual people were not always the same. We spoke with the manager about the discrepancies and they agreed that the weights in the care plan did not correspond with the weights in the note book. We saw there was no consistent or clear system being used. Daily records for all people at the home were kept in an unlocked filing cabinet in the communal lounge. This could be accessed by anyone in the lounge and therefore did not afford people confidentiality of their personal notes. This was a breach of regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Kimberley Nursing Home had recently come under the management of a new limited company, Kimberley Home Ltd and this was registered with CQC on 16 December 2014. At least one of the two directors attended the home each day. One was the administrator for the home and the other was now the nominated person. The registered manager remained the same person as with the previous company. The administrator explained to us that the policies and procedures for the new limited company were not in place during this inspection and the policies from the previous company were still being used.

People and relatives were not involved in the development of the service and were unaware of the recent changes to the provider's registration. They did not know who the manager of the home was and referred to the registered manager as the head nurse. Staff referred to the nominated person and the administrator as the owners of the home. However, relatives felt confident to raise issues with the registered manager. We saw staff spoke to the registered manager in an open and easy manner.

People, relatives and staff were asked for their opinion of the service through an annual survey; the last was conducted in April 2014 under the previous registration. A new survey was being conducted at the time of the inspection and the administrator asked a relative to complete a satisfaction survey while we were at the home and the comments were positive.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 (1) (a) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People who use services and others were not protected against the risks associated with unsafe or unsuitable premises, by means of the proper operation of the premises.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People using the service, staff and others were not protected against identifiable risks of acquiring an infection by the means of the maintenance of appropriate standards of cleanliness and hygiene in relation to premises or equipment used for the purpose of carrying on the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 19 (1) (a) (b) (c) (2) (a) (b) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The registered person did not operate effective recruitment procedures in order to ensure that no person was employed for the purposes of carrying on a regulated activity unless that person was of good character, had the qualifications, skills and experience**

This section is primarily information for the provider

Action we have told the provider to take

which are necessary for the work to be performed, and was physically and mentally fit for that work and ensure that information was available in respect of a person employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People who use services and others were not protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the safe keeping of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users safely and to an appropriate standard, including receiving appropriate training, professional development, supervision and appraisal**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulation 11(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people who use services in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People who use services were not protected from the risks of inadequate nutrition and dehydration, by means of the provision of support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs and monitoring their nutritional status.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1) (a) (b) (c) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People who use services were not protected against the risks of inappropriate care and treatment by means of the planning and delivery of care to meet the service users' individual needs and to ensure the welfare of the service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 10 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Action we have told the provider to take

People who use services were not treated with respect and dignity at all times while they are receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 17 (1) (2) (c) (d) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user nor maintain securely such other records as are necessary to be kept in relation to the management of the regulated activity.