Barchester Healthcare Homes Limited

Kingsland House

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection at Kingsland House on 8 and 9 January 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the care and welfare of service users, assessing and monitoring the quality of service, the management of medicines, respecting and involving service users, consent to care and treatment, staffing and supporting workers.

We undertook this focused inspection on 12 and 13 August 2015 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kingsland House on our website at www.cqc.org.uk

Since the previous inspection on 8 & 9 January 2015 there has been a change in the regulations that we use to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. For this inspection, we have

Summary of findings

transferred the regulations used at the previous inspection to the current regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Kingsland House is a purpose built home that provides nursing care and accommodation for up to 71 older people with a physical disability, dementia and/or related mental health conditions. The home includes 'Memory Lane Community', a dedicated part of the home that accommodates people living with a dementia and 'Bluebell Community', part of the home where people with complex and general nursing needs reside. Services offered at the home include nursing care, end of life care, respite care and short breaks. At the time of this inspection, there were 61 people living at the home.

There is no registered manager at the home. 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.

You can read a summary of our findings below.

There were 61 people living at the service during our inspection. We found improvements had been made in respect to the management of medicines and supporting workers. However, we continue to have significant concerns in respect to staffing, dignity of service users, consent to care and treatment, quality assurance, and the planning and recording of care. We also identified further significant concerns in respect to people receiving adequate nutrition and hydration. Concerns were also identified around the culture of the service and lack of consistent management.

People's safety was being compromised in a number of areas. People and staff spoke negatively of the service and commented they felt there were not enough staff to provide safe care. Our own observations supported this. Staffing levels were stretched and staff were under pressure to deliver care in a timely fashion. One person told us, "You never get anyone [staff] around here, it's disgusting. You pay all this money, I just can't get anyone and I'm just stuck here. I've been asking for a bath for two weeks and my hair needs washing, it's dirty and it itches. There should be more staff. If I want the toilet they keep saying to me 'I'm not the only one here', they need more people to look after us. I can be sitting on the toilet and pull the cord and I'm just waiting and waiting. You can call out, but they just take no bloody notice. They need more help, there are not enough girls [staff]".

People were at risk of malnutrition and dehydration. We found lunchtimes to be chaotic and unpleasant, with some people not receiving their lunch until 2:00pm. A member of staff told us, "I'm really hot on nutrition, but the staff don't have enough time to feed everyone properly". Assessed dietary plans were not being followed and people were not being supported adequately to eat and drink enough to meet their needs. The recording of food and fluids was inaccurate and incomplete and discrepancies were not followed up or acted upon.

Assessed plans of care for people who were at risk of pressure damage were not being followed. The recording of pressure care was not accurate and did not always reflect the care people needed.

People's dignity, privacy and choices were not respected especially around continence support. We observed people having their requests for assistance around continence being ignored. The delivery of care suited staff routine rather than individual choice. A member of staff told us, "If you have 28 residents to look after, how can you take someone to the toilet four times in an hour? I know it should be their choice, but we can't".

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the MCA Code of Practice.

Staff did not feel well supported or listened to, and the culture and morale at the service was poor. This negative culture had an effect on the wellbeing of people and staff, the ability to deliver care and the professional integrity of staff.

A manager was in post, but they were not the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

the service and shares the legal responsibility for meeting the requirements of the law with the provider. The home has been without a registered manager since February 2015.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that where required, DoLS applications had been made and the manager understood when an application should be made and how to submit one.

Staff had received both one to one and group supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place.

Overall, we found significant shortfalls in the care provided to people. We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. We will publish what action we have taken at a later date.

We have raised our concerns with the Local Safeguarding Authority.

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

Kingsland House was not safe. Improvements had not been made from the last inspection.

Staffing levels were incorrectly calculated and did not reflect people's level of care needs and support required to safely meet their needs.

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.

Medicines were stored appropriately and associated records showed that medicines were ordered, administered and disposed of in line with regulations.

Is the service effective?

Inadequate

Kingsland House was not providing effective care.

People were placed at significant risk of malnutrition and dehydration. People were not supported to have suitable amounts to eat and drink. Lunchtime was chaotic and unpleasant, guidance around diets was not being followed and the recording of food and fluids was inaccurate.

Mental capacity assessments (MCA) were not completed in line with legal requirements.

Staff had formal systems of personal development, such as supervision meetings and appraisals.

Is the service caring?

Inadequate

Kingsland House 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 in making decisions about their care and treatment.

Is the service responsive?

Inadequate

Kingsland House was not consistently responsive.

People did not always receive the care they required at the time they needed it. The delivery of care often suited staff routine, rather than people's individual preferences and choices.

Care plans were in the process of being reviewed, however, they lacked consistent detail around the care of pressure damage.

Is the service well-led?

Inadequate

Kingsland House was not consistently well-led.

There was a manager employed who had been in post for approximately four weeks. However, the management staffing structure did not provide consistent leadership and direction for staff.

Summary of findings

Staff told us they were not supported by management and were not listened to. Feedback indicated dissatisfaction with working at the service, and a negative culture.

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

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. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Kingsland House on 12 & 13 August 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 8 & 9 January 2015 had been made. The team inspected the service against all of the five questions we ask about services: is the service safe, effective, caring, responsive and well led. This is because the service was not meeting some legal requirements.

This visit was unannounced, which meant the provider and staff did not know we were coming. On the first day of the inspection, the inspection team consisted of an inspector and an expert by experience in older people's care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the visit the inspection team consisted of three inspectors. Before our inspection we reviewed the information we held about the service. We considered information which had been shared with us by the Local Authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with six people who lived at the service, the regional director, a registered manager from another service in the group, the operations manager, the deputy manager, four registered nurses and seven care workers. Some people had complex ways of communicating and several had limited verbal communication. We spent considerable 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 looked at areas of the building, including people's bedrooms, bathrooms, the dining rooms and communal lounges. We reviewed records of the service, which included quality assurance audits, staff supervision schedules, staffing rotas, food and fluid recording charts and policies and procedures. We looked at eight care plans and the assessments included within them, along with other relevant documentation to support our findings.

We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

At the last inspection in January 2015, the provider was in breach of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that at all times there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. People were also not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place for the safe administration of medicines.

Due to the concerns found at the last inspection, CQC found people were at significant risk of not receiving safe care and the delivery of care required improvement. An action plan was submitted by the provider that detailed how they would meet the legal requirements by 17 March 2015 and 9 January 2015 respectively. Improvements had been made with regards to medicines, and the provider is now meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we found the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As, CQC continue to have significant concerns in respect to staffing levels at the service and based on the evidence seen the rating for this key question has been revised to 'Inadequate'.

People and staff at Kingsland House told us there were not enough staff on duty to support people at the times they wanted or needed. For example, we observed that one person had been calling out for help for 20 minutes, they told us, "You never get anyone [staff] around here, it's disgusting. You pay all this money, I just can't get anyone and I'm just stuck here. I've been asking for a bath for two weeks and my hair needs washing, it's dirty and it itches. There should be more staff. If I want the toilet they keep saying to me 'I'm not the only one here', they need more people to look after us. I can be sitting on the toilet and pull the cord and I'm just waiting and waiting. You can call out, but they just take no bloody notice. They need more help, there are not enough girls [staff]".

We saw that one person did not have a call bell to hand as it was on a cupboard unplugged on the other side of their room. We asked them how they would get help. They pointed to a sensor mat by their bed and told us, "I'd stand on that and just hope not to have to wait too long. There are problems with the call bells. They sometimes need more staff. You can hear call bells going and people calling out a lot". A further person added, "There are so many things you take for granted until you're in this situation and you have to rely on others. The call bell isn't always working, if they [staff] hear you they're good, but if they're busy they're not always on the ball. It does seem a long time when you need to go to the toilet. The staffing is a bit tight. You can hear them talking, they hide it well, but you know when they're under pressure".

Throughout the inspection we heard call bells ringing repeatedly. We were shown records and analysis of the time taken across a two day period for staff to attend to someone once they had pressed their call bell. The records showed several occasions where people had waited an excessively long period of time to be assisted. For example, one record showed that a person had pushed their call bell at 07:55 and were not attended to until 08:42. Another showed that assistance was requested at 09:34 and the call was attended to at 09:54. Further analysis of the records showed that some people had waited between 34 minutes and 43 minutes respectively to have their calls for assistance answered.

Staff told us that they felt rushed and under a lot of pressure. They said they had not always been able to assist people or complete routine checks. A member of staff said, "We are so short staffed and morale is really low. It impacts on toileting and feeding. People dread coming in, so they ring in sick as it's too much of a slog". Another member of staff said, "The home is so understaffed, it's impossible to get all the tasks done". A further member of staff added, "I can't take the pressure any more. We can't actually attend to peoples' needs, it's disgusting. We have to stay on in our own time after shifts end to make sure everything is done. We are attending to their very basic needs and that's not good enough. We're so stretched and stressed, sometimes tea rounds are missed as we're too busy", Further comments from staff included, "The staff don't have time to sit with people and provide personalised care", "There are days when we don't get breaks. Some of us have our own health issues and it impacts on our lives" and "We have residents who need two care workers for support on Bluebell [unit], around 13 or 14 of them. We have four care workers in the morning, three in the afternoon and one at night, it's impossible".

Inadequate

Is the service safe?

Our own observations supported the feedback we had received. During our visit we viewed care delivery at different times throughout the service. Staff often rushed between tasks and had poor interactions with people. The staff appeared stressed and preoccupied and several people were ignored and had questions or requests unanswered. For example, we heard member of staff who had just served a cup of tea to someone in their room say, "The girls will be in to attend you shortly, I'll see if I can get you one". On leaving the room the person asked "Are you coming back?" the member of staff replied, "At some point". Shortly afterwards we went in to see the person, who was in their night clothes in bed at 11.45am. They promptly became distressed and said, "I've wet myself. I feel lousy". We asked if they should ring their call bell for assistance, but the person again got upset and panicky and said, "I can't ring now, it's nearly lunchtime and I'll be in trouble, they're so short staffed". Additionally in the Bluebell Unit, we heard a nurse repeatedly asking people who had been calling out for assistance to wait, as they were late administering the morning medication to people.

We observed that staff were present most of the time in communal areas such as the lounges. However, we did observe times when there was not a staff presence in a lounge where 12 people who were living with dementia were sitting. We observed one person attempt to get up from a chair, but they could not do this by themselves as they required the use of a zimmer frame. There were no members of staff present, therefore a member of the inspection team needed to assist this person as they were at risk of falling. Additionally at 1:30pm in the lounge of the Memory Lane unit, there was one member of staff supervising the meal of 16 people living with dementia. We saw one person get distressed, who repeatedly called out "Help me, please help me". This continued for six minutes and the member of staff did not intervene or offer any reassurance as they were busy with other tasks. Gradually several other people became distressed by the person calling out, with one person shouting, "Quick, quick, help them". A further person became agitated and called out, "They're all too busy to help you, you'll need to wait". The person continued to call out until 1:40pm when a member of staff entered the room and wheeled them out of the lounge in their chair, without offering reassurance, or endeavouring to determine why the person was distressed.

The regional director and registered manager from another service in the group told us they felt the home had enough staff to provide safe and person centred care. The regional director told us that 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. However, our own observations showed that staffing levels were not calculated appropriately. The regional director told us that the DICE assessment had been carried out in February 2015 and had been "locked down" until July 2015, meaning that assessments of people's need in relation to hours of care required had not changed in this time. We were told on the day of our inspection that the information in the DICE tool was currently being updated. However, in the time between February 2015 and our inspection, despite overall numbers of people living at the service remaining approximately the same, 19 new people were living at the home, replacing people who had moved on to different care settings, or had sadly passed away. In addition to the changing needs of people already at the service, each new person would have their own unique care requirements. This had not been reflected in the assessment used to determine the current staffing levels at the service. The current assessment was out of date and 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 was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the management of medicines. Registered nurses were trained in the administration of medicines. A member of staff described how they completed the medication administration records (MAR). We saw these were accurate. Regular checks of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks and cleaning of the medicines fridge. This ensured the system for medicine administration worked effectively and any issues were identified and addressed.

We observed a member of staff administering medicines sensitively and appropriately. We saw that they

Inadequate

Is the service safe?

administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. Medicines were stored appropriately and securely and in line with legal requirements.

Inadequate

Is the service effective?

Our findings

At the last inspection in January 2015, the provider was in breach of Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured suitable arrangements were in place in order to ensure that persons employed were appropriately supported by receiving appropriate supervision and appraisal. Additionally the provider had not ensured suitable arrangements were in place for obtaining and acting in accordance with the consent of service users, or establishing and acting in accordance with best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

Due to the concerns found at the last inspection, people were at risk of not receiving effective care and the delivery of care required improvement. An action plan was submitted by the provider that detailed how they would meet the legal requirements by 31 April 2015 and 17 March 2015 respectively. Improvements were made with regards to supporting workers, and staff were now receiving supervision and appraisals. However, we found the provider was still in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as we continue to have concerns in respect to the recording and assessment of consent at the service. In addition, we found significant concerns in respect to people not receiving adequate nutrition and hydration. Based on the evidence seen the rating for this key question has been revised to 'Inadequate'.

We observed lunchtime on both days of the inspection. We observed lunchtime in the Memory Lane and Bluebell units respectively. The lunchtime on Memory Lane was chaotic, the service consisted of one sitting, that started at approximately 12:00pm. Food was still being served to people at 2.00pm. Cutlery and food were spilled on the floor and were ignored by staff, and people were not supported to eat and drink appropriately. For example, one person had been calling out that they were hungry since 11:50am, and by 12:50pm they had still not received their lunch. We saw another person sat at a table with their food for 20 minutes. In this time they had not eaten any of their lunch and had put their cup and necklace on their plate of food and repeatedly pushed them around the plate. This person eventually got up and left the dining room, without eating any of their meal. The staff present did not intervene and had not offered any encouragement for this person to eat their meal.

In the Bluebell unit we saw that two people had their main courses in front of them for 20 minutes before they received support from staff with their meal. One person in particular struggled to eat their main course with a knife and fork. They spent a long time trying to get food on their fork, then tapped the fork, then gave up and closed their eyes before trying again. After several minutes a member of staff noticed they were putting food in a glass and intervened stating, "What's going on here, you're loading your cup and it's interfering with your food, do you want your salmon, do you want a hand?" This person was keen for the assistance, however the meal was by now cold, and after a couple of mouthfuls the member of staff left to check on other people in the dining area. The member of staff did not say they were leaving, and did not check if the person could manage. The person then carried on as before, struggling to eat their food and then subsequently gave up.

Where a need for a specialist diet had been identified we saw that this was provided. However, people were not routinely supported to eat it. For example, some people were on a soft or pureed diet due to problems with swallowing, and others were assessed to eat 'finger food'. In the Memory Lane unit, we saw that one person had been given a bowl of pureed food. We observed this person for 20 minutes and in that time they did not eat any of the food in front of them. The person had no cutlery as it had fallen on the floor and they repeatedly dipped their cup into their food. After 20 minutes a member of staff came to assist them, but by this time the food was cold, so the member of staff removed the bowl. A further person had been assessed as requiring 'finger food'. They had a plate of boiled potatoes and aubergine in front of them, and had been given a spoon to eat it with. The cutlery was inappropriate for the food and the person could not pick it up. They eventually dropped much of the food on themselves and the floor, before dropping the spoon also. At no point did a member of staff assist or notice that the person was struggling to eat. Eventually staff removed the plate of uneaten food and gave the person a yogurt. They were not given any more cutlery and the person ate the yogurt with their fingers, pouring much of it over themselves, again no member of staff offered assistance.

Inadequate

Is the service effective?

Staff told us how they monitored what people ate and drank and said they completed food and fluid charts for people every day. In respect to the two people mentioned above who required a specialist diet, both had been assessed as being at high risk of malnutrition. Despite our observations that neither person had eaten their lunch, their food recording chart for the day stated they had both eaten all of their lunch. We looked at a further sample of food and fluid charts, and it was clear that staff had no oversight of people's daily intake and were not following guidance on how much people should be eating and drinking. All of the fluid recording charts that were looked at showed that people had not received the recommended amount of fluid per day. Staff were instructed to record when the recommended amount had not been reached and identify action to be taken if this was the case. This had not been done on any of the fluid recording charts that we saw.

An audit of people's nutrition was carried out by the operations manager in July 2015, that showed which people were assessed as high risk of weight loss. The results showed that 28 people were at high risk of malnutrition, seven were at medium risk and that 15 were low risk. 21 of the people reviewed had lost weight in July 2015. We asked staff if they had any concerns around people receiving adequate amounts of food and drink, and what their views were on mealtimes. One member of staff told us, "There seems to be a culture amongst staff of not taking time to feed people, they're too busy". Another said, "I'm really hot on nutrition, but the staff don't have enough time to feed everyone properly". A member of staff added, "The dietary plans are not being followed. The food is good, but staff don't have the time to actually get it into people. Maybe lunchtimes could be staggered or something, because the weight loss is worrying". Other comments from staff included, "On Memory Lane people need support to eat because of their dementia. There's not enough staff to sit and support them to eat properly" and "I took 30 minutes to feed someone today as they need prompting, and they ate. That's rare though and we don't get the time to sit and feed people like that".

The above evidence demonstrated that people are being placed at significant risk of malnutrition and dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 was designed to protect and restore power to those vulnerable people who lack capacity and are unable to make specific decisions for themselves. Staff were not working within the principles of the Mental Capacity Act 2005 (MCA). Staff members told us, that many people at the service would be unable to consent to care and treatment, and had a mental capacity assessment completed. However, in the mental capacity assessments we viewed, it was not clear what decision was being made, in particular around the use of bed rails. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found mental capacity assessments did not record the steps taken to reach a decision about a person's capacity. We asked a registered nurse to talk us through how they completed the mental capacity assessments. They were unable to tell us how they undertook the assessments and what steps they took. Mental capacity assessments were not decision specific and were not recorded in line with legal requirements.

Assessing capacity in the right way at the right time is vital in care planning. Determining whether or not someone has capacity to make a decision has significant consequences. A person assessed as lacking capacity may be denied their rights, or could be put at significant risk if they are making decisions that they do not really understand. There was a risk that blanket judgments, such as assuming a lack of capacity because of the varied level of each individual's impairment could be made by staff.

The above evidence demonstrated there remained a lack of clear processes for ensuring that people's rights were protected when consenting to their care. This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm.

The provider was meeting the requirements of DoLS. The operations manager understood the principles of DoLS and how to keep people safe from being restricted

Inadequate

Is the service effective?

unlawfully. They also knew how to make an application for consideration to deprive a person of their liberty. DoLS applications had been made for people at the service who required them and on the second day of our inspection, a member of the DoLS assessment team from the Local Authority was present and assisted the general manager with the referrals they had made.

Feedback from the operations manager and staff confirmed that formal systems of staff development, including one to one and group supervision meetings and annual appraisals had now been put in place.

Inadequate

Is the service caring?

Our findings

At the last inspection in January 2015, the provider was in breach of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider had not, so far as reasonably practicable, made suitable arrangements to ensure the dignity of service users.

The concerns identified at the last inspection found Kingsland House was not consistently caring and the delivery of care required improvement. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by 30 April 2015. However, we found the provider was still in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We continue to have significant concerns in respect to people's privacy and dignity not being respected at the service and based on the evidence seen the rating for this key question has been revised to 'Inadequate'.

We observed some care practices which upheld people's privacy and dignity. 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, "They are kind to me" and "They're gentle when they hoist me up in that machine thing and tell me where to hold on". However, we found the principles of privacy and dignity were not embedded into every day care practice, especially around supporting people with their continence and people having their choices and independence supported.

At 9:50am in the Bluebell unit, we observed a person ring their call bell as they wished to use the toilet. The nurse on the corridor was administering the morning medication. The nurse responded to the person and asked what they wanted. They stated they needed the toilet. The nurse replied, "I can't help you, but I'll try to find someone to help you". The nurse returned and said "[Member of staff] is coming, but is washing someone else, so can you wait five more minutes?" The person replied "Oh gosh", and the nurse said, "I know, but they will come then, I'm next door if you need me". No explanation was given to the person as to why the nurse was unable to assist them. Another member of staff went in the person's room and said, "You ok, what's up?" The person repeated they needed the toilet and the member of staff replied, "You'll have to be patient, they'll come in a minute". At 10:00am care staff went in to assist, meaning that the person had been requesting help for ten minutes, and despite having interaction with two members of staff in this time, had not been assisted to go to the toilet.

At 11:00am there were eight people sat in the lounge of the Memory Lane unit, with two members of staff present. We observed a person in a wheelchair ask to be taken to the toilet. For two minutes the person called out, "Please can you take me to the toilet? I need to go to the toilet". A member of staff replied, "In a minute, I am busy, I am just doing this". The person responded, "Please help me out, I can't help it, I don't know how many times I've asked". One member of staff ignored this person and the other stated, "I'll be back in a minute" and wheeled another person out of the room in their wheelchair. The person became visibly more distressed and tried to get out of their wheelchair, they called out, "Why can't I get taken out like that, I need the toilet?" The other member of staff present replied, "You can walk yourself, it'll only take you a couple of minutes". The person responded, "I can't walk far, I don't feel right. Please help me". The member of staff present saw another member of staff enter the lounge and said, "Honestly, he won't stop". The member of staff who had entered called out to the person across the lounge, "You have a catheter don't you?" The person responded, "I need both, I need to do both, please help me, why do you refuse? I'm going to the toilet, I can't stop, help, help". The staff continued to ignore this person and they were not taken to the toilet. Their dignity was not respected and people sitting in the lounge could see and hear what had happened.

On the second day of our inspection at 2:10pm in the Memory Lane lounge a person asked a member of staff if they could take them to the toilet. The member of staff called across the lounge to a colleague, "I'm supposed to finish at 2:00pm and [X] needs the toilet". The person who wished to go to the toilet then apologised to the member of staff for asking them. Their dignity was not respected and people sitting in the lounge could see and hear what had happened.

We asked staff about supporting people with their continence and whether they thought people's needs were being met. One member of staff told us, "If you have 28 residents to look after, how can you take someone to the toilet four times in an hour? I know it should be their choice, but we can't". Another said, "Someone will need the

Is the service caring?

toilet, then someone else will, and we have to hurry the person up on the toilet". A member of staff added, "There are regular people who need toileting who need two carers, and we can't get to them in time. We know what we have to do, but we can't split ourselves four ways".

Throughout the inspection we saw that people were not offered day to day choices around their care, did not routinely have their independence promoted, or had their dignity and privacy compromised. For example, at mealtimes staff placed 'bibs' on people without asking or explaining what they were doing. People were given drinks without being offered a choice of what they wanted. We saw one person being transferred by means of a hoist. The process was carried out safely by staff, however no reassurance or explanation was given to the person. People's independence was not routinely supported. For example, adapted cutlery and plate guards were not routinely made available for people whom it may have assisted them to eat independently. People were not encouraged to mobilise independently. One person told us they had a walking frame they could use, but said they were not offered the opportunity to use it. They told us, "They put me in a chair to move me anywhere, perhaps it's safer for them, I know they prefer it".

We saw that not all staff were compassionate towards people, and did not have an understanding of how they communicated their care needs. For example, at 11:50am on the second day of our inspection in the Bluebell unit, we saw a member of staff come out of a person's room in a very agitated state. They called out to a colleague, "I can't do any more for him. Apparently I'm a liar according to him. You try and sort him out, I've come out of the room". The member of staff then walked off without explaining to their colleague what the issue had been. At 12:15pm we saw the same member of staff come out of another person's room. They said loudly to their colleague, "I've had enough. I don't know what she wants. She doesn't want the toilet, she's just pointing at the side of her cupboard, maybe you can understand her. I've come out the room", and again walked away. The other member of staff went in and shortly after, got another colleague and said, "Can you help me please, [X] wants to get into their wheelchair, that is what she was pointing at". This member of staff clearly took the time to find out what the person wanted and assisted them accordingly.

We asked staff what they thought of the care delivered and whether they understood the needs of the people they cared for. One member of staff told us, "We do know our residents, but we don't have enough time for them. One resident is very quiet and needs reassurance and attention, but we don't have time to do that. We have two other residents who shout and want the toilet a lot. Mainly it's because they are lonely or in pain. If we could just sit with them for a bit, we could calm them and give them care that suits them". Another member of staff said, "Some people just want you to sit with them and have a chat, that's why they scream out. We don't have time though".

Dignity and respect are key principles of the Human Rights Act. When a person's dignity is compromised and no respect is afforded them, it is an abuse of their human rights.

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 was a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At the last inspection in January 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not taken proper steps to ensure each service user was protected against the risks of receiving care or treatment in such a way as to meet service user's individual needs.

The concerns identified at the last inspection found Kingsland House was not consistently responsive to people's needs and the delivery of care required improvement. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by 31 June 2015. However, we found the provider was still in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We continue to have significant concerns in respect to people's individual care needs being met and based on the evidence seen the rating for this key question has been revised to 'Inadequate'.

At the last inspection in January, it was identified that the needs of people who required care around pressure damage were not being met. We found that this was still the case. Pressure ulcers commonly occur in those who cannot reposition themselves to relieve pressure on bony prominences. The ability to reposition is often reduced in people who are very elderly, malnourished, or who are acutely ill. A fundamental way in which care staff can contribute to pressure ulcer prevention is by repositioning those people who are unable to do so themselves. Repositioning involves moving people into a different position to remove or redistribute pressure from a particular part of the body.

Approximately 18 people at Kingsland House were identified as having varying degrees of pressure damage, and most of these people required repositioning at certain intervals. We asked staff about the management of peoples' pressure care. A registered nurse told us, "There are 18 residents with pressure care damage. It is a work in progress with pressure care, but we're having a lot less skin tears". Another member of staff said, "Sometimes we're missing the repositioning times by a couple of hours, as we're too busy. It gets too busy to check". A further member of staff added, "We have people on hourly turning and two hourly turning, but it's not possible to get to everyone in time". Our own observations supported this. We observed one person sat in the same position in the Memory Lane lounge continuously between 11:30am and 5:00pm. Their care plan stated they needed to be repositioned every two to four hours. Additionally, we saw that charts used to record when people were repositioned were not routinely completed accurately and contained gaps in the recording. This meant that not all people had not been repositioned in line with their care plans.

An audit of people's tissue viability had been carried out by the service in July 2015, showing which people had pressure damage and whether it was improving, staying the same or deteriorating. Much of the information on the audit did not reflect the information contained in peoples' care plans. Within the care plans, we found inaccuracies. Recording around people's care was wrongly calculated and people's levels of needs were wrongly assessed. For example, one person was assessed as being able to feed themselves 'independently' and has a 'good appetite'. We observed this person throughout their lunchtime meal. Their lunch was served at 2:00pm and by 3:00pm they had not managed to eat their food and required assistance from staff at this point. Another person was assessed as having pressure damage to two parts of their body, however it was unclear in their care plan exactly what and where the pressure damage was, and what treatment was required. We raised this with the operations manager who told us that some care plans had become out of date, but they were in the process of being reviewed. We saw that registered nurses were reviewing and updating care plans throughout our inspection.

Several people commented they were well looked after by care staff. However, care was not personalised to the individual, and there was an acceptance by people they had to comply with how care staff wanted to do things. For example, people did not get up or go to bed when they wished. One person told us, "They get me up at six. I don't want to get up straight away, but I have to. I do like to go to bed at seven and watch films, that suits me". Another person said, "I go to bed when they put me". We asked staff if people's choices and preferences were respected around getting up and going to bed. A member of staff told us, "Not really, we do our best, but it's too busy. We have the day staff putting people to bed and the night staff getting people up. We have one resident who needs two carers. He likes to get up early, but he can't, because there is only one carer working at night with a nurse, so he can't be got up".

Inadequate

Is the service responsive?

Another said, “If you want to get up at 7:00am you should be able to. If you want to get up at 11:00am that’s fine too, but it doesn’t happen here. It’s like a factory, all task driven, not for the individual”. A further member of staff added, “Six or seven people want to get up at the same time, but they have to wait until the shift changes”.

We received further feedback around people’s needs and preferences not being met. We asked people if they had a choice as to when they received a bath. One person told us, “They give me a strip wash, they suggested it, so I left it to them”. Another said, “I’ve been asking for a bath for two weeks”. A further person added, “Sometimes a shower, not time [for a bath]”. We raised this with staff who told us, “People are not getting washed properly. We try to get round the baths and showers the best we can”. Another said, “We can’t give person centred care. The demands of the residents are too much. We can’t get things done, we just cannot get everything done”. A further member of staff added, “Everything is task orientated. I want to provide person centred care. I’m fed up with having to tell people to wait a minute”. This reflected the delivery of care that was centred on staff routine rather than individual preference and choice.

The above evidence demonstrated that people did not receive the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the last inspection in January 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not protected service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of services provided and identify, assess and manage risks relating to the health, welfare and safety of service users. The provider had not had regard to the complaints and comments made and views expressed by those acting on behalf of people. The provider had not, where necessary, made changes to the treatment or care provided relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a service user.

Due to the concerns found at the last inspection, we found that the service was not well led and required improvement. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by 17 March 2015. Improvements had been made with regards to the recording and analysis of accidents and incidents and complaints. However, we found the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as we continue to have concerns in respect to the provider's ability to monitor the quality of care delivery, recognise areas of concern and deliver improvements at the service. In addition, at this inspection we found significant concerns in respect to the culture, morale and professional integrity of staff. Based on the evidence seen the rating for this key question has been revised to 'Inadequate'.

People did say that apart from the service not having enough staff, they thought the home was well run and organised.

A registered manager was not in post. The service had been without a registered manager since February 2015. Several interim management arrangements had been in place at the service and the current operations manager had been in post for approximately four weeks. No one living at the service we spoke with was aware who individual members of the management team were. Staff also expressed their concerns that the management staffing structure at the service did not provide consistent leadership or direction. One member of staff told us, "The managers keep changing, there is no continuity. The new manager is really good, she is super". Another added, "There has been no consistency of manager for a long time. The new manager is good though".

Quality assurance is about improving service standards and ensuring that services are delivered consistently and according to legislation. At the last inspection, we found the provider's audits were incorrect and did not follow up on concerns identified. For example, audits had identified that there were gaps in the recording of care delivered, levels of DoLS applications, staff supervision were not up to date and meaningful activities within the service had not been developed. However, agreed action points from these audits had not been followed or implemented.

At this inspection, some improvements had been made and systems were in place to record, assess and manage accidents, incidents and complaints. Accidents and incidents were now recorded appropriately and staff knew how and where to record the information. Remedial action was taken and any learning outcomes were logged. Steps were then taken to prevent similar events from happening in the future. Records also showed that comments, compliments and complaints were now recorded, monitored and acted upon. Complaints had been handled and responded to appropriately and any changes and learning recorded. We saw that feedback from complaints was analysed in order to identify any trends and to improve the service delivered.

However, not all systems of quality monitoring were robust, and there was not an effective quality assurance framework in place. Quality monitoring visits from regional management were undertaken which looked at the home's practices, documentation and health and safety. We looked at 'Quality First Visit' carried out on 30 July 2015. The audit identified concerns which included, the recording of fluid charts, the lunchtime dining experience, nutritional risks, pressure care and the information stored in care plans. At the time of our inspection, recent audit activity around nutrition, pressure care and the information held in care plans had resulted in work being underway to update care plans, and management had established who was at risk of malnutrition and pressure damage. However, these audits had not ensured that people received a consistent and good quality service that met individual need. Additionally,

Inadequate

Is the service well-led?

the provider had not met all of the required improvements set out in their action plan created in light of the concerns identified at the previous inspection. This placed people at risk of receiving poor outcomes and care that did not meet their needs.

We discussed the culture and ethos of the service with staff, and found that feedback from staff was not positive, and staff did not have a strong understanding of the vision of the service. Although some staff spoke positively of how they all worked together as a team, feedback from staff was mixed and indicated that there was a lack of cohesion and a negative culture in the service. One member of staff told us, "I love it here, and I love the staff and residents, but I hate what is happening at the moment, I just hope it improves". Another said, "I think the caring spirit has gone, as we are demotivated. More staff are needed, but things need to change in people's minds to care better. I'm just fed up". A further member of staff added, "I'm happy, but the mood in the home is so low. I wouldn't put my Mum here".

We raised these concerns with the regional director and operations support manager. We were shown analysis of staff turnover, which showed that the number of staff leaving the service each month since February 2015 had reduced, and that a staff forum had been set up to enable staff to air their views. They told us that in line with their action plan put in place from the previous inspection, they thought the service was improving, that enough staff were in place and that staff morale was good. CQC evidence shows that this was not always the case. Staff said they did not feel listened to and we received negative comments around the support they received from management. We saw documentation whereby staff had formally raised their concerns in writing in respect to poor care delivery and the lack of staff. A member of staff told us, "It's getting me down, I feel flat. We need more staff, but we just get told, 'we're looking at it'. I want to enjoy work and put a smile on people's faces, not be like this". Another told us, "The managers know about the staff shortages, everyone does, but nothing gets done about it. We are so stressed". A further member of staff added, "The care staff are brilliant, but management are intimidating and make me feel worthless. They don't want to hear we've not got enough staff, they don't listen. They brush it under the carpet and tell us not to be so stressed. There is a real lack of understanding between management and us. We do have meetings and air our views, but we're fobbed off". Additionally we were told, "I see carers struggle, residents struggle, we're not happy. The pressure is so much, everyone is so angry. There are not enough of us. We were told we would get another care worker at night, but it hasn't happened".

Staff were aware of their responsibilities, accountabilities and the need to maintain professionalism. However, throughout the inspection we saw that staff were under pressure to carry out their roles adequately and provide care and support. We saw examples of staff ignoring people, continually telling people they must wait for their care and having poor interactions with people. The lack of a supportive, positive culture and dissatisfaction with the service had impacted on the ability of staff to deliver care and maintain their professional integrity. This was reflected in the quality of care that some people received and in the feedback that people gave us. The culture of a service directly affects the quality of life of people.

The above evidence demonstrated that people were placed at risk as the provider did not have effective systems to monitor and improve the service, and several improvement plans for concerns previously identified had not been put in place. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.