Buckland Care Limited

Kingland House Nursing & Residential Home

Inspection report

Kingland House
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16 February 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 15 and 16 February 2016. Two inspectors visited the service on 15 February 2016 and one inspector visited on 16 February 2016. On both days of the inspection we were accompanied by a dietitian specialist advisor.

Kingland House Nursing & Residential Home is registered to provide accommodation for up to 44 people who require nursing or personal care. At the time of the inspection there were 41 people living at the home. There was a new registered manager in place. 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.

At the last inspection we found that people were not safely supported because the medicines management system was not safe. At this inspection we found that people were safely supported with their medicines.

At this inspection we found that people who were more independent were satisfied with the service they received. One person told us, "Everything is lovely", and a family member said, "Staff have been very good and supportive".

Staff were warm, friendly and caring towards people. Staff smiled with people and gave them time to say what they wanted to.

People's consent was sought before staff assisted them and people were supported to access healthcare professionals when they needed to.

Complaints information was displayed and there was a consistent system for investigating, managing and responding to complaints.

We received positive feedback about the new manager in terms of the changes they had started to implement, and the support they provided to staff.

However, at this inspection we identified four new breaches of the regulations.

Risks to people's safety were not consistently assessed and managed to minimise risks. For example, we identified people who were at risk of choking because staff were not supporting them to drink fluids in a safe way. In addition, nutritional risks were not accurately assessed or managed.

Care plans were not updated or did not include all the information staff needed to be able to care for people. For example, one person had lost weight, however their care plan review did not note this or provide guidance to staff on how best to support the individual with their nutrition.

Staff had not been supported to have the knowledge they required to effectively and safely care or support people.

The systems in place for assessing and monitoring the quality and safety of the service were not effective. This was because the shortfalls we found had not been identified by the service.

CQC is now considering the appropriate regulatory response to the shortfalls we found. Where providers are not meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

People were not kept safe at the home.

Risks to people were not managed to make sure they received safe care.

People told us they felt safe. However, we identified some issues with the safeguarding system that meant people were at risk of not being safeguarded against abuse.

Medicines were managed safely.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff training was insufficient to ensure people were effectively cared for or supported.

People's consent was sought before staff assisted them and where people lacked mental capacity, best interests decisions were made in accordance with legislation.

People were supported to access healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

Staff were respectful and polite when they were supporting people.

People and their relatives told us staff were mostly kind and caring.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care delivery was affected because staff did not have easy access to guidance that would have enabled them to support people in a person centred way.

Care plans were reviewed but this did not always lead to accurate information in people's care records.

There was an effective complaints system in place.

Is the service well-led?

Requires Improvement

The home was not always well-led.

There was a newly registered manager in post. We received positive feedback about the changes they had started to implement, and the support they provided to staff.

There were ineffective systems in place to monitor the quality of the service.

The governance systems were not effective and did not ensure people were cared for safely.

Kingland House Nursing & Residential Home

Detailed findings

Background to this inspection

This unannounced inspection took place on 15 and 16 February 2016. Two inspectors visited the service on 15 February 2016 and one inspector visited on 16 February 2016. On both days of the inspection we were accompanied by a dietitian specialist advisor.

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.

As part of the inspection we spoke with 16 people who lived at the home. We looked at five people's care, treatment and support records in full, and sampled specific care records for most of the people who lived at the home. We also looked at records relating to the management of the service including staffing rotas, staff recruitment, appraisal and training records, accident and incident records, premises maintenance records, staff meeting minutes and medicine administration records.

We spoke with the manager, the deputy manager and the general manager. We also spoke with eight other members of the staff team. As part of the inspection we talked with four healthcare professionals and five family members.

Before our inspection, we reviewed the information we held about the service. We also looked at information about incidents the provider had notified us of, and requested information from the local authority.

Inadequate

Is the service safe?

Our findings

People who were able to tell us about their experience of the home said they felt safe. Relatives we spoke with told us their family member was safely cared for. However, we found that some people were not cared for or supported safely.

At the last inspection we found a breach of the regulations regarding medicines management because the provider did not have a safe system in place to manage people's medicines. At this inspection people's medicines were managed so that they received them safely. Medicines were stored safely and there were systems in place for storing medicines that needed refrigeration. The medication administration records (MAR), which contained a photograph of the person and noted any allergies, were well maintained. Some people required PRN (as needed) medicines, and plans were in place so that staff knew when and how often to administer these medicines. Staff had received medicines training and the manager had developed a new system of checking staff were competent to administer medicines safely. A medicines audit had been undertaken that had identified some issues, but these had not been acted upon. This is an area of improvement.

Risks were not always managed so that people were protected. Risks to people were not fully assessed and management plans were not always in place or followed by staff to minimise these risks. The home had equipment to weigh people who were at nutritional risk. However, the weighing scales were not working properly and had not been serviced or repaired. This meant that staff did not have the appropriate equipment to protect people who were at risk because of their weight. Staff completed malnutrition risk assessments (MUST). These included records of people's body mass (BMI) to enable them to assess when people were at risk from weight loss or gain and take action. However, in addition to the weighing scales issues we found some people's BMIs were inaccurately recorded and others showed action was required but this had not been taken. Staff audited malnutrition risk assessments to check that they were supporting people safely. However, this was not effective as it had not led staff to act on the issues the audit identified.

The home used other specialist equipment to maintain people's health such as pressure relieving mattresses. Some people's pressure relieving mattresses were fixed at the wrong setting. This meant they were not working effectively and posed a risk to people's skin integrity.

Some people who had difficulty swallowing were at risk of choking because staff gave them drinks that were not thickened to the right consistency. They were not supported to eat and drink as directed in the safe swallow plans written by their speech and language therapists (SALT). For example, during the first day of the inspection one person's fluids were not thickened as detailed in their SALT plan. Staff were aware that the person needed to have their fluids thickened and the person's safe swallow plan was visible to staff within their bedroom. However, we found unthickened fluids on their bedside cabinet. This placed them at risk of choking and aspiration because staff may have given the drink to the person. Another person who had a safe swallow plan had an unthickened drink placed in front of them during the lunchtime meal. We drew this to the attention of staff who removed the drink.

We fed this back to the manager during the inspection. The manager took action by speaking with staff in handover and speaking with kitchen staff. However, this was not effective because we found further people on the second day of the inspection that were placed at risk of choking and aspiration. For example, we visited another person and found they had a safe swallow plan visible in their bedroom that stated drink needed to be of custard consistency. We saw they were independently drinking a hot, unthickened drink. A member of staff told us that this person required thickener to ensure their safety. We asked the person's permission and removed the drink. We took it to the manager to draw their attention to the risks this posed to that individual.

In addition we checked the person who had been placed at risk of choking on the first day of the inspection. We visited their room and found an unthickened hot drink on their bedside table. We also noted inaccurate guidance for staff was displayed in the kitchen/dining area about how this person needed to be safely supported. This placed them at risk of choking and aspiration because staff had incorrect guidance in one area, and were not following correctly the guidance which was displayed in the person's bedroom.

We raised our serious concerns with the manager who took immediate action to safeguard these people.

We also found that whilst most containers of thicker were stored safely in line with National patient safety guidance, there were two instances where thickener was accessible to people. We asked the manager about this. They were not aware of the national patient safety guidance.

On the first day of the inspection at 12:25 pm we visited one person in their room. They were fully dressed and in their bed which had no sheet or duvet. The bed had bed rails. The bed rail protectors were not in place and the person had their leg crooked through the bed rail. The manager and other staff members told us the person was sometimes cared for in bed for their and other people's safety. This meant there was a risk that this person was inappropriately restrained because they were confined to their bed.

We immediately asked the manager to ensure this person was not placed at risk of entrapment in the bed rail, or inappropriate restraint. The manager took action to ensure the person was as safe as possible. However, staff had not put measures in place to safeguard this person before our intervention.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as risks to people were not accurately assessed or managed.

Staff recognised signs of abuse and understood what action to take if they were worried or concerned about someone. The home kept a safeguarding log to make sure they were aware of allegations of abuse and knew what action they needed to take. However, we identified two instances where an alert had been made that were not in the log. The manager could not provide us with information about one of these concerns. This meant there was a risk that staff did not know what they needed to do to keep people safe.

We looked at four staff recruitment records. Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. These checks included the use of application forms, an interview, reference checks and criminal record checks. This made sure that people were protected as far as possible from staff who were known to be unsuitable.

The manager had assessed people's dependency and so understood the needs of people and the required staffing. We checked staff rotas and asked the manager for information about the numbers of staff on duty. We found that the manager was on duty Monday to Friday and the deputy worked a range of hours including weekends. This meant there was management cover in place that enabled staff to seek guidance when they

needed to. In addition, there was nurse cover on each shift and during the day people were supported by between six and seven care workers and one senior care worker. At night people were supported by one RGN and three to four care workers. The increase to four care workers at night had recently been agreed by the provider following a request from the manager. Staff told us there were enough staff on duty but that sometimes they needed additional staff. For example one staff member said staffing levels depended, "How the day goes, if there is a problem can fall behind". Another member of the staff team told us, "Usually ok, we struggle sometimes". We asked another staff member whether there were enough staff on duty and they said, "Just about".

On the first day of the inspection the home had a calm and unhurried feel. On the second day of the inspection call bells rang for longer periods of time, and staff appeared more task focussed. The manager told us they were aware that due to people's high dependency they needed to carefully consider future admissions to ensure there remained sufficient staff on duty.

There was an accidents and incidents system in place that recorded and investigated any accidents and incidents. The manager analysed trends and patterns and put in place measures to reduce the risk of reoccurrence. For example, they had identified a pattern of people falling in the lounge area. These falls were largely in the afternoon and were unwitnessed. To mitigate this, the manager had made changes to ensure there was always a care worker in the lounge. This reduced the risk that people would fall, and meant that staff would be able to take immediate action and helped them understand what had caused the person to fall.

Requires Improvement

Is the service effective?

Our findings

People told us that staff tried hard to help them, although they were often very busy. They said that staff knew what they were doing.

However, we found staff had not been supported to provide effective care based on good practice because they had not received up to date training. For example, we identified serious concerns about how people were supported to drink safely. The staff training matrix recorded either that staff had not been trained or where staff had been trained, that this had not been updated since 2014. Some training had been completed such as manual handling and the Mental Capacity Act 2005, and first aid training was taking place on the day of the inspection. However, the training matrix showed a significant number of staff who either had not received the training they needed to support people effectively, or whose training was out of date.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff supervisions and appraisals were out of date. However, staff told us they could seek informal advice and guidance whenever they needed to and said that they felt supported by the manager. One staff member commented, "Informal support is always there". The manager showed us the supervision and appraisals system they had developed. This showed they had a new system in place that would enable staff to receive effective support.

Staff told us they knew how people were, and what their needs were because the home had effective communication systems. For example, staff had handovers twice a day to enable staff coming on duty to learn how people had been and follow up on any problems that had been identified. The manager attended handover meetings most days to make sure they understood how people who lived in their home were, and to support staff where this was required.

Consent to care and treatment was sought in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed.

Some people who lived at the home had mental capacity to make their own decisions. We talked with them and they told us staff listened to the choices they made and acted upon them. Where staff were concerned that someone might lack mental capacity to make a specific decision, assessments of their capacity had been undertaken. These led to best interests decisions taken in accordance with the legislation.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). These safeguards can only be used when there is no

other way of supporting a person safely. The responsibility for applying to authorise a deprivation of liberty rested with the manager. We looked at whether the service was applying the DoLS appropriately. The manager had made the appropriate applications and had a system in place to alert them when they needed to review whether a further application was required. However, we found one person had conditions attached to their authorisation which the manager had not been aware of.

Kitchen staff ensured food was safe for people by checking temperatures of meals, regular stock rotation, checking fridge and freezer temperatures and making sure food was used or disposed of before its use by dates. One person told us the food was, "Lovely", and another person said they were, "Well fed".

We observed a mealtime during the inspection. Food looked appetising and was well presented. People were supported to eat their meal although the pace of support was quite hurried because there were only four staff attempting to support 29 people to eat their meal. Staff told us the numbers of staff on duty in the dining room had reduced because more people were being supported to eat their meal in their bedroom as their care needs increased. Some people had eating aids but other people struggled to eat their meal independently. Their independence could have been better promoted with the use of eating aids such as adapted cutlery and plate guards. Some people's records noted they had allergies to specific foods. However, staff were unaware of these and our review of their care records suggested that these might be dislikes to a particular food rather than an allergy.

People were supported to access healthcare services and received on-going healthcare support. Records showed and people told us that they saw their GP or nurse when they needed to. We spoke with other healthcare professionals and they told us that they had seen significant improvements in people's healthcare following the appointment of the newly registered manager.

Good

Is the service caring?

Our findings

People told us staff were caring. We received a range of comments from people which included, "Staff are always very pleasant", and "Nice and kind, they are friendly", and "They talk to you in a very friendly manner".

We saw staff were friendly and caring towards people. Staff smiled with people and gave them time to say what they wanted to. Staff knew people well and were able to tell us about the people whose care plans we looked at.

Observations showed good interactions between staff and people who lived at the home. For example, during an activities session we saw the staff member explaining what they were doing and making sure all the people were engaged and involved. They had a warm conversational style, and people were smiling and joining in with the session.

We saw that staff knocked at people's bedroom doors before they went into their room, and people confirmed that staff respected their privacy. Some people had little stimulation when they were mainly cared for in their bedroom. This is an area for improvement.

The manager told us staff were beginning to have conversations with people about their end of life care wishes. People's care records did not have a great deal of information that would enable staff to understand people's needs and wishes.

Requires Improvement

Is the service responsive?

Our findings

People who were able to talk with us told us that staff made efforts to respond to their needs, and that they felt confident they raise a concern with the manager.

People's needs were assessed before they came to live at the home. This was to make sure staff understood their needs and were confident they could meet them.

People's assessment information helped staff develop care plans about how someone wanted or needed to be supported. Care plans covered a variety of needs including skin integrity, nutrition and hydration, continence, cognition and sleep. Staff were further supported by smaller room files that provided information about an individual's personal care and mobility needs.

People's care records were not well organised which meant it was difficult to easily understand specific aspects of people's care needs. In addition, people's room files primarily contained task related information. This meant that valuable information about the person was not easily accessible to staff. For example, one person required support with personal and continence care and sometimes was reluctant to allow staff to support them. Staff could have used a variety of different approaches to support and encourage the individual but they did not have easy access to the information that could have helped them to better understand how to support this person.

Care plans were reviewed regularly, however this did not always lead to changes in the plans. For example, one person was not eating well and staff told us this was because of their cognitive impairment. However, the person's weight loss and lack of appetite was not reflected in their care plan review.

Staff did not always act on the information in care plans. For example, one person's records showed that they liked to have the television or radio on in their bedroom, and that they needed to wear glasses. However, when we visited them they were not wearing glasses and their TV and radio were switched off.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care plans did not contain up to date information and care was not always delivered in accordance with people's plans.

On the first day of the inspection call bells did not ring for long periods of time. However, on the second day of the inspection call bells rang for longer periods. The manager told us that they had not completed any call bell audits to enable them to identify any problems or peak times where people were not being responded to promptly.

The home had a complaints policy and this was publicised in communal areas. There was information on what to do if someone was unhappy or worried about something. This included contact details for external organisations people or staff could contact if they wanted to raise a concern about the service. People and relatives told us they knew how to raise a concern or complaint and were confident these would be acted

upon. We reviewed the complaints the home had received in the past year; these were investigated in accordance with their policy.

Requires Improvement

Is the service well-led?

Our findings

We spoke with relatives and they were positive about the care their family member received, and the improvements in the home. One relative told us there was a, "Different atmosphere in the home since the manager had taken over".

The manager was newly registered at the time of the inspection. They had started to make changes that were improving the quality of service people received. We saw examples of improvements they had made. These included the introduction of a pain scale to enable staff to understand people's pain when they could not express this easily. They had also made changes to ways of working to improve people's experience and safety. These included changes to the care worker rota to make sure people were supported whilst they were in the lounge area. The manager was fairly new to the local area and was identifying community resources such as the Alzheimer's Society to further improve staff knowledge and people's experiences of living at the home.

The manager used a variety of methods to ensure they knew how people were and could assess the quality of people's experiences. For example, they walked around the home each day, visiting people in their bedrooms and sitting in the dining area to check how people were. The manager told us they held quarterly residents meetings to make sure people could make suggestions or raise concerns. The manager had recently held a relatives meeting although no one had attended. There was also a comments box in the reception area where people could make a suggestion, ask questions or raise a concern. The manager told us the comments box was used and they acted on suggestions. For example, they had changed the brand of lemon squash as a result of a comment.

The provider had a whistle blowing policy and staff read this during their induction period. The manager was planning to discuss whistle blowing at the next staff meeting to make sure staff knew how they could raise a concern either within the service or with external organisations. The manager told us they had an open door policy and staff confirmed this.

Staff told us the service had improved as a result of the appointment of the manager. They described an open, transparent approach which enabled them to raise concerns or make suggestions, and gain the support they needed promptly. We received a range of positive comments about the manager from staff. These included, "Nice, better than the old one" and, "I like them, if I need some help they never say no" and, "It's the best it's been".

Learning from safeguarding incidents and complaints was shared with staff at handovers and staff meetings. Staff and managers undertook a variety of audits to check the service people received was of a good quality. These included room and care plan audits, medicines and weight audits and overall audits of the home. However, the audits completed by staff were not effective because they had not identified the issues we found. In addition the governance systems were not effective. For example, the manager was not fully aware of one safeguarding concern. This led to a risk that the actions that needed to be taken would not have been shared with staff. The DoLS system was not fully effective because it did not identify any conditions attached

to the authorisation. The manager told us that no-one living at the home had any conditions. However, records showed that one person did. Whilst the home had attempted to adhere to the conditions as part of the person's care plan they were not aware that the conditions were there. Records also showed that some people had allergies. Our discussions with staff showed the allergies identified might not be accurate, and some staff were also unaware of them.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the governance systems did not ensure people received safe, effective care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care that met their needs. People's care records did not always accurately reflect their assessed need.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems in place were ineffective and did not identify the issues found in the inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not been supported to receive the training they required to meet the needs of the people they cared for and supported.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People received unsafe care and treatment because risks were not mitigated to their safety and some equipment was not working properly.

The enforcement action we took:

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