Colville Care Limited

Kite Hill Nursing Home

Inspection report

Kite Hill
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Date of inspection visit:
25 October 2018
30 October 2018

Date of publication:
30 November 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 25 and 30 October 2018 and was unannounced.

Kite Hill Nursing Home is registered to provide accommodation for up to 30 older people. There were 28 people living at the home at the time of the inspection. The home is a large extended property and accommodation is arranged over two floors. All bedrooms were for single occupancy and many had ensuite facilities. Bathrooms and toilets were provided on both floors. There was a lift and stairs available to access the first floor. There was also an external lift to facilitate access to a patio and rear garden area.

Kite Hill Nursing Home is a 'care home'. People in care homes receive accommodation, nursing and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. We found the home to be clean and well maintained throughout the inspection.

A registered manager was 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.

Quality assurance process had not identified areas for improvement found during this inspection, including around the safe management of all medicines, risk management systems, wound care and inconsistencies in care plans. When we identified concerns to the provider's nominated individual and the registered manager took action or committed to consider how things could be improved.

The premises and equipment were safely maintained. Incidents or accidents were reviewed and action taken to reduce the likelihood of any reoccurrence.

Sufficient numbers of care and ancillary staff were deployed to meet people's needs. Checks were made to ensure staff were suitable to work in a care setting. Staff were trained and felt supported and valued.

People's nutritional needs were assessed and people were supported to eat and drink. There was a choice of food. People's health care needs were monitored and referrals were made to other services appropriately to ensure there was a coordinated approach to people's care.

People were treated with kindness, respect and compassion. People's privacy and dignity were promoted. People were supported to have choice and control of their lives and staff promoted independence where possible.

Care and support were centred on the individual needs of each person and staff responded promptly when people's needs changed. People and external health professionals were positive about the service people

received.

Staff supported people to receive end of life care that helped ensure their comfort and their dignity. Activities were provided seven days per week offering a range of mental and physical stimulation.

There was an effective complaints procedure in place. People and their relatives confirmed they were listened to and changes were made when requested.

Staff were organised, motivated and worked well as a team. They felt supported and valued by the management team.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always receive their medicines in a safe way.

Equipment to help reduce the risk of pressure injury was not always used safely. Other individual risks and environmental risks to people were managed effectively.

Staff understood their safeguarding responsibilities and knew how to identify, prevent and report abuse.

There were enough staff deployed to meet people's needs. Recruitment practices helped ensure only suitable staff were employed.

There were appropriate systems in place to protect people by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People's care and treatment was not always delivered in line with current legislation, standards and evidence based guidance to achieve effective outcomes.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff felt supported although the providers policy for regular recorded supervisions had not always been followed.

Staff followed legislation designed to protect people's rights and freedom.

People were supported to eat and drink enough and had access to health professionals and specialists when needed.

When people were transferred to hospital, staff ensured key information accompanied them to help ensure their received ongoing healthcare support.

Adaptations had been made to the environment to make it supportive of people who lived at the home.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion at all times.

Staff interacted positively with people and promoted their independence. Staff protected people's privacy and respected their dignity.

Staff supported people to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

Care and support were centred on the individual needs of each person. Care plans were developed in conjunction with the person or their family members and staff responded promptly when people's needs changed.

The provider was looking to increase the range and amount of activities available to people to ensure they received an adequate level of mental and physical stimulation.

Staff had the necessary training and commitment to support people to receive end of life care that helped ensure their comfort and their dignity.

People knew how to raise a complaint and there was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance process had not identified areas for improvement found during this inspection. The registered manager responded promptly when we identified areas for improvement.

People were happy living at the home and had confidence in the management.

Staff were organised, motivated and worked well as a team. They

felt supported and valued by the management team. People described an open culture. Visitors were welcomed at any time.	

Kite Hill 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 25 and 30 October 2018 and was unannounced.

The inspection was undertaken by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed information within the Provider Information Return (PIR) which was completed in January 2018. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 13 people living at the home and eight visitors. We spoke with the nominated individual (provider's legal representative), registered manager, two nurses and five care staff. We also spoke with ancillary staff including, a catering staff member, two activities staff members, a maintenance staff member, an administrator and two housekeeping staff. During the inspection we received feedback from a visiting healthcare professional.

We looked at care plans and associated records for six people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance.

We observed care, support and activities being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People did not always receive their medicines in a safe way. Several people had been assessed by a Speech and Language Therapist (SaLT) as requiring their meals in a pureed [no lumps] texture due to swallowing difficulties and high risk of choking. However, nurses were administering tablets and capsules to these people, placing them at high risk of choking. We found that there were no additional risk assessments or best interest decisions which had been completed relating to this risk, or further guidance sought from SaLT. This meant that these people were consistently being placed at risk of choking on medicines which were not in a suitable form for them to swallow safely.

Nursing staff told us that one person was prescribed a large capsule of a slow release medicine. Slow release capsules are designed to release the medicine over a period of time once in the person's stomach. Nursing staff told us they were opening the capsule and administering the contents this way to the person as they were unable to swallow the capsule safely. This meant that the slow release aspect of the medicine would no longer be effective. The person would receive the whole amount of the medicine at one time and not over a period of time as prescribed. Three months prior to the inspection, nursing staff had contacted the person's doctor to request the medicine in a liquid format, however they had not followed this up and although aware of the risk, had continued to administer the medicine in an unsafe way. The registered manager could not explain why this had not been further followed up with the person's doctor.

Medicines were not always stored in a safe way to ensure they remained effective and safe for use. Some medicines were required to be kept at a cooler temperature and were stored in a locked medicines fridge. Nursing staff were recording the temperature of the fridge. Records showed that throughout September and October 2018 maximum and minimum temperatures had repeated been lower or higher than is considered safe for the storage of medicines. Records also showed that on occasions the actual temperature at the time of recording was lower than safe for the storage of medicines. The recording tool contained a space to comment on any action taken but this was not completed. Other medicines were stored in two secure medicines trolleys located on the ground and first floor of the building and additional stocks were in a locked cupboard. Whilst recordings were being made of the temperature in the cupboard there was no process in place to record the temperature of the medicines trolleys. The failure to ensure all medicines were stored at safe temperatures meant these medicines may no longer be safe for administration.

One person was prescribed medicine to be administered when required. However, there was a lack of clear information as to when this should be administered. The person's care plan stated this should be administered if the person was distressed however it did not detail how the person behaved when distressed. When this had been administered there was no additional information to show why this had been required. For people prescribed 'as required' medicines (PRN), there was a lack of recording of the effectiveness of their action. This information would be needed to determine if the PRN medicines had resolved the problem or if alternative medicine or action was required.

Best practice guidance states that staff who administer medicines should have their competency assessed on an annual basis. The registered manager told us this was not occurring, although they were aware of the

need for this and were in the process of identifying a suitable competency assessment. Medicines audits were undertaken; however, these had not identified the areas of concern we found in respect of the management of medicines.

The failure to ensure people received their medicines safely was a breach of Regulation 12 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

Despite the comments above, people told us they received their medicines as prescribed. One person told us, "They [staff] do that [medicines], they always seem to remember them." The person also confirmed they could receive additional medicines such as for a headache, if they asked for it. At the previous inspection in April 2016 we identified that where a person was self-administering their medicines this was not managed safely. At this inspection nobody was self-administering medicines. The registered manager was aware of how this should be managed safely if required. There were appropriate systems in place to ensure adequate supplies of medicines were available for people and these could be obtained promptly should there be any amendments to prescriptions. Medicines administration records (MARs), recorded that people were receiving their medicines as prescribed. Systems were in place to ensure that prescribed topical creams were applied and managed safely.

Not all risks to people were effectively managed. For many people, risk assessments had identified that they were at medium or high risk of developing skin damage due to pressure injuries. Where this was the case, most people had been provided with an alternating airflow mattress, which works to reduce pressure on the body and reduce the risk of pressure injuries. However, we found that where mattresses were being used, they were not set at the correct setting, according to the person's weight, placing the person at risk of a pressure injury. Furthermore, there was no system in place to check mattress settings regularly, to ensure they were being used correctly. For one person, their risk assessment and care plan stated they required an alternating airflow pressure relieving mattress, however we found this was not in place for them. We spoke with the person, who told us their mattress had broken several weeks previously and been removed but not replaced. The registered manager was unable to explain why this person was not cared for on a suitable mattress as identified in their care plan. For another person, their care plan stated they should be seated on a pressure reducing cushion, however we saw this was not in use. This meant people's risk of developing a pressure injury was not being managed as per their care plan and risk assessment.

On the second day of the inspection, the registered manager told us a system had been implemented to check that pressure mattresses were being used correctly and the person who had previously been without an airflow mattress now had one in place.

Staff were aware of the risks posed by fluid thickening powder if consumed in its dry powder form. The registered manager told us that where this was prescribed, the provider's policy stated the powder should be stored securely in a locked drawer in the person's bedroom. For one person, we found the drawer was unlocked and an empty tin of powder was within this drawer. The registered manager was unable to find the key meaning that the drawer could not be locked and therefore the powder could not have been stored safely as per the provider's policy. This was corrected on the second day of the inspection.

Other risks were being managed safely. Risk assessments had been completed for identified risks, together with action staff needed to take to reduce the risks. These included the risk of people falling, nutrition and moving and repositioning. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm. Staff had been trained to support people to move safely and we saw equipment, such as slide sheets used for moving people safely in bed, were available for all people who required these. Staff explained the risks relating to individual people

and what action they needed to take to mitigate these risks.

Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. For example, where people had fallen, records showed the person had been monitored for any head injuries, assessments were completed of all known risk factors and additional measures put in place to protect the person where possible. All incidents and accidents were reviewed with the management team to identify any patterns or trends.

Environmental risks were assessed and managed appropriately. Risks associated with the environment and the running of the home had been assessed and actions to mitigate risks were in place. Environmental risk assessments were robust and were reviewed as and when required and as part of the provider's quality monitoring procedures. They included the use of electrical equipment and fire risks. Cleaning chemicals and other substances hazardous to health (COSHH) were stored securely.

There were clear emergency procedures in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Nursing staff had undertaken first aid training. A call bell system was located within all areas of the home and staff told us this included an emergency button, meaning staff could get prompt support in an emergency. Emergency suction and resuscitation equipment was available should this be required.

People, their relatives and a visiting health professional said they felt the service was safe. People's comments included; "I feel really happy and safe here", "This home is excellent, well run with good friendly staff who make me feel safe and comfortable" and another said, "I am very happy here and think the home is well run and I feel safe."

Staff had received training in safeguarding adults and were able to discuss their understanding of their responsibilities and the responsibilities of others. We spoke with staff including registered nurses, care staff, activity co-ordinators and housekeeping staff, who were confident in recognising signs of potential abuse and how to report and respond to concerns. One staff member said, "I would go to [the registered manager] and if they didn't take action, I would pick up the phone and contact you or the safeguarding team", another said "I would definitely speak to [the registered manager] and tell CQC or safeguarding if I wasn't happy." The service had a clear policy in place to support people to know how to respond and report safeguarding concerns and saw safeguarding flow charts for staff were visible in accessible areas. Staff also commented on their training and stated, "We have all done training in safeguarding, the numbers are [location of safeguarding teams numbers] if we needed them. I would tell [the registered manager] or I could also go to one of the owners." The registered manager explained the action they would take if they had a safeguarding concern. The action described would ensure the person's safety and help reduce the risk of any further concerns.

People told us staff were available when they needed them. One person said, "The staff are available for me, I do not feel rushed." Another person said, "The staff are available when I need them." A visitor told us, "There are always staff around."

There were sufficient numbers of care and ancillary staff on duty to meet people's needs. People told us staff responded promptly to call bells. One person said, "Staff respond to call buttons quite quickly." The registered manager told us that there were problems recruiting registered nurses and although ideally, they should have two nurses on duty in the morning, this was not possible. The registered manager, who was also a registered nurse, stated that they often worked alongside a nurse on duty, which enabled them to

provide support, such as administering medicines. This meant the risk of not having a second nurse on duty was mitigated. The registered manager stated that when they were working in addition to a registered nurse they could provide support such as undertaking some of the medicines administration round. When necessary, shortages of nurses were covered by nursing staff from another nursing home owned by the provider, located close by.

The registered manager told us staffing levels were based on the needs of the people using the service. There was a duty roster system in place, which detailed the planned cover for the home. This provided the opportunity for short term absences, such as those due to staff sickness, to be managed using agency staff and existing staff working additional hours. Care staff felt that staffing levels were suitable to meet people's needs. Staff comments included, "They [management team] will always try to get agency staff if we are going to be short, such as if someone [staff] is unwell."

Safe and effective recruitment processes were in place. There was a clear recruitment pathway which ensured all new staff underwent relevant pre-employment checks, including obtaining references and disclosure and barring service (DBS) checks before they commenced employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. During the inspection, we looked at three staff recruitment files, which confirmed these processes had been followed. Additional checks were completed where the employee was a registered nurse, to ensure their fitness to practice with the Nursing and Midwifery Council (NMC) register. We also spoke with a recently employed registered nurse and care staff member who confirmed pre-employment checks had been completed and they had received an interview. The registered manager stated they considered candidates answers at their interview to ensure staff recruited reflected the service values of being "compassionate" and "thoughtful".

People were protected from risk of infection and there was a dedicated housekeeping team responsible for daily and deep cleaning tasks in people's bedrooms and communal areas. One person commented, "I feel this is a lovely, clean and safe home, with a good safe environment and well run by all." Another person said, "The home is very clean and tidy with good friendly staff making it a safe place to live." Staff received infection control training and had a good understanding of their individual roles and responsibilities. Housekeeping staff kept daily recordings and used colour coding to prioritise actions needed, for example where additional cleaning tasks were required on a weekly basis to maintain the environment.

The service sought advice and guidance from the local infection control team and had processes and flow charts in place to reflect best practice guidance, along with monthly and annual auditing. Staff confirmed they had plenty of personal protective equipment available, such as single use gloves and aprons and these were observed to be used consistently by all staff across the service. The registered manager maintained oversight of infection control policies and appropriately described how they managed any specific infection concerns. Best practice guidance was in place and available to all staff around specific infection risks, for example Department of Health publications. The laundry room was being refurbished to provide greater storage for people's clothing and appropriate processes were in place to minimise potential cross infection risks in relation to soiled items.

Requires Improvement

Is the service effective?

Our findings

People's care and treatment was not always delivered in line with current legislation, standards and evidence based guidance to achieve effective outcomes. For example, where people had wounds, which required regular monitoring and redressing, nursing staff were not ensuring that safe and effective processes were being followed. We reviewed the wound management records for all people who were having regular wound care. Although the provider had a formal process in place for the assessment and recording of wound care, this was not being followed by nursing staff. No photographs were available for any of the wounds. Photographs help when staff are reassessing wounds, especially if there is a change of nursing staff who undertook the previous assessment. The registered manager agreed photographs would help when reviewing wounds and that their inclusion would reflect best practise for wound care. For several people's wounds we found documentation had not been kept up to date, including when there had been an indication of a change in the wound and changes in the type of dressing used. The registered manager confirmed that for one person's wound, which had been redressed the day prior to the inspection, the dressing and covering used was inappropriate and was placing the person at risk of an infection, as this would not provide a waterproof barrier. The registered manager ensured this was redressed using an appropriate dressing.

Systems had not ensured that where people received their nutrition via a PEG this was managed correctly and that the required fluids were always provided for the person. A PEG is a tube which allows liquid nutrition to be received directly into the person's digestive tract. We viewed the records of nutrition and fluids provided for a person and found these were confusing and did not record the amount of fluid being provided each day. Permanent nursing staff could describe how the person's hydration needs were met, however some nursing shifts were covered by nurses not permanently employed at the home and where this had occurred we were unable to confirm if the person had received all prescribed fluids. The registered manager and provider's nominated individual agreed that the documentation was inadequate. On the second day of the inspection, new documentation was in place. This was clearer and a change in the administration regime had been introduced. A nursing staff member told us how this had benefited the person who was now less disturbed at night, meaning they were sleeping better. In addition, they told us the person was having more of their fluids when sat upright in a chair and was coughing less, indicating the risk of aspiration on fluids was reduced.

Otherwise where people had specific needs in relation to their health, there were systems in place to ensure they received the necessary care required. Records showed people had regular appointments with health professionals, such as chiropodists, opticians, dentists and doctors. All appointments with health professionals and the outcomes of consultations were recorded in detail, showing staff identified medical needs and sought appropriate treatment promptly. A visiting health professional told us, "The nursing staff are good, they use common sense." They also commented that there was good communication between the home and local doctor's surgery, which "helped continuity of care." The registered manager said they always requested medical information at the time of a person's admission to the home. They identified that this helped ensure they were aware of the person's complete medical history, meaning this could be considered as part of the care planning process. Should a person require hospital treatment in an

emergency, there was key individual information prepared to ensure hospital staff understood the person's needs and how these should be met.

People told us staff knew how to care for them and told us their health and personal care needs were met. A person told us, "I don't think there is anything more the staff can do for me that they are not already doing." Another person said, "Staff do a good job of looking after me." A visitor said their relative always looked clean and well-presented, indicating personal care needs were being met. Care staff described the care and support provided to various people which corresponded to information we had viewed in their care plans.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. New staff were supported to complete an induction programme which included shadowing experienced staff and undertaking the Care Certificate. This sets out the standards people working in adult social care need to meet before they can safely work unsupervised. Records showed staff had completed training when first employed; however, they were not all up to date with refresher training, as required by the provider's training policy. The registered manager said they were reminding and encouraging staff to complete all training. Much of this was provided via computer and required staff to complete a knowledge check following this. The nominated individual had completed training to enable them to provide some practical training including moving and handling. Additional training courses were also available for registered nurses. One staff member said, "There is training." Another staff member told us they were completing a care qualification which they had been supported to undertake by the home.

Staff said they felt supported appropriately in their role. They said they felt able to approach the registered manager or the provider's nominated individual if they had any concerns or suggestions for the improvement of the service. However, they had not all received recent or regular individual support meetings with the registered manager or their team leaders. The registered manager acknowledged that individual meetings had not been occurring as frequently as per the provider's policy. The registered manager was completing annual appraisals for staff who had worked at the home for longer than a year. Records viewed showed this was a formal process. An on-call system provided staff with access to a member of the management team when one was not immediately available in the home.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People told us that staff asked for their consent when they were supporting them. One person said, "They [staff] seek my consent before helping me." Staff had received training about the MCA and understood how to support people in line with the principles of the Act. The registered manager and provider's nominated individual had identified that the computerised care planning and management system in use was not enabling them to be fully compliant with the principles of the MCA. They were addressing this issue at the time of the inspection. The registered manager was undertaking additional assessments of people's ability to consent to specific aspects of their care. Where this showed they lacked the ability to give consent, a best interest decision involving relevant people had been made.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager had applied for DoLS for people that required these. Where DoLS had been approved by the local authority, there was a system in place to ensure any individual

conditions were known and complied with. There was also a process to ensure DoLS were reapplied for when necessary.

People were complimentary about the meals they received; one person said, "The food is very nice here and there is plenty to eat and drink." A visiting professional commented, "The food always smells good." People were given a choice between two set options at meal times and alternative snacks such as soups and sandwiches were also available on request. Where people had specific dietary requirements, there were assessments in place to identify possible risks and people were observed to have access to appropriate support. There were processes in place to inform kitchen staff of people's preferences and dietary requirements. The food on offer was observed to be of good quality and nutritious. Catering staff sought feedback from people and acted on this where appropriate to ensure people had an enjoyable experience. For example, the chef reflected, "One person said their food was bland so I spoke with them and added more spice to theirs and now they love it."

People were supported to eat their meals if required, which they could have in the communal dining area or their bedroom. People had access to regular hot and cold drinks throughout the day and staff supported people attentively and in a dignified manner. For example, by allowing people to be independent where possible and assisting only when required. Where appropriate, people's weight was monitored and action was taken when required. The chef ensured that food and drink available met people's individual needs, such as providing milkshakes and calorific options for those who required a greater nutritional intake.

The home had been adapted to support the needs of people living there. A passenger lift gave access to all floors and most bedrooms had en-suite facilities. There were handrails throughout the communal areas, which were painted in contrasting colours to make them easy for people to spot. There was level access to the home and to an outside decking area, providing a pleasant place to sit in warmer weather. An external lift provided access to the lower rear garden. There were systems in place to monitor the safety of the environment and to ensure redecoration occurred when required.

Staff made appropriate use of technology to support people. For example, movement alert equipment was used to alert staff of the need to support people when they moved to unsafe positions. An electronic call bell system allowed people to call for assistance when needed and we were told this would be upgraded to allow data to be analysed.

Good

Is the service caring?

Our findings

People were positive about the attitude and approach of staff. One person said, "The staff are very friendly and caring." Another person said, "This is a very safe home with good friendly staff." Visitors echoed these views, including one who told us, "The staff all do a good job in listening and caring for the residents." The registered manager told us staff would often bring in small treats for people, such as their favourite chocolate or other personal items that they knew the person would appreciate.

We observed positive and supportive interactions between people and staff. Staff engaged with people, checked they were comfortable, bent down to their level and used touch appropriately to reassure them. Staff could tell us about people's life histories and this information was also available within care plans. For example, they were aware of people's previous occupations and family members that were important to them. Staff were also able to tell us about people's individual preferences, such as what drink they liked or what name they preferred to be called. Care plans also contained information as to how the person's emotional and social needs should be met and what was important for them.

Staff expressed a commitment to treating people according to their individual needs, wishes and preferences. One staff member said, "We ask them [people] what they want – if they can't say, we have got to know them and know what they like." People and their relatives told us they were involved in discussing the support they wished to receive. A relative said, "I met with the manager [registered manager] before she [relative] came here. The manager [registered manager] asked lots of questions and staff have also asked us more things as we have gone along." Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. We heard people being offered choices throughout the inspection. People confirmed staff offered them choices and respected their wishes. For example, one relative said, "The staff stop and take time to listen to residents."

We noted that one bathroom did not have a screen or curtain at the window meaning people within the bathroom could be viewed from outside. We asked the registered manager about this and they were unsure why there was no screen present, but stated staff would "fix up a sheet or something when the bathroom was used." We spoke with the maintenance person who confirmed that they had been asked to provided screening for the window "some time ago" but identified that this had not been done. Once we raised this, the registered manager acted and arranged for screening to be put in place, which had occurred by the second day of the inspection.

Staff understood the importance of protecting people's privacy and dignity and ensuring people were happy to receive care before providing this. A person said, "I feel I am treated with dignity and respect." A relative confirmed this saying, "The staff do ask if it's ok before doing anything." All bedrooms were for single occupancy, many with ensuite facilities, which would help ensure privacy and dignity was maintained when personal care was provided. Staff described how they kept people covered as much as possible when providing personal care. One staff member said "I use a large towel and cover them [people] up. It helps keep them warm as well as protecting their dignity." Some people had asked to receive personal care from staff of a specific gender only. Staff were aware of these wishes and told us they always respected any such

requests.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. People's care plans included information as to what support they needed and what parts of personal care, such as washing their own face, they could do independently. At lunch time, we saw a range of adapted crockery and cups were provided when necessary, meaning people could continue to eat independently.

People's relationships with family and friends were encouraged and staff ensured family members were kept up to date with events that had occurred for their relative. One relative told us how staff always welcomed them when they visited and offered them a refreshment such as a hot drink. We saw staff knew visitors by name and welcomed them on their arrival. Visiting, including with pets such as dogs, was unrestricted.

During pre-admission assessments, the registered manager explored people's religious needs and staff supported people to follow their faith. The registered manager told us they explored other aspects of people's cultural, sexuality and diversity needs during ongoing discussions with people about their backgrounds, interests and beliefs. Staff had completed diversity training. During the inspection, we saw some visitors from a local church were providing a service for a person. The registered manager was aware of how to contact various religious or faith leaders should people request this.

Confidential information, such as care records, were kept in the registered managers office and only accessed by staff authorised to view them. Any information which was kept on the computer was also secure and password protected.

Good

Is the service responsive?

Our findings

Assessments of people's needs were completed by the registered manager before people moved into Kite Hill Nursing Home. This information was then used to develop a care plan in consultation with the person and their relatives, where appropriate. Care plans were developed using a computerised care planning system by the registered manager and updated and reviewed by nurses. Copies of essential parts of the care plans were printed so they were available for care staff in people's bedrooms should they need to check details when providing care for people.

Staff were aware of people's individual needs and how these should be met. One person told us "The staff are very supportive of my needs." Care staff could describe the care and support required by individual people. For example, one care staff member described the support a person required with their personal care and when mobilising. Another was able to describe how they cared for a person who required to remain in bed at all times. This corresponded to information within the person's care plan and was appropriate to ensure their needs were met. For one person who may have behaved in a way that placed themselves or staff at risk of injury there was clear information to guide staff. This included information about possible triggers such as situations which may result in unpredictable incidents as well as guidance for staff as to how they should respond. We joined staff for a handover between the morning and afternoon shift and saw that appropriate information was passed onto the next staff team. Staff told us that if they had a few days off, they were given additional information to ensure they were updated about any changes to people's needs. Staff were allocated to work in specific parts of the home, however they were clear that, should the need arise, they would always help staff working in other areas.

Staff kept records of the care and support they provided for people and these confirmed that people's needs had been met consistently. For example, they included 'turn charts' for people who needed support to reposition regularly and monitoring charts of the food and drink people received.

At the end of their lives, people were supported to have a comfortable, dignified and pain-free death however care plans did not reflect individual detail as to how this should be achieved. The registered manager was reviewing how this information could be included in a meaningful way within care plans. Although we identified that people's end of life wishes were not always recorded consistently within their care plans, staff were able to describe how they supported family members and people as they approached the end of their lives. The registered manager, nursing and care staff were able to describe how they supported family members and people as they approached the end of their lives. These discussions showed that people would be treated with kindness and compassion and staff would ensure they were as comfortable as possible. External health professionals would be involved to help ensure people received appropriate care to manage any symptoms.

Opportunities for mental and physical stimulation were provided everyday by activities staff and visiting activities providers. Most activities took place within the communal lounge area, however activities staff told us they also offered a range of activities to people who remained in their own bedrooms either by choice or due to their care needs. To support people to be orientated, activities were themed throughout the year,

such as creating crafts to celebrate and remember important historic events. Activities staff also encouraged community participation. For example, we saw pictures of a garden party that had be held to fundraise for a local donkey sanctuary and visits from a local girls' brigade to attend at Christmas for a musical and social event. Activities were planned daily, however this was flexible to people's interest and participation. People were also encouraged to interact together during activities and activities staff demonstrated a good understanding of people's likes, dislikes and approaches to encourage engagement, for example purchasing books and films residents had requested.

People and visitors were provided with information about how to complain or make comments about the service through information given to them during the admission process and information displayed at the entrance of the home. Relatives and people told us they had not had reason to complain, but knew how to if necessary. They said they would not hesitate to speak to the staff or the registered manager, who they said they saw regularly and was very approachable. Should complaints be received, there was a process in place which would ensure these were recorded, fully investigated and a written response provided to the person who made the complaint.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems in place were not always effective. They had not identified the areas of concern we found during this inspection in relation to: the safe management of medicines, risk management systems, wound care and inconsistencies in care plans. Where we raised identified concerns to the provider's nominated individual and the registered manager, action was taken to rectify the issues, or consideration was given to make improvements.

People were happy at Kite Hill Nursing Home. A person told us, "The staff are all happy working with residents and we have a laugh together." Another person said, "The management are prepared to listen and act." A visitor told us, "We are very happy with the level of care and support being given." People and visitors also felt the home was well run. One visitor said, "Yes, I think it's well run." A visiting healthcare professional said, "Relatives all seem very happy with the level of care and support being given." Visitors said they would recommend the home to others in need of a similar care service. A visiting health professional said, "I'd put my own relative in here."

The service had a registered manager. 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. The registered manager was a registered nurse and had just completed a level 5 management course. The registered manager said they wanted people to feel able to "Think of Kite Hill as their home." These values were reflected in how people received a service. Care staff told us the home's values were to ensure everyone received the best possible person-centred care and that they were happy. All staff stated they would be happy for a family member to receive care at Kite Hill Nursing Home.

There was a management structure in place, including a registered manager, deputy manager, registered nurses and team leaders. Each understood their role and responsibilities. Staff told us there was strong sense of motivation amongst their colleagues and all would help each other out where ever required. They told us the registered manager regularly covered shifts or assisted with tasks when required. Staff said they felt able to approach the registered manager and other members of the management team should the need arise. All staff said they felt valued and part of a team.

The directors of company which owned Kite Hill Nursing Home were actively involved in the day to day and ongoing management of the service. The nominated individual (provider's legal representative) had a nursing background and was knowledgeable about the people living at the service and their needs. They were actively involved in organisations to improve health and social care within the local community. Another director was also involved in ensuring the environment and facilities at the home were well maintained and safe for use. The provider and registered manager monitored accidents and incidents and analysed information to look for patterns and trends. There was an open, positive working relationship between the directors and the registered manager.

People were consulted in a range of ways about the way the service was run. The registered manager told us they undertook individual discussions with people and their relatives both formally when care plans were reviewed and informally when they met visitors at the home. Each person had a keyworker who was a named member of staff responsible for ensuring their rooms and personal possessions were managed safely. There was a programme of ongoing improvements to the service, such as improvements to the laundry, which we saw were underway during the inspection.

The approach of the provider and registered manager contributed to the open and supportive culture within the home. The provider and staff worked in partnership with health and social care organisations to ensure a coordinated approach to care. The registered manager notified CQC of all significant events and the home's previous inspection rating was displayed prominently in the home's entrance hall. There was a duty of candour policy in place, which required staff to act in an open way if people came to harm. The registered manager was clear about how and when it should be used. A whistleblowing policy was in place and was easily available to all staff. Staff were aware of the whistleblowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

The provider was aware of the recent changes to legislation regarding access and retention of personal data on staff and people which was effective from May 2018. The provider had specific policies and procedures to ensure compliance with this legislation and the registered manager understood their responsibilities in respect of this.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that medicines were managed in a safe way.