Barchester Healthcare Homes Limited

Kingsland House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Kingsland House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can provide accommodation and nursing care for up to 71 people in one adapted building. The service is arranged into three areas, Memory Lane, which accommodates people living with dementia, Adur which accommodates people with less progressed dementia and mobility needs and Bluebell, which accommodates people with a range of health and nursing needs. There were 58 people using the service at the time of the inspection. The service provides support for people living with a range of healthcare needs, including people living with dementia and chronic conditions.

The service had an acting general manager who was in the process of applying to be the registered manager as a temporary measure, while the provider recruited to the registered manager's post. The service had not had a registered manager for four months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered managers, 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 on 13 August and 7 September 2017, the service was rated 'Inadequate'. This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

At this inspection the provider was found to have met the previous breaches of regulations, having carried the actions from the action plan they provided to tell us how they would address the breaches. These breaches were in relation to shortfalls in staffing levels, medicines administration practice, the promotion of dignity, notifying the Care Quality Commission of serious events and the management and governance of the service. We undertook this inspection to check that the provider had followed their action plan and to confirm if they had met legal requirements. Many improvements had been made, however we found continued improvements were needed to sustain and embed those made. The overall rating for Kingsland House has been reviewed to Requires Improvement. This report discusses our findings in relation to this.

People and their relatives told us that staff were available to support them when required and our observations during the inspection demonstrated that staff were available to assist them with their needs, preferred choices and comfort. One person told us, "I don't know how many staff are here but there seems to be quite a few of them. Considering it's a home, it's a very good home. I've not had problems waiting for someone to help me. I'm happy." The service was not full to its capacity of 71 people during the inspection. However, the acting general manager and the regional director explained that it was staffed on the days of the inspection as it would be at capacity. Although, the feedback from people, relatives and staff was that

there was sufficient staff. We were unable to determine whether the current service provision could be sustained over time, should the number of people living at the service increase.

People and their relatives told us, and our observations demonstrated, that the management of the service had improved. The quality assurance systems in place ensured they were meeting people's needs. Shortfalls were recognised and the provider and management team had worked hard and taken a considered approach, concentrating their efforts and additional resources on specific areas of practice to ensure that improvements were made.

Although, feedback from people, relatives and staff and our own observations demonstrated improvements had been made and people's care needs. Including; dignity, preferences and choices were being met. We could not fully determine whether the improvements made could be sustained. The service had experienced several periods, without a registered manager in the previous four years, and this had impacted on their quality assurance systems. We were unable to determine whether the governance systems could be sustained over a defined period of time. As the quality assurance systems and processes were still in the process of being embedded, and as they had benefitted from the experience of the general manager, an extensive period of review and the involvement and additional management support from the provider.

People and their relatives told us they were safe. One person told us, "The people make me feel safe. It's very warm and comfortable. I like it here very much." People were protected from the risk of harm and abuse as they were cared for by staff that understood how to recognise and report abuse and all types of discrimination. Staff and relatives were confident that if they reported a concern it would be taken seriously and acted on by the service's management. Risks to people's safety, in relation to their physical, emotional and healthcare needs, were regularly assessed and appropriate care was provided to ensure that people received safe care that ensured their dignity was maintained.

People could make choices about how their care was delivered and suitable levels of staff were available to support their preferences in relation to mealtimes, personal care, daily routines and activities. Comment's from people included; "There's two kinds of food every lunchtime and if I don't want that they'll get me something else." "I've never had any problem when I press my bell. Someone always comes along. I don't time them but I don't think I wait very long. I think the staff are excellent. They make me feel very much at home. I've no complaints." "I have the freedom to make my own choices. Generally, there is no problem with getting up or going to bed when I want and do what I want during the day. I may go out, I may have a visitor, I may go to the activities, it's my choice."

People were able to live in an environment that was adapted to meet their physical, sensory, emotional and cognitive abilities. People could freely access all areas of the building and could choose where they spent their time including; the garden, quiet spaces, the foyer or one of three lounge dining areas. One person told us, "I like that we're on one level like a bungalow. There are lovely gardens and it's safe to go out there as it's enclosed." People were supported to be an independent as they could be.

The provider had arrangements in place for the safe ordering, administration, storage and disposal of medicines. People were supported to have their medicine safely when they needed it. One person told us, "They are very good and conscientious about giving medicine; very cautious and make sure you take it and not just leave it on the side." The management team had worked hard to improve the auditing and management of medicines, and to ensure staff were suitably trained and guided in administering all medicines, including time critical and as required medicines.

Care plans and risk assessments were comprehensive and provided detailed guidance for staff in how to

support people with their needs including; moving and handling, personal care, skin integrity and nutrition. Staff received the training they needed to support people and worked closely with healthcare professionals completing assessments relating to the risks that were managed.

Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar incidents occurring. Risks associated with the environment and emergencies including fire and infection control were identified and managed. We observed audit activity for areas including, medicines, and fire safety and infection control. The building was freshly decorated in all areas and odour free.

People, relatives and staff told us there were suitable levels of skilled staff available to meet people's needs safely. One person told us, "They're very good, all of them. Yes, I think they know what they're doing and they always ask if I'm happy." Staff received an induction and training to ensure they understood how to support people living with dementia with complex health needs. Staff told us they felt well supported through supervision, appraisal and training and could demonstrate how to work with people's complexity of need. Staff received suitable specialist training including; dementia awareness, medicines, Mental Capacity Act 2005 (MCA). The provider ensured that when new staff were employed, safe recruitment practices were followed to ensure they were suitable to work with people.

People's diversity and right to maintain important relationships was respected and promoted within their day to day experience and care planning.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People's capacity to make decisions had been assessed. People were supported to make choices and take decisions where they could. Staff supported people in the least restrictive way and when required they had access to advocacy services.

People's relatives told us and we saw that the staff were caring and respectful. One relative told us, "My relative has been happy, comfortable and peaceful here." Care and support provided was personalised and met peoples' diverse needs. People and their important relationships were respected and promoted within the service. People when needed received 'end of life care' that was responsive to their health care needs and respected their wishes and diverse cultural needs.

Feedback received showed relatives were satisfied overall, and felt staff genuinely cared. The provider was committed to improving the service through satisfaction surveys and regular meetings with people and their relatives. The provider consistently demonstrated that the service monitored and made improvements to the systems when required. When required the acting general manager submitted notifications in line with the Commission's registration requirements.

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 consistently safe.

There were sufficient numbers of suitably trained and experienced staff to ensure the current numbers of people living at the service were safe and cared for. However, the service was not at full occupancy and the provider needs to demonstrate that sufficient staffing can be sustained should occupancy levels increase.

Medicines were administered and managed safely by staff that were trained and assessed as competent to do so.

People were supported by staff that were trained and understood their responsibilities in relation to protecting people from harm and abuse. Safe recruitment practices were in place.

Is the service effective?

Good

The service was effective

People were supported by staff that were knowledgeable and received suitable training and support, including specialist training including; dementia

Staff had a good understanding of the Mental Capacity Act 2005 and worked towards meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutritional needs were met and their health needs were monitored, reviewed and planned for by staff who communicated well with health professionals.

Is the service caring?

Good

The service was caring

People's dignity, diversity and privacy was respected and promoted. Where people had important relationships, these were encouraged and respected

People were supported by kind and caring staff that adapted

their communication style to meet the needs of the person.

People's personal spaces and how they spent their day reflected their individual needs and taste preferences.

Is the service responsive?

Good

The service was responsive

People were provided care and information in an accessible and personalised way and care plans and records reflected this.

People were supported to access meaningful activities, at service and in the community.

The views of people and their relatives were encouraged to inform changes and improvements in the service. Complaints were managed suitably.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People, relatives and staff were complimentary about the leadership and management of the service and told us that improvements had been made. However, the service had been without a registered manager for more than four months on three occasions in four years.

Quality assurance processes were in place and had encouraged improvement. The systems had been developed and were still being embedded. The provider needs to demonstrate that quality assurance can be sustained should the management arrangements change.

There was a positive culture of staff morale and an approachable, visible leadership. People, relatives and staff spoke positively of the management of the service.

Kingsland House

Detailed findings

Background to this inspection

We carried out this comprehensive 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 19 and 20 April 2018 and the first day was unannounced. The inspection team consisted of two 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 care service.
Before the last inspection on 13 August 2017 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted stakeholders, including the local authority contracts team and social care professionals who gave feedback regarding the service.

During the inspection we observed the support that people received in the communal areas. We were also invited in to people's individual rooms. We spoke to nine people, three relatives, one visitor, six staff, the acting general manager, the deputy manager, a registered manager from another service and an on call regional director. We spent time throughout both days observing how people were cared for and their interactions with staff and visitors to understand their experience.

We reviewed two staff files, nine medication records, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, meeting minutes, training records and surveys undertaken by the service. We also looked at the menus and activity plans. We looked at seven people's individual records, these included care plans, risk assessments and daily notes. We pathway tracked some of these individual records to check that care planned was consistent with care delivered.

At the last inspection on 13 August 2017, the service was rated Inadequate. At this inspection we found the service Requires Improvement overall.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and were happy with the care given. One person told us, "The people make me feel safe. It's very warm and comfortable. I like it here very much." Another person told us, "It's very safe living here because everything is done for you and there's always someone around checking." Relatives told us that they felt people were safe. One relative told us, "It's knowing that they are watching out for people leaving that makes a big difference for me. If I had any concerns I'd speak with the manager." People were also able to tell us how they kept themselves safe, "If I had to speak to someone it would be the senior person around."

At the last inspection in August 2017, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) 2014. This was because there was not always a sufficient number of staff to safely support people's care needs. This included; timely assistance with personal care and call bells, people requiring staff observation with their mobility, being unattended, and people's individual choices and preferences not being respected. At this inspection on 19 and 20 April 2018 we found the provider had made improvements to comply with the legal requirement and the breach of regulation had been met. However, further improvements were needed to ensure the suitable deployment of staff was sustained.

We looked at staffing, rota schedules and staff deployment in all areas of the service, including Memory Lane, Bluebell and Adur. The acting general manager told us that staffing levels had increased by one person per shift since the last inspection. We asked people, relatives and staff about the staffing levels. People told us that the staffing had improved and that they always received the support they needed. One person told us, "Lots of nice people, all very nice and somebody always available. I feel very safe. There are no strict restrictions." Another person told us, "I've never had any problem when I press my bell. Someone always comes along. I don't time them but I don't think I wait very long. I think the staff are excellent. They make me feel very much at home. I've no complaints." A relative told us, "I've not seen any shortage of staff. I can't commend them highly enough." Staff told us the staff levels had improved, one staff member told us, "One staff member told us, "Staffing levels are a lot better, five staff in the morning and four in the evening." Another told us, "Yes, it feels like enough staffing, we are an efficient and good team at the moment." Our own observations supported the feedback we had received.

We observed care delivery at different times throughout the day including; morning activities, lunch meal times and during and between activity sessions. Each day a team meeting took place and people's needs, preferences and changes in needs were discussed. This ensured all staff were aware of what needed to happen and were delegated suitably within the service. For example, people who required observation were not left alone without a staff member present in each of the communal areas, and people with mobility needs were supported to transfer and move around the communal spaces safely and without being rushed.

Throughout the inspection, people's emotional and physical needs were met. Staff had sufficient time to meet people's needs and spend time with them to talk about their day or interests. People told us and we observed that requests for support made verbally or using call bells were responded to promptly. A relative told us, "When my relative first came in here they were on hourly observations during the day and every four

hours at night, I think that may now be hourly. I know though, because I'm here, that the staff are come in checking around every 15 minutes or so. They really do care and they are so respectful, kind and welcoming to me."

The acting general manager monitored call bell response times and carried out spot checks of call bells when spending time with people in their rooms. Where delays were noted we saw evidence that this was addressed and explored in supervision with the staff involved, and their performance monitored closely during the following weeks. All areas of the building were odour free, including people's rooms and personal care was delivered promptly and at the frequency required by people's care plans and needs.

People told us that there were still agency staff at night, however they confirmed that their care was not affected and records showed that the service used regular agency workers. Where agency nurses were used, they were established in the service. For example, one agency nurse told us they had worked regularly at the service for a year. The acting general manager told us that they had recruited a significant amount of staff since the last inspection and were using less agency. One staff member told us that the provider supported recruitment and professional development of staff and had actively recruited people from outside of the United Kingdom to improve recruitment. The service also retained agency staff to ensure they had continuity of regular people providing cover when shifts required covering at short notice.

This evidences that there were sufficient numbers of suitably experienced staff on duty on both days to keep the 54 people present safe and ensure their needs were met.

However, despite the improvements made in relation to staffing levels and deployment. We were unable, at this inspection, to fully determine that sufficient staffing levels could be effectively operated and sustained over a longer time. The provider used a dependency tool called the dependency indicator care equation (DICE) to calculate staffing levels and monitor its workforce numbers. The tool looks at each person's care needs and then calculates the staffing level. The acting general manager told us this continued to be used and they were reviewing staffing levels and the deployment of staff daily in line with people's needs. Whilst we acknowledged that the current levels of staff deployment were suitable to meet the needs of the 58 people present during the inspection, we cannot at this stage determine if this would be sustainable. For example, the acting general manager and regional director told us that the service was currently staffed at a level that it would require when the service capacity of 71 people was reached. Therefore, we are not assured the provider staffing levels currently would be sufficient to meet the needs of 71 people as it would depend on those individuals needs at any given time. The service would therefore need to demonstrate that staffing levels and deployment could continue to meet people needs and preferences safely over a defined period of time with increased numbers of people. We have therefore identified this as an area of practice that needs improvement.

At the last inspection in August 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) 2014. This was because safe procedures for the administration of medicines were not always practiced in relation to; time critical medicines, PRN medicines, covert medicines and the storage and disposal of medicines. This placed people at the risk of not receiving their medicines safely. The provider sent us an action plan on 24 November 2017 explaining what they would do to ensure that they were meeting the regulations by 30 January 2018. At this inspection we found the provider had made improvements to comply with the legal requirement and the breach of regulation had been met.

We looked at medicines and how they were managed in the service. We observed medicines being given safely by nurses that were trained and assessed as competent to do so. People who could communicate

clearly told us they received their medicines on time and were confident that they were getting the correct medication. One person told us, "They are very good and conscientious about giving medicine; very cautious and make sure you take it and not just leave it on the side." Medicines were given as detailed in people's support plans. For example, one person after having had their blood sugar levels checked by a nurse, received their insulin as prescribed and this was recorded on their records. The nurse demonstrated that they understood what to do if the person's blood sugar level had been too high. They also had guidance in place within a diabetes care plan that detailed what action they should take if the person was sick after eating.

People's choice was respected and consent gained when medicines were offered and requested. One person told us, "If I have pains I can always ask for paracetamol and the nurse will come to see me and then give me it." Where covert medicines were in place people rights were protected, as the use of covert medicines were authorised and reviewed six monthly by their GP.

The Medication Administration Record (MAR) sheets demonstrated that medicines were given safely. For example, one person's time critical medicines for Parkinson's Disease were given at the required time and records and observations evidenced that people were receiving their medicines with suitable time gaps between doses. When people were prescribed PRN 'as required' medicines. For example, paracetamol for pain management there was clear guidance describing when to give the medicines, the dose, the frequency it could be given at and the intended effect. We observed that when PRN medicines were administered staff signed the MARs and completed the reverse side of the document in line with good practice.

Clear guidance and systems were in place to ensure the safe storage; auditing, reordering and disposal of medicines took place. We reviewed the stocks that were held and the disposal arrangements of medicines, and they were found to be suitable, with no overstocked areas or out of date medicines. The provider had introduced monthly medicines audits for each of the three areas of the service, and was identifying actions and ensuring they were completed. For example, when new nurses were recruited their competency assessments were noted to be completed.

This evidences that the provider had ensured that people's medicines were being administered safely. There were sufficient numbers of suitably experienced staff on duty on both days to keep people safe and ensure their needs were met.

People were protected from the risk of harm. Staff had attended safeguarding training and knew how to recognise abuse and report any concerns they had. Staff received training in equalities and diversity awareness and confirmed they understood the importance of protecting people from all types of discrimination. Staff understood their responsibilities and followed safeguarding policies and procedures to protect people from abuse and were confident any concerns they raised would be taken seriously by managers. One staff member told us, "Yes I would be confident that the acting general manager would take concerns seriously." Staff had access to a whistleblowing policy and procedure and knew how to escalate concerns to the acting general manager, director of operations and external agencies when needed. Records showed the acting general manager reported concerns to the local authority and the CQC to ensure people's safety and rights to be protected from harm.

Accident and incident records demonstrated that staff and the acting general manager continued to take appropriate action following incidents. Where the incident involved actions of people, these were investigated and recorded in more detail. This was done by looking at what happened prior to the incident, during and after, so that risk assessments could be developed, lessons could be learned and care plans adjusted to reduce the likelihood of reoccurrence. For example, one person who had experienced an

increase in falls, was referred to the falls team, had their medicines and risk assessments reviewed and this resulted in fewer falls.

Environmental risk assessments, audits, and a programme of regular health and safety checks ensured measures were identified to minimise environmental risk. The acting general manager had oversight of health and safety through audits and checks of fire safety, LOLER, COSHH, Legionella, gas safety, food hygiene compliance checks and emergency plans. Personal Emergency Evacuation Plans (PEEPs) were in place for people. PEEPs provide information to staff on what action should be taken with people should the service be required to be evacuated in the event of an emergency.

People were protected by the prevention of infection control. Staff had good knowledge in this area and attended regular training. PPE (personal protective equipment) was used when required including aprons and gloves. The provider had detailed policies and procedures in infection control and regular cleaning schedules were followed in relation to medicines equipment including; suction machines, syringe drivers and nebuliser.

Staff recruitment processes were followed to ensure that new staff were safe to work with people. Staff files included previous work history, detailed application forms including equalities statements, proof of identity, interview records and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to ensure staff were suitable to work with people or children. The DBS is a national agency that keeps records of criminal convictions. Documentation confirmed that nurses employed had up to date registration with the nursing midwifery council (NMC). The acting general manager told us that that when agency staff came to work at the service, the agency would send them confirmation that all necessary checks in relation to their suitability to work at the service had been completed.

Good

Is the service effective?

Our findings

People's preferences, choices and care needs were met by staff that had the skills, knowledge and competencies to do so. People told us that the care given was good and suitable for people living with dementia and health needs. One person told us, "The staff are all well trained; they are very friendly and remind me that this is my home and they want me to be happy." Another person told us, "I haven't seen anybody who doesn't know what they're doing. They show compassion. The care cannot be faulted."

At the August 2017 inspection people's dignity, choice and independence had not always been promoted in relation to their access to food choices and the communal areas in the service. This was because staffing levels did not always ensure staff were available or had the time to promote choice. At this inspection we found improvements had been made.

People living with dementia and additional mobility issues had access to communal spaces and private spaces in the service. One person told us, "It's safe enough here. I like that we're on one level like a bungalow. There are lovely gardens and it's safe to go out there as it's enclosed."
There were three lounge areas, dining areas, quiet rooms and well-maintained gardens and a courtyard. Bathrooms were accessible and equipped for people with limited mobility and some bedrooms had en-suite facilities. People living at the service and their relatives had access to WIFI and pendant alarms, this technology supported them to be more independent around the building and to have access to communicating with relatives and friends. One person we spoke with was considering buying a tablet to replace their computer. One relative told us that they lived in another country, but always had good access to talking to their loved one by telephone.

People were free to access all areas of the building and gardens, and where they needed assistance staff were available to ensure this happened. For example, one person used an electric wheelchair to access an area of the building where their relative lived, daily. Their relative told us, "My relative has an electric chair and they whizz off around the home. Everyone here knows them." One person who needed assistance with their mobility told us, "I love the garden, I was out there three hours yesterday and will sit out there later." Another person told us, "Although my room is over this side, I like to go over to Memory Lane because the staff over there are excellent. They are here too, but there's a special skill in Memory Lane and I like to go there sometimes just to see them."

People's nutritional needs were consistently met. We saw that menus were varied and offered fresh fruit and vegetables to encourage healthy eating. We observed lunch time in three areas of the service. People were supported to eat where they chose either in the dining areas or they could choose to eat in their rooms. Consent was sought when people required support with eating and staff assisted with for example cutting their food. In all three areas of the service we saw that the atmosphere while people ate, was enjoyable and tailored to people's needs. People we spoke with told us that if they didn't like what they had chosen they were offered an alternative. One person told us, "There's two kinds of food every lunchtime and if I don't want that they'll get me something else." Another person told us, "The food is excellent. A choice of two hot meals at lunch or supper. They're good with drinks and snacks throughout the day." Relatives were welcome

to join their loved one's during mealtimes and one relative told us, "The food is excellent. It's lovely and there's plenty of it." People with communication needs had meal choices presented in a way to aid their understanding, meals were plated up so that people could see their meal. This ensured they could make an informed choice. People were encouraged to be as independent as they could be and staff were available if people wanted additional support, more food or to choose another food option. In addition, there was a cereal dispenser in the dining area and a self-service tea, coffee and cake selection in the foyer where residents enjoyed sitting.

Due to their health conditions, some people were at risk if malnutrition and dehydration. Staff understood the importance of monitoring people's food and drinks and monitored their weight and hydration. Where people were at risk of choking risk assessments and guidance was in place. For example, one person who had a period of constant weight loss, post illness in 2017, was now gaining weight for the first time in over a year. There nutrition and hydration care plan was informed by Speech and Language Therapists (SALT) referral and the person was supported with prescribed supplements, a puree diet and thickeners. We observed staff supporting people to eat in a gentle and patient manner, ensuring people were ready to have more food before offering more food.

The premises had been refurbished and decorated to ensure they remained safe, dementia friendly, well maintained and without odour. The provider's dementia specialist had met with relatives and was working closely with staff to implement a programme to improve the living standards of people living with dementia. This included; ensuring the different areas in the service were clearly defined by décor, improving people's access to food to promote a healthy weight and introducing memory boxes and getting to know me books. Memory boxes can be added to by the person and families and staff told us these memories can stimulate the person, prompting conversation linked to people's life time experiences. Staff told us that people's living environment had greatly improved and that they felt people in all areas of the service were happier.

Staff told us they felt well supported and equipped to carry out their roles. Staff received mandatory training and full inductions that included, shadowing experienced staff who could demonstrate how to work with people with complex needs. The staff also had access to training that was specific to the needs of the people using the service, including; dementia and Parkinson's awareness, wellbeing of the person, wound care and mental health awareness. Agency staff also received inductions that included shadowing opportunities. The acting general manager arranged infection control training and had revisited the nursing team's medicines competency training in response to a recent safeguarding action plan.

Staff told us they had regular supervisions, team meetings and appraisals. One staff member told us if they were worried they would talk to acting general manager as they were very approachable. Staff who had specific learning needs, for example dyslexia, were given support in relation to writing and reading tasks. The provider and acting general manager recognised the importance of continual professional development to inform best practice, and were actively promoting the use of dementia specialist training and programme in the service. Staff described how useful they had found dementia training. One told us, "It's important to put yourself in the person living with dementia's shoes, they are still that person with feelings, they can feel sad and feel loss." The staff member told us this had helped them develop greater empathy for the people they supported. New staff completed the Skills for care certificate. The certificate is a set of standards for health and social care professionals that ensure workers have safe introductory skills and knowledge. One of the nursing team told us that they updated themselves regularly on best practice through the Nursing and Midwifery Council website.

The service supported people to maintain good health with input from health professionals including psychiatrists, physiotherapists, Parkinson's specialists and speech and language therapists on a regular

basis. People told us they could see a doctor quickly if it was necessary and had regular appointments with a chiropodist, dentist and optician. For example, one person told us, "The nurse has been monitoring an itch that I have and she has arranged for the doctor to visit me when she comes in later today." The acting general manager and nurses told us that they worked closely with GPs to monitor health and seek further guidance when required. For example, one staff member told us that they had recently noticed a change in someone's mood and behaviour, and tested their urine, that showed they had a UTI and ensured the GP was contacted. A GP who visited the service regularly told us that the care had improved at the service and seemed pretty good. Staff followed guidance from GP and specialists, and provided them with helpful information including; blood tests. The clinical nursing team worked proactively at improving communication with visiting health professionals. For example, the service's diary would make note two days prior to a health professional visit that any requested information was prepared and made ready for them.

People who lacked mental capacity to make particular decisions were protected. Staff demonstrated they understood and were working in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). A visiting social care professional who was carrying out a DoLS assessment, confirmed that in relation to DoLS and MCA staff had a good understanding and was impressed with the knowledge staff had of people's needs. Mental Capacity Act 2005 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 capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA.

Staff had a good understanding of the MCA and the importance of enabling people to make decisions and received training in this area. Where decisions were needed in relation to complex matters including; finance and medical interventions, mental capacity assessments and best interest assessments took place and their decisions recorded. For example, one person's choking risk assessment detailed that they required visual checks at night and that they had capacity to decide how often this occurred and would do so by using their call bell. Another person who lacked capacity had mental capacity assessments and best interest decisions recorded in relation to the use of bedrails and key pads.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Throughout the inspection people and their relatives were positive about the care provided by staff that they described as conscientious and hard working. One person told us, "They are all lovely here. They are very kind. I can't think of anyone being unhappy here." People spoke positively about their relationships with staff. One person told us, "They are kind, I get on very well with them." Another person told us, "I haven't seen anybody who doesn't know what they're doing. They show compassion. The care cannot be faulted."

At the last inspection in August 2017, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) 2014. This was because people's care was not always delivered in a way that respected their choice, dignity and promoted their independence. The provider sent us an action plan on 24 November 2017 explaining what they would do to ensure that they were meeting the regulations by 31 December 2017. At this inspection we found the provider had made improvements to comply with the legal requirement and the breach of regulation had been met.

People's dignity and wellbeing was considered and promoted. When people required assistance from staff with personal care they did this in a timely and discreet way and did not rush people. For example, during the medicine's round one person asked if they could use the toilet before they were given their medicines. The nurse ensured staff supported this request before administrating their medicines. Staff knocked on doors and always waited for consent before providing support. Staff described how they maintained people's dignity during personal care by; speaking calmly, gaining consent, ensuring curtains and doors were closed and approaching people gently. The acting general manager had introduced further quality assurance mechanisms to regularly review response times to call bells and monitored that people's personal care needs were being met and recorded in a timely way.

People had choice in how they spent their time and their day to day needs were met in a timely way. One person told us, "It's up to me what I want to do. I need help to get up and dressed. I can get up or go to bed when I want. I just say when I'm ready to go and if I really wanted to get up early I could press my bell and let them know. They're very obliging." Another person told us, "I have the freedom to make my own choices. Generally, there is no problem with getting up or going to bed when I want and do what I want during the day. I may go out, I may have a visitor, I may go to the activities, it's my choice." People's choice and independence was further supported in relation to their mobility needs. For example, one staff member spoke in relation to one person's moving and handling assessment that included information on how staff could support them to improve their mobility. They told us they promoted a person's independence and wellbeing by supporting them to exercise regularly so their muscle strength improved to the point that they could try and stand more independently.
The atmosphere in the communal spaces was comfortable and relaxed and friendly. People who communicated verbally used humour with staff and were equally as relaxed with the care staff and acting general manager as they were with visitors. In response to communication needs of people living with dementia staff made good eye contact with people, adapted their tone, spoke slowly and responded to questions in a reassuring and consistent way. Staff showed genuine regard for people and responded to

their physical and emotional needs in a timely manner. For example, one staff member ensured one person arriving in the lounge had a good view of the television, and went to get their glasses so they could see. The person responded, "Thank you I was looking for those." Another person we spoke with told us, "Some of the staff are very caring and they come and give me a cuddle. I sometimes get quite sad and they will hold my hand."
Personal spaces had photographs, pictures and furniture that reflected individual needs and taste preferences. Staff told us and demonstrated that they had a good knowledge of people's needs, backgrounds and likes and dislikes. Relatives described visiting the service regularly and always being made to feel welcome and arrive at any time. They told us, "It's a very friendly atmosphere here and lovely and clean and bright and visitors are made to feel very welcome."

People's diversity and right to maintain important relationships was respected and promoted within their day to day experience and care planning. People's religious beliefs and how these were expressed were detailed in care plans, and where they practiced their faith, they had access to continue this. For example, one person had spent part of their life as a religious preacher and contributed and enjoyed the weekly prayer sessions that took place. These sessions were inclusive of many faiths and were not restricted to any specific religion. Another person chose to not eat meat on Friday's due to their religious beliefs, and this was respected and supported through their diet. People's important relationships were recognised and maintained. For example, an established couple with differing support and emotional needs were supported to spend their days and mealtimes together, and their relatives also joined them for mealtimes when visiting. Staff told us they had received positive feedback from a same gender couple in relation to why they chose Kingsland House. When one of them had recently stayed at the service. The partner told the deputy manager that they had looked at a few other service's. However, they were made to feel very comfortable when visiting the service.

People's privacy was respected, staff understood their responsibilities in maintaining people's privacy in relation to confidential information. For example, one staff member told us, "Confidentiality is part of our duty of care to people. We don't discuss people in corridors where you can be overheard." Care plans and electronic records were kept secure and access limited to people who needed to know.

People had access to relevant advocacy services so that they could be actively involved when making decisions about their care. The deputy manager and staff told us that people who did not have relatives involved had statutory advocates involved, such as an Independent Mental Capacity Advocate (IMCAs) and Relevant Person's Representative (RPR). An IMCA provides a legal safeguard for people who lack capacity to make specific important decisions; these can include making decision about where they live and about serious medical treatment options.

Good

Is the service responsive?

Our findings

At the August 2017 inspection, we could not fully determine that people always received the care and treatment that met their assessed needs and preferences. This was because care plans and records were not always updated in a timely way or to reflect changes in people's needs and preferences for example, bed times could not always be met. At this inspection we found improvements had been made.

People and their relatives told us staff were responsive to their needs. Relatives and staff told us that people were involved as much as they could be in developing care plans. Staff told us that care plans and guidelines were clear and that they built on this knowledge through the contact they had with people and the choices they made. Records demonstrated that people and their relatives were involved in designing and reviewing care. Staff met every day and received updates from each other in relation to people's physical and emotional wellbeing. At these meetings the allocation of staff and planning timelines in relation to care needs were confirmed. All documents including; daily charts, continence, repositioning, and nutritional charts were reviewed and shared along with the resident of the day report with the acting general manager. The service had introduced a 'resident of the day' meeting so that people could be more involved in their care planning and talk about their care needs. For example, one person used this meeting to organise an eye appointment they had planned before entering the service and chose to attend the appointment with a relative. Another person spoke about their sadness that a good friend was ill and was unable to talk with them the day before.

Pre-admission assessments were completed for new people to ensure the service could meet their needs and fully understand how to support their preferences and needs. The service developed more detailed care plans from this information and staff had clear guidance in place to help them understand how people liked and needed their care and support to be provided. Care was planned for and people were given a choice in relation to what food they ate, when their care was given. For example, one person spoke about their bed time routine, "I get the night staff to get me up early in the morning, this is my choice. At around 8pm they get me ready for bed and this again is my choice. I think having a routine helps everyone. I know what I'm doing and the staff do to. Of course, if I wanted a lie in or an early bed time they will always oblige." Staff we spoke with confirmed this. One staff member told us, "Each person has a different bedtime, some go early others later, they choose daily, there is a usual routine, but we always ask."

Care plans remained personalised and reflected the individual care and support staff provided to people. Personal backgrounds and life histories were used effectively to assist staff to improve personalised care and ensure people were protected from isolation. For example, one staff member ensured that one person always had access to their favourite brand of toiletries, and knew that the person did not like to wear make-up. People were protected from isolation and their relationships promoted within their care planning. For example, staff were available to support people who were keen to visit friends in Memory Lane to move safely from the Bluebell at different times of the day. Staff ensured when this happened that their care notes and monitoring charts were still completed accurately.
Relatives continued to be involved in the review and planning of their relative's care, when they had the legal authorisation to do so. They told us they were always informed of any issues relating to the health and

wellbeing of their loved one. One relative told us, "Whilst this is not the place I ever expected my relative to end up, I have to say I am comforted by how safe and well attended my relative is." "I've had no concerns, everything has been totally proactive and I am kept completely updated." Another relative told us that their relative's care was better than previous service, "My relative has been happy, comfortable and peaceful here." A GP that visited the service regularly told us the service was very responsive when people's health deteriorated.

When needed the service provided compassionate end of life care for people. Staff told us that good end of life care involved, ensuring people were comfortable, without pain and that their relatives and suitable health professionals were involved. People's care plans described their preferences including if they wanted to remain in the service or go to a hospice or hospital. People's religious and cultural needs were supported through the 'end of life' care planning. A GP feedback how supportive staff had been in relation to one person's end of life care. Confirming that staff arranged anticipatory medicines, and liaised well with the family, ensuring the person's wishes not to go to hospital were respected.

People had access to activities that followed their interests. There was a wide range of activities planned for mornings and afternoons every day; people's wishes were respected if they did not want to attend. One person told us, "I enjoy all the activities and regularly join in." Another person told us, "There's plenty going on. I'm happy with my own company and have plenty of CDs and I like watching gardening programmes. If there's something that I'm interested in, I pop my head in." The service had two activity workers and a volunteer and used external entertainers. Activities provided included exercise sessions, quizzes, music and dance sessions and a regular religious prayer session. We observed a crossword session and people were engaged, relaxed and happy. People were smiling making good eye contact and expressed great delight when they got the answers right. The service had a mini bus which provided regular trips out for example to garden centres. One person told us, "I join in sometimes. I do like the outings, I'm very happy."

Information for people and their relatives, if required, could be created in an accessible format to meet their needs and in a way to aid their understanding of the care available to them. For example, there were pictures available showing which staff were on duty and information boards detailing activities and outings available. Staff received guidance and information in relation to people's needs. Care plans included detailed information about people's communication needs and specialist health needs, including diabetes and sight loss.

People and relatives were confident that complaints would be taken seriously and were happy to discuss any issues with the acting general manager. One person told us, "I know there is a complaints procedure. If I wasn't happy I'd follow it up." Another, told us, If I needed to complain I'd speak up and if that didn't work I'd write to the owners." There was evidence that where people had raised issues with the acting general manager in their resident's meetings that action had been taken. For example, one person could not use their light switches easily. The maintenance person provided additional lamps and then replaced the switches so they were more accessible. We looked at the complaints policy and complaints records and saw that complaints had been taken seriously, investigated fully and actions taken to resolve concerns in a timely way.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in August 2017, the provider was in breach of Regulation 18 (Registration Regulations) 2009. This was because the provider had not submitted notifications in line with the Commission's registration requirements. The provider sent us an action plan on 24 November 2017 explaining what they would do to ensure that they were meeting the regulations by 24 November 2017. At this inspection we found the provider had made improvements to comply with the legal requirement and the breach of regulation had been met. However, we found further improvements were needed to ensure that quality assurance systems that had been introduced were sustained and embedded in practice should the management arrangements change.

Since the last inspection the acting general manager and deputy manager had submitted several notifications in line with the Commission's registration requirements. These included; notifications in relation to DoLS authorisations, safeguarding people from abuse and deaths. This demonstrated they understood their responsibilities and enabled us to confirm that appropriate action had been taken by the provider in response to these events. The deputy manager had completed training to ensure in the acting general managers absence they could make timely notifications. There was a policy in place in relation to the Duty of Candour and the manager was aware of their responsibilities under the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment of people.

At the time of this inspection there was an acting general manager who was a registered manager from another of the provider's services. They had been managing the day to day running of the service with the support of a deputy manager, a buddy registered manager from another service, and senior managers since November 2017. The previous registered manager had deregistered in November 2017. The acting general manager told us they were applying to be the registered manager; however, their role was temporary, and their intention was to manage the service until a suitably experienced registered manager was recruited and inducted. The provider had completed interviews for the post and was carrying out ongoing recruitment and due diligence activities to ensure they recruited a general manager of the calibre needed to improve the service. However, the service had been without a registered manager for four months. The service had been without a registered manager for more than four months on three occasions in four years. During this time the service had been rated by the CQC 'requires improvement' or 'inadequate' in four of the five inspections completed. The Health and Social Care Act 2008 requires that as a condition of the provider's registration, that they have a registered manager. We have identified this as an area that needs to improve and not a breach as there is a registered manager's application being made to the Commission.

At this inspection it was evident that the quality of the service had improved. Quality assurance systems were in place and being embedded to monitor the overall quality of the home and to identify any shortfalls and improvements necessary. The acting general manager completed daily and weekly management reports and spot checks that informed clinical risk governance meetings and organisational oversight systems. The regional director completed monthly visits and audits which included the oversight of areas including; internal audits, safeguarding activity, complaints, incidents, staff training and notifications. In

addition to these visits additional medicines and operational systems audits were completed and action plans developed and acted on. Where shortfalls in practice was identified the acting general manager and senior managers worked systematically to ensure their efforts were concentrated on one area at a time. For example, following external medicines audit an action was identified and completed where nurse's supervisions included awareness raising of PRN protocols and the homely remedy policy. However, as the provider had not always maintained a suitable level of quality during periods of management change, involving its registered managers and as quality assurance systems and processes were still in the process of being embedded. We were unable to determine whether the governance systems could be sustained over a consistent period of time should the management arrangements change the resources reduce or the number of people being supported increase. This was because recent improvements had benefitted from the experience of the acting general manager, an extensive period of review involving external resources and additional management support from the provider. We have identified the sustainability of management arrangements as an area that needs to improve.

People and relatives spoke positively of how the service was managed and the improvements that the acting general manager had made since arriving at the service in December 2017. One person told us, "The manager is a breath of fresh air and has made many changes for the better." Another told us the acting general manager was kind, approachable, got things done and was popular with both residents and staff. One relative gave feedback through a survey, "Since the new manager has taken over the service it is so much better. The manager and their team really care about the residents and take time to speak to relatives. My relative is happy and well cared for."

Staff told us the leadership of the service had improved. Staff told us there were clear lines of accountability and responsibility through their roles and management structures. This was demonstrated on the day of the inspection through observations of staff interactions with the management team. Daily plans and management schedules underpinned the day to day service delivery tasks ensuring that staff were supported and individual one to one support needs were met.

The provider regularly reviewed the service value base and culture and we saw this was demonstrated by how they and the acting general manager spoke to and about the people they supported and was reflected in team meeting records. Staff told us that people and staff were more relaxed and happy. Comments from staff included; "The Manager is absolutely lovely, approachable, it's a lot better now, it's well run." "The service is well managed, we have enough staff, there could be more, but there are enough, I don't feel that I have to rush people." "I would be happy for my mum to come here." Staff told us they had been well supported by the acting general manager and had seen many improvements since they arrived including; improved staffing levels, clearer lines of accountability and responsibility and improved communication. This was demonstrated on the day of the inspection through observations of staffing levels and staff interactions with the acting general manager.

The acting general manager was committed to improving the service and was actively involved in developing relationships and improving communication with relatives, local GP services and the local authority contracts team who had completed an audit of the service in February 2018. The acting general manager had also promoted the provider's programme, which focussed on improving the experiences of people living with dementia. For example, they arranged for relatives to meet with the provider's dementia specialist so they could better understand the programme and share any concerns they had about their relative's dementia care needs. Staff demonstrated their understanding of this programme and the wider service value base through their interactions with people and each other. Staff spoke with a genuine respect and regard for the people living with dementia and other complex needs.

The provider encouraged an open and transparent culture. Staff and relatives were encouraged to provide feedback and to make suggestions for improvements in the service. A satisfaction survey was completed in December 2017, which provided people and relatives with the opportunity to feedback about the quality of the service provision. The survey outcomes were consistently positive and the acting general manager has arranged relative's meetings following this to continue to update relatives on the improvements they had made. The acting general manager told us, that in response to relative's suggestions at the meetings, they had decided to revisit the name of the Memory Lane area of the service and were actively asking people and their relatives to have their say on any new names. This demonstrated that improvements were made to the service in response to comments.