Buckland Care Limited

Kingland House Residential Home

Inspection report

Kingland House
Kingland Road
Poole
Dorset
BH15 1TP

Tel: 01202675411
Website: www.bucklandcare.co.uk

Date of inspection visit:
03 December 2018
06 December 2018
07 December 2018

Date of publication:
15 July 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Kingland House Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing or 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. There was an application with the CQC to remove the regulated activity enabling nursing care to be provided in the home. This was being processed; we did not inspect against this regulated activity because it has not been provided since September 2018.

Kingland House Nursing and Residential Home was registered for 44 people. There were 32 older people living in the home at the start of our inspection. A further three people who resided in the home were in hospital at this time. People had a variety of care and support needs related to their physical and mental health.

This unannounced inspection took place on 3, 6 and 7 December 2018.

The service did not have registered manager. The previous registered manager had ceased their employment with the service and deregistered in December 2107. 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. A new manager had been appointed and had started their employment six weeks before the inspection. They had put in an application to become registered with the CQC.

We carried out this inspection in response to information of concern we received alleging that people were not receiving safe care and that there were issues with the management and oversight of the service. During our inspection we gathered evidence that reflected these concerns.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another

inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At this inspection, we found that the management of risk did not ensure people received safe care and treatment. Risks related to people's mobility, nutrition and skin health were not being managed effectively. This was a breach of the regulations.

Notifications had not been made to the Care Quality Commission where required. This was a breach of the regulations.

Staff understood how to report abuse but we found two examples where allegations of abuse had not been responded to robustly and transparently. We also found that restraint was being used without an appropriate framework to ensure peoples' rights were protected and a Deprivation of Liberty Safeguard had not been applied for someone who was not free to leave the home and was indicating regularly they wished to leave. This was a breach of the regulations.

People were not always supported to make choices or to consent to their care within the framework of the Mental Capacity Act. This was a breach of regulation.

People told us the food was enjoyable. The meal time experience was variable for people: some people were not treated respectfully and care plans were not followed. We found other care plans were not followed. This was a breach of regulation.

The home had been through a period of unsettled leadership and change, the impact of which had not been adequately assessed or planned for.

Oversight and governance in the home had not been effective in identifying shortfalls and unsafe practices. This was a breach of regulation.

Care staff were kind throughout. People's dignity and privacy was not always respected.

People had access to health care for acute and chronic health conditions. Referrals had not always been made when people's needs indicated that this should have been sought. .

Some staff training was not up to date. This meant that staff may not have always had the skills to provide appropriate care and support. People told us they sometimes had to wait for staff and staffing levels impacted on people's experience of care.

People knew how to raise concerns and were confident they would always be heard.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks were not managed and monitored effectively.

People did not always feel safe when staff were not available.

Allegations of abuse had not been addressed robustly.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always provide care within the framework of the Mental Capacity Act 2005. This lack of understanding regarding the MCA also meant that DoLS legislation had not been complied with.

People's needs had been assessed but this had not always been sufficient. Action to meet people's needs had not always been taken

People did not always have food and drink provided in a way that met their needs and kept them safe.

Is the service caring?

Requires Improvement

The service was not always caring. People received compassionate and kind care some of the time.

Staff developed relationships with people and took the time to get to know them individually.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive the support they needed.

People, and relatives, were confident they were listened to and knew how to complain if they felt it necessary.

People enjoyed a range of activities.

Is the service well-led?

Inadequate

The service had not been well led.

The service had been through a period of unsettled leadership. A new manager had recently been appointed.

Staff had confidence in the management and considered themselves to be part of a strong team.

There were systems in place to monitor and improve the quality of the service. This included seeking the views of people and relatives. These had not been effective in highlighting the concerns identified during our inspection.

Kingland House Residential 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 the 3, 6 and 7 December 2018 and was unannounced. The inspection team was made up of two inspectors on the first day and one inspector on the subsequent visits.

The inspection was prompted in part by concerns raised with the commission about the safe care and treatment of people and oversight. We were aware that the local authority was also investigating safeguarding concerns about the service.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us and information received from other parties. The provider had not submitted a Provider Information Return (PIR) since their last inspection because we had not requested that they do so. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather this information during our inspection.

During our inspection we observed care practices, spoke with eight people living in the home, two relatives, nine members of staff, the manager and a representative of the provider. 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. We also looked at records, including medicines administration records, relating to ten people's care, and reviewed records relating to the running of the service. This included four staff records, training records, quality monitoring audits and accident and incident records.

We also spoke with health and social care professionals who had worked with the service.

Inadequate

Is the service safe?

Our findings

Risks to people were not managed effectively and this put them at risk of harm. People were not protected effectively from the risk of developing wounds and damaged skin. Monitoring records were not complete or used to reduce the risks people faced. Two people were identified as being at high risk of developing pressure wounds. Records did not reflect that they received support to reposition themselves as described in their care plan or that where areas of vulnerability were noted these were monitored. One of these people had regular gaps in their repositioning records suggesting that they had not been helped to move for eight hours, when their care plan indicated they should be repositioned every four hours. The other person had a red mark noted in early October 2018. This was not monitored in their notes and a pressure wound developed on the site. We also looked at records related to topical creams for four people who were prescribed creams to protect their skin. Records indicated that these creams were not administered as prescribed.

Some people were unable to communicate and needed to be checked regularly. One person's care plan indicated that they could not communicate their needs and that they were dependent on staff to support them with all their physical needs. There care plan was not specific about how often they should be checked but a form was held in their room to record hourly checks. Staff told us they should be checked regularly. There were regular gaps in the recording of these checks of up to three hours meaning it was not possible to tell if they had been checked as often as was required.

Incidents were not effectively monitored. One person was noted in their care delivery records to have had their legs over the bed rails in October 2018. This is an indicator that a person is at high risk of falling over the rails. This observation had not led to a review of the use of bedrails. We raised this with the manager who reassessed the person and ordered an alternative bed. Another person was at high risk of falls and whilst falls were recorded their care plan was not updated accordingly. For example, in November 2018 they were recorded as having been found steadying themselves by holding onto another person. This put them both at risk of falling. This incident had not been added into their care plan. Their care plan was unclear about when supervision was required; stating that they required both supervision when unsteady and stand by support. We observed this person walking holding their mobility aid in one hand and a bannister in the other without staff supervision. Staff told us that this was common but no referral had been made to seek appropriate professional advice. We also observed them sitting in their chair without their sensor mat in a position that would identify if they moved. We discussed their support needs with a senior member of the team and they went and moved the mat.

We found body map records for four people who had sustained injuries. These had not been reviewed by a manager and there was no evidence that there had been any follow up. These included unexplained bruising, skin markings and swelling. This meant that the reason behind these injuries had not been identified and nothing had been put in place to reduce the chance of repeated injury. We made safeguarding alerts to the local authority about this.

Emergency planning was not kept up to date. Personal emergency evacuation plans held in a folder near the

front door, designed to assist emergency service personnel, were not up to date. The details of three people who were no longer living in the home were in the folder, one person was recorded as being in the wrong bedroom, and two people living in the home were not listed. This meant up to date information was not available to emergency services staff in the case that people needed to be evacuated from the building and put people and staff at risk.

Some training in safety processes needed to be refreshed or taken. For example, two care staff working when we visited did not have current infection control training. Two domestic staff had also not undertaken this training. Staff understood their responsibilities to ensure infection control was managed effectively and we saw they used appropriate protective clothing when supporting people with personal care or cleaning. However, staff told us it was not always easy to find and access personal protective equipment. People's rooms were cleaned throughout our visits. However, we noted that sometimes this was not sufficient. We saw a person had food on their bed after a cleaner had visited in them in their room. Another person had food on their bedroom floor throughout one day of our inspection.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were policies in place to support good safeguarding practice. Staff had received training in how to follow the safeguarding process and could describe how they would report suspected abuse. However, we found two examples of alleged abuse made in September and October 2018 that had not been reported to safeguarding authorities or the CQC. Sufficient action to protect people had not been taken. Measures had not been implemented regarding the deployment of staff whilst allegations were investigated. This meant that people had been put at risk of harm. We made the safeguarding authority aware of these.

There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and visitors gave mixed feedback about staffing levels. There were times during our visits when staff were not deployed in a way that met people's needs. One person reflected on this saying: "Often they are short staffed and that is reflected in what they can give you." Another person told us: "I think they are always short staffed. I don't feel safe when I can't get someone."

Staff also told us that staffing levels could be challenging. On the first day of our inspection staff explained that there were six members of staff working but that two of these staff were new; one was on their first day of shadowing. Staff who are shadowing usually work alongside experienced staff in a supernumerary capacity. This member of staff had previously worked in a care setting but their competency had not been assessed by their new employer. This new member of staff supported a person who was at risk of choking to eat their lunch and assisted a person, who was at risk of falls to move around the home. The member of staff was not supervised or checked on during either of these tasks.

People and a health professional told us that people sometimes had to wait around ten minutes or more for bells to be answered and that people were often still in bed late in the morning. We noted this to be the case on a day when the staffing level we were told was required, was in place. We observed staff were busy throughout our visits and supernumerary management staff were often needed to support people to ensure their safety and reduce distress. One person told us that they got up when staff were free to get them up and they had not been asked their preference regarding this. Care plans did not reflect people's preferences and whilst deployment and staffing levels were under review, this had not been impacted by people's expectations. It was not possible to review call bell response times as the system was not giving an accurate

reflection of response times.

Peoples need's and dependency levels were calculated to determine the staffing levels provided. These were not always accurate. One person, who had all their care provided by staff and was cared for in their bed, was described as being able to feed themselves and move independently . The dependency tool that was used did not reflect people's social and emotional needs. The manager explained that staffing levels were being reviewed. They told us that additional staff were brought in at key times such as meal times and the way staff were deployed around the home was also being reviewed.

The service had an appropriate recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. Staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check.

Equipment owned or used by the registered provider, such as specialist beds and hoists, were suitably maintained. Where equipment had broken or became damaged this had been identified and replacements ordered.

Staff responsible for the administration of medicines had undertaken training and had their competency assessed. People told us they received their medicines safely and we saw that an electronic system was being used effectively to reduce the risk of medicines errors. Whilst visiting people in their rooms we noted that one person had not taken their medicines and another person told us they were in pain. Information about how people indicated pain and when medicines like pain relief that are given when needed was not available. This put people at risk of not receiving their medicines when they needed them. We spoke with staff about the person who had not taken their medicines and they told us this was not usual and they went back immediately to resolve this.

Some people took medicines that required stricter controls by law. These medicines were being administered and stored safely. Some medicines were being used that required cold storage, there was a medicine refrigerator at the service and the temperature was monitored and within the acceptable range. The temperature of the room where medicines were stored was also monitored and was within the acceptable range.

People told us they generally felt safe and relatives also shared this view. One person told us: "I feel safe. There are people around me." A relative told us: "I have no worries about safety."

Inadequate

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any decisions 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 interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We identified mixed understanding regarding the implementation of the MCA amongst the staff: they told us they checked with people before providing any care; however, we did not always observe this to be the case. Whilst some people were offered choices such as where they wanted to sit and whether to get involved with activities, other people were taken to chairs without any attempt to gather their views or seek their consent to be moved from one area to another.

Care records did not always reflect principles of the MCA. People with the legal right to make decisions on other people's behalf, had not always provided consent to care. For one person this meant it was not possible to see who had provided consent for them to live in the home when they were sometimes stating they did not want to. Two people had provided consent for some aspects of their care but not for their care in general. There was no evidence that they had been consulted in reviews or care plan changes or if their capacity to consent to personal care had been assessed. Best interest decisions had been made for a person described as having variable capacity rather than efforts made to enable them to decide when they were able to.

There was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This failure to follow the MCA meant that a DoLS had not been applied for appropriately and that restraint was not recognised by staff. Within an allegation made about verbal abuse reference was made to a member of staff holding a person who was agitated. This had not been recognised by senior staff as a restraint. We asked staff how they assisted this person with personal care and they described using a soft restraint. The decision to do this had not been reached with input from health professionals. It had also not been discussed with the person's family and was not included in the person's care plan. Staff had not identified this practice as unauthorised restraint. The manager and registered provider's representative acknowledged that this had taken place and took immediate action to seek advice from appropriate professionals. They also began to implement a policy related to the use of restraint. We contacted the local safeguarding team about this unauthorised restriction of the person's liberty.

We also identified another person who was requesting to leave the service whose liberty was restricted

without authorisation. Staff told us the person often said this. The person was described in their care plan as not having capacity to make decisions about their care. The was no request in place to deprive the person of their liberty by seeking a Deprivation of Liberty Safeguard (DoLS). This meant the person was at risk of being detained without legal authority. We asked the manager to contact the local authority DoLS team about this.

There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before moving into the service people had their needs assessed across a wide range of areas. This assessment process identified initial support needs. Admission assessments on people's files identified basic needs. These assessments were used to develop a care plan for the person and guidance from professionals was incorporated. Where people moved into the home in an emergency, information provided by statutory agencies had been used.

People were asked about what they liked to eat as part of their assessment process and this included any dietary, cultural or religious needs. People had varied experiences of mealtimes. Some people enjoyed a social experience however this was affected by meals not being brought to people sitting together at the same times. This meant that within small social groups, some people had finished eating before others were served. People who needed assistance to eat did not have an equal experience. On the first day of our inspection one person was assisted by a member of staff who stood next to them, talking to other people and leaving to do other tasks throughout their meal. On the second day they had more skilled and compassionate support but still waited for an hour to receive their meal whilst sat at the dining room table with others eating around them. Another person was brought to the dining room in a specialised chair. They waited an hour to be supported with their food and were not spoken to in this time despite their chair being moved three times by staff. This person's care plan identified the importance of staff communicating all interactions. On one occasion we noted their eyebrows raised and they appeared startled when their chair was moved from behind when they had been sitting with their eyes closed and had no idea this was about to happen. People who sat waiting for long periods spent this time passively watching others or withdrawing and closing their eyes.

There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risks associated with people's dietary intake were not managed safely. Some people had been identified as being at risk because they struggled to eat or drink enough to maintain their health. One person's care plan identified that they needed small portions in order to encourage them to eat. They had full portions at both of the meals that we observed. We reviewed the records associated with their eating and drinking and found that calculations about their risk of malnutrition were incorrect which meant heightened risk had not been identified.

Another person's care plan stated that they needed prompting with food. They were seated in the dining room for half an hour before a member of staff noted that they had not received their meal. The member of staff asked other staff if this person had had their dinner before asking the person themselves. When the person did receive their meal, they ate a couple of mouthfuls before pushing their plate away three minutes later. A member of staff removed it after a further five minutes without trying to prompt them further. The records for this person stated that they had eaten well when they had not eaten more than a couple of mouthfuls of their main course. They had also not eaten well at another meal we observed. No record was made of their eating related to this second meal. The person was put at risk because guidance around their

need for prompting was not followed and records did not highlight their poor nutritional intake.

Not drinking enough raises the risk of developing infections and falling due to dehydration. Where staff had identified that people were at risk of dehydration, people's fluid intake was recorded and monitored. We sampled fluid records for two people during October and November 2018. One person who had recently suffered a chest infection and the other was at high risk of falls. Records indicated they did not meet their daily fluid target and there was no evidence that any action had been taken to address this or make health professionals aware. Where these two people's intake was low, records indicated they were not offered any additional drinks beyond scheduled drinks. They both had gaps in their records indicating that they were not offered any additional drinks between tea time and supper time on days when they had drunk less than 500ml of fluid.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they believed staff had the skills they needed to support them. One person told us: "The staff need to be well trained. I should think they are." Staff told us they felt supported by their colleagues, the manager and the operations manager. They also commented that they had access to training to support them in their roles. At the time of our inspection we noted that some staff were overdue refresher training and we discussed this with the manager. They acknowledged that this was the case and explained they were moving between two training providers. We spoke with the provider's nominated individual about training made available to senior staff undertaking additional leadership since the change from nurse led care. They told us that medicines training and epilepsy training had been provided and they had had increased input around the leadership part of their roles. Senior care staff had not all completed MCA, record keeping and person-centred care training. This meant they had not been provided with the knowledge needed to help staff maintain and develop the quality of care people received. Nursing staff had stopped leading the care staff before the senior care staff were trained to undertake this role. The manager and provide representative had identified that this was an area for development and were seeking training opportunities.

Newer staff had the opportunity to undertake induction training and shadow more experienced staff. One new member of staff was working independently on their first day. The manager told us that they were happy to do so and that they had experience. If staff needed to undertake the Care Certificate this was available. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector.

There had been concerns identified by health care professionals about the timeliness of referrals and we noted that care records did not always reflect that referrals took place appropriately. For example, whilst people had been referred for contractures and the recommended daily fluid intake had been checked for individuals, we did not find information relating to dental input for oral care for two people who were regularly refusing support with this. This did not reflect NICE guidance. This meant alternative methods for reducing the risk of infections and pain were not explored. During our visits, however, people were supported to access health care for both ongoing and acute health issues and we received feedback from district nurses that communication had improved. We saw that liaison took place with people's GPs to ensure the most appropriate treatment and that where appropriate relatives were kept informed.

The physical environment was not always used in a way that supported people to maintain relationships and spend their time meaningfully. People were not always supported to sit with people of their choosing and the dining area was not large enough to seat everyone should they wish to eat with others. A quiet

lounge was used as a throughway for staff but not regularly used by people. There was access to secure outdoor spaces where seating and planting provided a pleasant environment. National good practice in dementia care such as that produced by the University of Stirling's Dementia Service Development Centre suggests that buildings accommodating people living with dementia should be designed and decorated in a way that supports people. For example, doors should be in a contrasting colour as should toilet seats and handrails and there should be easy to read signage. Colour was not used to demarcate areas and corridors looked similar. Whilst, there was signage available around the home we saw that some people, who were living with cognitive difficulties, found navigating their way around the building difficult.

Some parts of the home were very noisy. Where people's rooms were by alarm panels, the sound of the call bells was very piercing. We asked a person about this when we were in their room and finding our conversation was impacted by the bells. They told us: "The bells are a nuisance."

Requires Improvement

Is the service caring?

Our findings

The staff were caring. We heard comments such as: "They have been unbelievably good here" and "We have never had to question if the staff really care" from relatives. People told us that mostly the staff were very caring: "The staff are very kind here – you can feel it, you can experience it." When staff spoke with us about people they spoke with warmth and familiarity. They told us they wanted to create a homely environment and relatives we spoke with said they felt comfortable in the home; could visit at any time and always felt welcome.

Staff all told us they enjoyed their work and enjoyed spending time with the people they supported. They were compassionate and caring and spoke with enthusiasm for their work. They all expressed their motivation for their work being the people living in the home, making comments such as: "It is my job to make the people here happy." and "We have lovely residents here." They also spoke with kindness about their colleagues.

Throughout our inspection there was a welcoming atmosphere in the home. However, we observed that whilst many interactions were kind and caring, people were not always treated with respect and their dignity was not upheld. One person was sat in their room with the door open. They were not dressed in a dignified fashion. We saw that visitors had stopped in the corridor with the staff member showing them around near the person's door. This meant that their privacy and dignity had not been protected.

Another person, who no longer used words to communicate, spent most of their time in their room. We saw a member of staff take a hoist into their room for storage without acknowledging them. A member of staff cleaned another person's room without engaging with the person. The person told us they were in discomfort but the member of staff missed this because they did not engage with them.

Task allocation was discussed in communal areas in a way that could be heard by everyone present. This meant that people were spoken about in a way that publicly focussed on the tasks staff needed to do rather than on the person themselves.

We also observed compassionate care: a person was reassured tenderly when upset about a relative; staff and people laughed at 'in jokes' that made it clear they were comfortable with each other and enjoyed each other's company.

We spoke with staff about people who could no longer communicate easily with words due to the impact of dementia. They were able to describe how a combination of their facial expressions, movements and noises communicated how they felt and what they might need.

People's bedrooms were personalised with belongings, such as furniture, photographs and ornaments. People were encouraged to make decisions about their appearances, for example what they wished to wear. People had been supported with their personal appearances.

Some care plans reflected what people needed to retain their independence. For example one person's care plan referred to the parts of their personal care they could undertake for themselves.

We heard about support for people's personal relationships. The manager identified that expression of sexuality was an important part of people's identity and that privacy was respected. Relatives told us that their relationships with their loved ones living in Kingland House Nursing and Residential Home were supported and that they were made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

People expressed varied views about the care they received. Most people and relatives spoke positively about the care. Relatives made comments such as: "If mum needs something she gets it" and "Needs have changed and the service has adapted". Other people identified that they were not always helped with things they needed. One person told us: "I wait for the carers to get me up." When asked if this time was of their choosing they told us that they had not been asked this. We noted that people's care plans did not contain this detail of preference. Another person told us they had not seen their care plan and expressed interest in its contents.

Care plans covered a range of areas including mobility, social activity, communication and nutrition and hydration and had mostly been reviewed. Some were individualised with information about people's likes and dislikes and histories. Others were more generic, for example the same guidance was written in a number of people's care plans related to what they ate and drank. The manager was aware of this and made an appointment to a head of care position during our inspection with the intent that this person would work with senior staff to develop more person-centred care plans.

Care plans did not always correspond with the care people received. Staff described people's needs without judgement and emphasised people's individuality in all their discussion with us. Their understanding did not always reflect the information contained in the care plans. This meant people did not always receive care that was responsive to their needs.

One person spent all their time in their bedroom. Their care plan referred to the need for "socialisation in my room" and was to be provided every afternoon. We reviewed a week of care records and identified only one reference to staff engaging with this person at a time when they were not supporting them with other tasks such as personal care or eating.

Another person told us that they had been woken by night staff to support them with personal care. We discussed this with the manager who agreed that this was inappropriate. The person had experienced disturbed sleep because information had not been handed over effectively.

During our visits we identified people who needed immediate support from staff. We raised these with the manager who acknowledged that staff should have responded to people before we needed to raise this. They had plans to highlight to staff the need to not take 'shortcuts' in a meeting scheduled for the day of our first visit.

There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also identified that some people's changing needs were addressed quickly. A person had been noted to be sliding in their wheelchair and we saw a new chair had been ordered. A relative reflected this and explained that with all changes they felt kept "in the loop".

There was ongoing work to ensure that people had meaningful things to do with their time. There were activities organised in the home six days a week. People enjoyed an array of visiting entertainers, groups form schools and craft activities. Those who stayed in their rooms had visits and there was work underway to extend this with the appointment of a second activities coordinator.

Staff were committed to providing good quality end of life care. The home worked closely with people's GPs to ensure that people received appropriate pain relief at this time of their lives.

People's communication needs were identified during an assessment before people moved into the service. These were recorded in the care plan so staff had information about people's needs. Opportunities to use pictorial information or other languages were not reflected in people's care plans or being fully used although staff had awareness of the benefits. Information about people's communication needs did not reflect the Accessible Information Standard which became law in 2016 to make sure people with a disability or sensory loss are given information in a way they can understand.

There was a system in place for receiving and investigating complaints. People and relatives confirmed they knew how to make a complaint. Complaints raised had been addressed within the timescales laid out in the provider's policy.

Inadequate

Is the service well-led?

Our findings

The home had been through a period of unsettled leadership. The home had stopped providing nursing care at the start of September 2018 and senior care staff had taken on the role of leading day to day care. They had been supported in this role by the home's deputy manager who had recently gone on parental leave. The area manager for the home who had provided a direct link between the manager and provider had also left in the summer of 2018. The last registered manager had left their post in December 2017 and the next manager, who had not registered with CQC, had left in August 2018. A new manager had been appointed and started in post in October 2018. They were in the process of applying for their registration.

The impact of this change was reflected by all the staff who identified that morale in the team had been adversely affected. Most observed that they felt that work was needed for the home to be back on an even keel with all care staff confident about their roles and responsibilities.

The provider had failed to plan sufficiently for this change. We spoke with the provider's nominated individual who explained how senior staff had been provided with additional training once the planned change had been made public and the nurses had been given their notice. This meant that the preparatory work had gone on during a time limited hand over period between the nurses and the senior staff who were taking over lead responsibilities. It was clear from the inspection findings that the assessment of the impact of this change and the resultant planning had not been sufficient and some staff had lost confidence as a result.

The registered provider had a quality assurance process that included regular provider visits to the home. The manager and senior staff also undertook audits. We found that these had not been effective in addressing all the issues identified during the inspection. The manager and nominated individual were reactive and responsive to concerns we raised and had also been proactive around issues they had identified prior to this inspection. For example, staffing levels were being reviewed and a new way of deploying staff had been implemented, a staff meeting had been scheduled for the first day of our inspection visit at which the manager was highlighting care practice issues; the manager had also identified the need to make care plans more person-centred.

Whilst they had not identified the issues in the calculation of people's risk of malnutrition they had reviewed fluid intakes and started to work on improving staff record keeping. At the time of the inspection this intervention had not been sufficient to ensure safe care and treatment and we found examples of records that were inaccurate, incomplete and illegible.

Other work identified had not yet been effective. A schedule on the wall of the office identified that all best interest decisions should be reviewed by the end of November 2018. This had not been achieved effectively.

There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered persons had not ensured that the legal registration requirements had been complied with. We identified two allegations of abuse and a police incident that had not been reported to the CQC. A pressure sore recorded by staff in the home as a grade three had also not been notified to the CQC.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

All the staff we spoke with remained certain that they would make improvements. They were proud to be part of a staff team that worked together to face challenges. We heard comments such as "We come together to help the residents. We all want this to be a happy home." This was reflected by the manager's view: "I believe we can do this all together as a team and achieve it for the residents here."

People liked the new manager and it was evident that they were comfortable in their company and sought them out with any concerns. The manager and provider representatives were visible within the service so were aware of day to day issues brought to their attention by staff, people and relatives. Formal feedback was also sought form people and their loved ones as part of ongoing quality assurance.

The new manager had reviewed the management structure of the home and determined that a head of care role would be beneficial in supporting senior staff. This role had been approved and interviews took place during our inspection visits.

Records were stored securely and there were systems in place to ensure data security breaches were minimised. Staff had individual access to computer-based records and rooms containing records were locked when not occupied by staff.

Feedback from other professionals indicated that whilst communication had not always been effective that they found the new manager to be responsive and transparent in their approach.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents CQC had not been notified of allegations of abuse.

The enforcement action we took:

We served a fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive appropriate care that reflected their needs and their preferences.

The enforcement action we took:

We have imposed conditions on the provider's registration requiring them to report improvement actions taken each month to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person.

The enforcement action we took:

We have imposed conditions on the provider's registration requiring them to report improvement actions taken each month to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not provided with safe care and treatment.

The enforcement action we took:

We have imposed conditions on the provider's registration requiring them to report improvement actions taken each month to CQC.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes did not operate effectively to protect people from abuse and improper treatment. A person was restrained without oversight or planning. A person was detained without legal authorisation.

The enforcement action we took:

We have imposed conditions on the provider's registration requiring them to report improvement actions taken each month to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated effectively to ensure compliance with the regulations. Records were not accurate, complete or legible.

The enforcement action we took:

We have imposed conditions on the provider's registration requiring them to report improvement actions taken each month to CQC.