Four Seasons Homes No.4 Limited

Kingfisher House Care Home

Inspection report

St Fabians Close
Newmarket
Suffolk
CB8 0EJ

Tel: 01638669919
Website: www.fshc.co.uk/kingfisher-house-care-home

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over two days 23 and 24 January 2017. The inspection was unannounced but the provider was aware that we were coming back for day two. The last inspection to the service was on the 23 March 2016 and the service was rated as Requires Improvement overall. We identified two breaches which were: Regulation 14 HSCA Meeting nutritional and hydration needs and regulation 18: staffing. The provider sent us an action plan following the inspection telling us what they had done to make the required improvements. However at this inspection we still had significant concerns about staffing levels and felt they were not always appropriate to people's needs or sufficient to provide timely, personalised care to people.

The service is registered to provide residential and, or nursing care. The service has four separate units and can accommodate up to 91 older people some who may have a diagnosis of dementia. At the time of our inspection there was one vacancy.

There is a registered manager in post. 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.

We noted since the last inspection there have been a number of visible improvements. The service was clean and welcoming. There was a lot of information around the service showing what was going on in terms of activities and changes which had been implemented as a result of feedback,
'You said we did' which showed the service listened and acted on feedback. In addition i-pads were placed around the service to enable people and visitors to give feedback which then went straight to the manager to access. The service published a newsletter and a team of activity staff provided different activities across seven days a week. There was evidence that a lot of staff training was taking place and staff practices were observed mostly as good.

However we identified a number of issues which were having an impact on the service delivery. The first was the staffing levels and whether these were actually appropriate to people's needs. Staffing levels fluctuated and we saw even with the numbers of staff the service said they needed people did not always get the care they needed in a timely way. Care observed was largely functional around people's needs but less so around the time people would like from staff. Some people were isolated and more vulnerable to declining health. For others who were able to socialise their lives were more enriched.

Risks to people's safety were managed but this was not always clearly evidenced through the records because they were not accessed by staff delivering the care. Records were not always completed and updated contemporaneously or accurately reflecting changes in people's needs.

Medicine practices were much improved and managed safely. Staff were familiar with people's health care needs and took steps to prevent ill health or manage long term conditions. However records did not always

show how this was done effectively.

Staff recruitment practices were adequate but could be improved upon.

Staff were supported through induction and training and were mostly familiar with people's needs. However staff simply did not have the time to ensure everything was followed through correctly.

People were mostly supported to eat and drink in sufficient quantities for their needs and this was monitored. However the level of support people got varied and this was not always established depending on their needs but more in relation to the staffing allocation.

Staff had a good understanding of legislation relating to the Mental Capacity Act and Deprivation of liberties and its application. The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People's care plans were comprehensive but not accessed by staff who needed them to inform them of the care they should be providing. Records were not always updated as and when needed to reflect changes in people's needs. Information was difficult to find which could result in people receiving the wrong care.

Social activities were provided across the service seven days a week but access to these were restricted either because the activities did not suit people's personal preferences or because people would require support to join in and this was not always available. Some people were fully engaged with the service whilst others chose to be less so but there was limited evidence of how staff spent one to one time with people.

The service acted upon feedback to help improve the service it provided. There was an established complaints procedure which showed actions taken in response to people's experiences.

The service was mostly caring and staff were highly regarded and considered kind and caring. However constraints around staffing levels impacted on people's experiences and meant people's independence and dignity was not always upheld.

The service involved and included people in the way the service was managed and care was delivered. There were many ways in which people could feed back their experiences but we found through our observations that care delivery was not always effective and many people would not be able to feed back their experiences due to their frailty or severe cognitive impairment.

The manager was working exceedingly hard to manage the service and support the staff. There were many audits in place to judge the quality and effectiveness of the care being provided. The manager was listening and responding to concerns but it was felt that due to the pressures of the job were not always available or did not always act on feedback.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not enough staff to continuously provide the standard of care people needed.

Risks were not fully mitigated because not all staff were aware of people's needs and gaps in record keeping meant we could not see how people's care needs were monitored and care delivered.

Training was in place to help staff recognise abuse and inform them what actions they should take to keep people safe from risk and harm

Recruitment processes were adequate and helped ensure only suitable staff were employed. However we have identified how these processes could be improved upon.

People received their medicines as intended by staff who were adequately trained.

Is the service effective?

Requires Improvement

The service was mostly effective.

The service monitored people's weights and took actions in terms of unplanned weight loss

Staff were supported through induction, training and formalised support. This was structured to help ensure staff got the support they needed for their role and poor practice where identified could be addressed.

The home acted lawfully in relation to the Mental Capacity Act and only deprived people of their liberty when it was in their best interest and had been granted by the Local Authority. People gave consent for their care and where consent could not be sought from the individual decisions were taken in the person's best interest with the involvement of relevant parties.

People's health care needs were planned for but we could not always see how risks were mitigated and found omissions in

records and care practices.

Is the service caring?

Requires Improvement

The staff were mostly caring.

Staff practices were mainly positive and staff enhanced people's experiences of care. However we did identify pockets of poor practice.

Staff promoted people's independence and provided care according to people's wishes. This was recorded in their care plans.

There were opportunities for people to feedback their experiences which was taken into account and helped shape the service provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not sufficiently personalised and care plans did not always reflect people's current needs or sufficiently accessible to staff.

Activities were provided but these were not readily and equally available to everyone.

The service had an established complaints procedure and the service took into account people's feedback.

Is the service well-led?

Requires Improvement

The service was mostly well led.

The service ran efficiently and was observed to be clean. Staffing levels were provided according to people's assessed dependency levels but we found this did not meet people's needs in the way we would expect. People were left waiting for care and care was at times compromised.

People had different experiences of the service with some people more engaged than others. We did not see equality of opportunity.

The manager had made improvements to the service and the service had the potential to be very good. However we felt staff were unacceptably busy which meant things were missed and

care could be more personalised if staff had more time.

The audits we saw did not always reflect people's experiences or demonstrate levels of care we observed.

Kingfisher House Care 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.

The inspection took place on the 23 and 24 January 2017 and was unannounced on the first day but we notified the manager we would be coming back for a second day.

The inspection was carried out by four inspectors, one based on each unit, an expert by experience, a Specialist advisor and a pharmacy inspector. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience with supporting older people. The specialist advisor was a registered nurse. Our inspection was over two days with reduced numbers of inspectors on the second day. During the inspections we observed the care being provided on each floor over a minimum of one day. We spoke with, the manager, the deputy manager, two registered nurses and the CHAP (Care Home Assistant Practitioner) on duty. We spoke with care staff on each floor. We spoke with twenty people who used the service, and five relatives. We completed a medication audit and case tracked over ten care plans. We looked at records relating to the management of the business.

Prior to the inspection we reviewed the information we already held about the service including notifications relating to important events the service is required to tell us about and also reported safeguarding concerns, complaints and share your experience forms, where people provide us with information via our website. We also looked at previous inspection reports and spoke with a number of professionals involved in the service.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were not always appropriate to people's needs and not all staff were sufficiently familiar with the needs of people they were supporting. We inspected over two days and found on every unit staff were working under pressure and people did not always get the care and treatment they needed in a timely way.

People using the service, relatives and staff overwhelmingly told us there were not always enough staff. People told us, "Staff are good but they can't get more helpers. They are sometimes short at night, on one night there was only one staff for a couple of hours." Another said, "I have to wait a good while when I call for help."

Staff spoken with said shift patterns varied but some staff were working on day and night shift and often worked a twelve hour shift pattern which was monitored to ensure staff were not getting unduly tired which could affect their effectiveness. However staff told us they did get tired and said they were always busy. Staff told us "We are regularly short staffed and this meant that things like bathing doesn't get done. I have been here days with two staff (for 26 people excluding the nurse). They do get agency staff but these should just be for an emergency and not on a permanent basis." They said they went home each day, "mentally and physically shattered. " Staff were deployed to other units to ensure there was an appropriate skills mix and also to ensure that if a unit was falling behind additional staff were made available to help. In practice this meant staff were continuously busy and did not appear to have time to sit down and chat with people. A staff member said, "There is always something to do, there is never a minute to just sit down."

The service used a dependency tool to calculate how many staffing hours they needed to meet people's care needs. However this did not seem to take into account people's individual and changing needs. Staff told us when people's dependency increased they do not get additional staff. A staff member told us, "We struggle with staff, the staffing levels were higher but we now only have five and some days this has dropped to three." Staff were unable to tell us how people's dependency was calculated. In addition we saw staff were required to undertake many tasks which were not directly related to the care they were being asked to provide. On the day of our inspection the service had the number of staff it said it needed. Regardless of this we observed staff on every unit busy throughout the day. The current levels of staffing had a clear impact on the quality of care being provided. For example we observed call bells not being answered quickly. On some floors they went off continuously and after three minutes call bells went to emergency mode. Staff did not answer them quickly because they were busy attending to other people and there seemed an indifference to call bells going off. There was no one on the floor to respond to bells. The concern we had was that staff had become accustomed to hearing the emergency alarm noise and did not instantly respond to it, as it is part of their normal work noise. An emergency call should be quickly recognised as requiring immediate assistance and staff should respond promptly to it. We met with one person who told us they needed the toilet. They said the carer came when I called the bell and then disappeared again. They said, "I am nearly doing this wee. They have brought this", pointing to the hoist but have gone to get another carer as I need two people….it is awful in here…..they are so shorthanded."
A relative told us that staff had turned off their relatives call bell without attending to them. We raised this with the manager for their immediate attention.

Some people were still in bed just prior to lunch and staff were observed as being busy attending to others so it was difficult to see if this was of people's choosing to remain in bed and the people themselves were unable to tell us. We spoke with one person who was waiting to go back to bed after lunch. They told us, "I first pressed my bell about half an hour ago; they will get to me eventually."

We observed a number of people in some distress calling out and constantly asking for reassurance. Staff were not always in the vicinity and not always able to respond quickly. Other people using the service were disturbed by the shouting and told people to be quiet causing them additional distress.

Staff and relatives reported that at times the service ran with less staff than they said they needed and the manager confirmed they did use agency but this had not always been possible leaving shifts short of staff. The service currently is experiencing difficulty in terms of covering hours created by long term and short term sickness leave and annual leave and had used in excess of 300 hours a week in agency cover. The manager told us they were recruiting to both permanent and bank hours and this was on-going. On the day of our inspection new staff were inducted and this was being managed appropriately. Unplanned reductions in staffing levels did not seem to be considered in terms of admission rates as the service only had one vacancy on the day of our inspection which was due to be filled. We were not confident there were enough staff to deliver the care or that there were sufficient contingencies to cover staff vacancies.

Additionally we found that the nurses on duty were stretched in terms of what was required of them and how they could effectively manage their duties. Nurses confirmed that there was only one nurse per shift on the nursing units, and nurses often had to support staff on other units which were mainly residential. On each unit there were people who required nursing care. There was currently no clinical lead and the deputy manager worked both on shift and had other duties for which they were given supernumerary hours. Nurses were also given supernumerary time. However we observed nurses carrying out duties and often not having time to provide supervision to other staff or provide effective leadership or direction on shift.

The above evidence demonstrates a Breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 18 (1) Staffing

People were protected as far as possible from potential harm and abuse. Prior to the inspection we were aware of a number of safeguarding referrals some of which had been substantiated. There were systems in place to help staff recognise and understand what constitutes abuse. Staff were forthcoming in terms of recognising abuse and understanding their duty to report concerns, although not all staff felt there was effective communication in the service so were not confident things were always adequately dealt with. However we saw from records that safeguarding concerns were reported and investigated internally when requested by the local authority safeguarding team. The service cooperated in investigations and showed clear actions taken following a concern being raised. We noted that sometimes there was a delay in identifying and reporting a concern so it could be properly investigated. We noted that changes in practice following a safeguarding concern were not always sustained by the service. This resulted in further safeguarding concerns around similar issues and themes.

Risks to people's safety associated with their care and health care needs were not always managed effectively because information was not readily available to staff. We spoke with people and asked them specifically if they felt safe. One person said "I do feel safe here, the staff are respectful to me, I can't fault them really." Another said, "I am safe here, I can look after myself"

During our inspection we identified a couple of air flow mattresses which were bleeping indicating low pressure and brought this to the nurses attention so they could address it. We found some air mattresses did

not have any attached information about what the setting should be so were not assured that care staff would know or know what actions to take if the setting was not correct. Having a mattress at the incorrect setting placed the person at an increased risk of developing a pressure sore. On other units we saw recorded information about pressure settings and this was correct according to the person's weight. We observed a number of people who were a very high risk of pressure damage sitting in their wheelchairs without pressure relieving cushions; one was sitting on a manual handling sling.

People's care plans documented known risks to people but this information was not easily accessible to care staff. Care staff told us they did not always have time to read the care plans before delivering care and information was not easily accessible or in a format staff could access quickly. Not all staff were aware of people's needs either because they were agency, new to the unit or had not been involved in handovers because they had been deployed to that floor during the day. Information about people's care needs was not always effectively disseminated to staff.

Care staff told us they used the room documentation to record people's needs and to get basic information about them. However records were not always fully completed and did not show us how risks were being effectively managed. For example one person had been referred to the GP as they had not had their bowels open for seven days. Room documentation was meant to be checked by the senior in charge who would action any concerns. The policy of bowel management was to report to the GP within three days of no bowel entry. This had not happened and there had been previous omissions/safeguarding concerns about the service practices and poor recording of care delivery and management of risk.

Gaps in nutritional assessments included poor evaluation of risk in terms of aspiration (where food and fluids are inhaled into the lungs) and poor recording and instruction for staff in terms of managing catheter care although we were advised all nurses had received training. Records, where completed correctly, showed good monitoring and evaluation of risk and needs but we found some records were not completed as required and therefore did not give us a full picture of the person's needs. For example people with catheters had their fluid input recorded but not their urine output. This was for individuals prone to fluid retention and infection so it was important to measure output.

People's weights were being monitored but we identified gaps in their records, the wrong dietary information was recorded on some records and there was a lack of guidance for staff about how to monitor a person's weight. We were not always easily able to see if interventions to promote/stabilise a person's weight were successful as records were not always complete or information was recorded in different places. .

The above evidence demonstrates a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 17(1) (2) a, b, c good governance.

The service was reasonably secure. There were key codes on all entry/exit doors. There was a signing in book at the main house building reception and the second unit entrance door. There was a list of staff on the notice board, indicating who was working and who was in charge of the shift. We noted some staff were not wearing their company name badges. During our inspection several staff asked us for our identity and did so when we first arrived. There had been a number of incidents in which several people had managed to leave the building when it was unsafe for them to do so. These were subject to a safeguarding referral to identify how people could be protected further from harm. We noted that one person was moved, after consultation, to another unit but still spent time preoccupied about how to 'get out.' Unfortunately there seemed little in the way of strategies to support them or enable them to have regular access to the garden/outside.

People's medicines were managed safely by staff who were adequately trained. We spoke with people about their medicines. One person told us "I do my own medication; the staff help me with putting on cream. I think the staff take more care of me here, than other homes I have been in, with my medical needs."

A member of the CQCs medicines team did an extensive review of medication records and completed a medication audit. They found that medicines, including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were stored securely. Previous concerns about medicine management have been identified in the past by CQC but there has since been significant improvement in this area.

The medicines administration records we looked at included allergy information, a photograph of the person to make sure they were correctly identified and guidance for staff on the different ways that each person preferred to take their medicines. The charts were signed to show that medicines were administered regularly however some of the cream charts we looked at had not always been signed to confirm that the cream had been applied, so there was no record of whether they were being used as prescribed.

Some medicines were prescribed to be taken when needed, for example for pain, and we saw that in most cases there was information available to help staff who did not know the person well to decide whether the medicine was needed. However we also saw two medicines, one for agitation and one for pain, where the information was not available so people might not have received the medicines in a consistent way and when they were needed.

One person was given their medicine covertly, hidden in food or drink, to make sure they took it regularly. We saw that an assessment had been made of the need to give medicines in this way, and that the right people had been involved including the person's family and healthcare professionals.

There was a process in place to enable people to take their own medicines if they wished to do so, and we saw that one person looked after their own inhalers.

We looked at the equipment in the medicines room, there was a suction machine in a box, and it had in date suction catheters with it. There was a syringe driver with correct equipment to set this up. A nurse showed us a new finger pulse oximeter, for oxygen levels in the blood, there was also manual and electronic blood pressure recording devices, a new electronic temperature recording device for the ear. These had protective covers. Equipment was not checked regularly despite guidance in the service which said it should be checked daily.

Staff recruitment processes were in place and these helped to ensure only suitable staff were employed. A person made reference to male carers saying "I don't want male carers you hear such things on the TV, do you think the carers have been checked to see they are alright?" We checked staff records and staff had disclosure and barring checks in place to check that they had not committed an offence which might make them unsuitable to work in care. We looked at two staff files and found satisfactory checks were in place for new staff before they were given a contract of employment. Staff checks including an application form with previous types and dates of employment, two written references, identification, proof of address and eligibility to work in the UK. Staff were subjects to checks from the disclosure and barring service to ensure they had not got previous offences which might made them unsuitable to work in care.

Information collated as part of the recruitment was not as robust as it could be. It did not tell us how the potential applicant was judged as suitable for the job role they had applied for. We found application forms were not completed in full making it difficult to assess how the person was selected for interview. We also

found interview notes were not comprehensive and had not explored gaps in employment of how the applicant's responses were judged in line with the person's specification and job description.

Requires Improvement

Is the service effective?

Our findings

People were offered a balanced diet and there were systems in place to monitor risks to people not eating or drinking sufficiently for their needs. However, people's dining experiences were mixed as was the feedback about the food. One person told us, "A lovely meal can be ruined by the way it is cooked. I do feel hungry here especially in the evenings as supper is at 5pm. In other homes I have lived in there is food in the evening. I don't get anything here after 5pm. 'My family have to bring in food for me to eat. I only get drinks if I ask." Another person said "the food is horrible, I can get egg and bacon every morning, but the food is chronic. My family member came and told the cook how to make stew. The cook isn't a chef it is all frozen food." One person said "By the time my food comes it is always cold. I'm sure it would taste a lot nicer if it were hot – that's why I don't eat much. They ask me what I would like but then they only offer what they have – and it is still cold.

Staff told us," Breakfast, if the resident wants early, it can be 8.30am. Some will eat in their bedroom. Breakfast 9am, Lunch 1pm, Supper 5pm. Snacks will be at 11am and 3pm. Residents can ask for other times." However on some units there was no evidence of snacks being readily available to people other than the offer of biscuits. The catering staff were short of staff on the day of inspection due to annual leave and they were not visible at lunch time or supporting care staff in the serving of meals on all units.

We saw in some instances people received the support they required with meals and the atmosphere was conducive to people's well-being. In the main building, Kingfisher down, additional staff including the domestic staff and activity staff helped to ensure people received their meals in a timely way and were given the support they needed. People were observed having individual choices according to their preferences. The main meal options denote two choices but we observed people having what they wanted within reason. Staff were pleasant and gently encouraged people. For example we observed staff sitting with people, chatting and offering support at an appropriate pace. We observed staff saying, "Have you had enough? Are you comfortable? I shall go and leave you in peace."

In contrast, on the nursing floor for people with dementia we observed people being supported by staff but no additional staff were deployed which meant that not everyone received timely support and encouragement as staff were busy assisting other people. A number of people ate very little of their meal and food was taken away without asking people if they wanted anything else. We noted everyone except one person had the same meal choice. We were informed that people's menu options were requested the day before but people could change their mind if they wished. However staff did not present people's food in a way which maximised their choices. We noted there were menu cards on the tables of the dining rooms. The font size was small and there were no pictorial prompts to support people.

The portion sizes were too big and the same size was provided for everyone regardless of their needs. We observed one person who had not eaten much of their dinner, being given a pudding which they then struggled for several minutes to cut through with a spoon. When this failed they used a knife to cut it but did not have the manual dexterity to do so. They then started calling out but staff did not notice. They then tried to pick up their pudding and then gave up and pushed the whole pudding away without eating anything.

Another person was observed chasing food round their plate with difficulty. No one had adaptive cutlery and no one had a slip mat which might make it easier and facilitate their independence. Some people were able to leave the table as they wished but others had to wait to be assisted by staff. The dining room was too small and did not enable everyone to sit round the table or sit in smaller groups. Staff sometimes had to move someone in order to assist another person out of the room.

A record we looked at concerned monitoring of a person's weight. We saw weight loss had occurred and the person was poorly with an infection. There were no other records to show actions taken by staff or how the weight loss was being monitored by staff to ensure further weight loss did not occur.

The above evidence demonstrates a Breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 14. Meeting nutritional needs.

People's health care needs were not always met. We spoke with people about this. One person told us "I have an infection at the moment, and I feel I can't move from here (bedroom). I am on antibiotics. The staff sent for the GP. Staff have to report my needs here, then a report has to go to the GP before anyone visits." Another said "I tell the staff if I need a health professional and they get one for me."

People had their health care needs overseen by nurses who monitored people's needs and ensured people's needs were met. We noted folders were in place to indicate where people were coming to the end of their lives and this documented if the person was for active resuscitation and any other information to help ensure the person was adequately supported in their final hours. We noted delays for one person in getting their pain relief increased. The nurses told us the GP practices reviewed people's needs every three months but for some people this was much more often. However staff felt continuity of care was sometimes an issue due to different doctors in attendance who were not always familiar with people's needs. They also said getting prescriptions for people could be slow with a lot of time wasted chasing GPs.

We reviewed people's health care records and found poor information around catheter care and how to mitigate risks around reoccurring infections. Nurses were not clear how often catheters should or had last been changed. Dates for re catheterisation had not been added to the diary so could be easily missed. Information about continence care was recorded in different places in different sections of the care plans making it difficult to find how the person's needs were being met.

We found that another person had a high temperature and had vomited. An out of hours GP had attended and prescribed antibiotics. However there were no further records concerning this episode, either in terms of their progress or any other monitoring of their temperature or continued ill health or progress showing if their health was improving.

We reviewed the management of ulcers and found in one instance no measurement of the wound and instructions about pain relief not clearly documented on the wound care chart. Nurses knew when to administer this but they were regular nurses. Agency nurses would be less familiar with a person's needs.

The nurses told us any specific instructions or changes in people's needs would be documented and handed over using the handover sheet to communicate people's needs between night and day shifts. However when we looked at this sheet there was insufficient space to include information needed and the list did not correlate to the people actually currently living on unit some of whom had passed away.

The above evidence demonstrates a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 12, 1, 2 a, b Safe care and treatment.

People were mostly supported by staff who had sufficient skills and experience to meet their needs. We spoke with staff about their induction and training. One staff member told us: They had achieved additional qualifications and had opportunity to do regular training, and there was a list of training in the office of training coming up. All staff were completing more in-depth training around providing good dementia care and this included a number of different elements. From this the service were going to develop dementia champions who could support and coach other staff. Most staff spoken with were able to demonstrate a clear understanding of people's needs and how people's needs should be met. The service already had a number of champions in other areas of health care and their role was to promote good practice and support staff.

We saw the training matrix which showed over 90 % compliance with initial training and refresher training, although we have since been informed by Four Seasons that this information could not be relied upon to be accurate. Most of the training was completed using e-Learning which staff commented on, stating that new staff had a three day induction but in addition had e-Learning as their main source of training which they did not feel was sufficient. Staff's initial induction also included being shadowed by a more experienced care staff but this was not recorded to show initial observations of the staff's performance or identifying any areas of concern/strengths. However the manager told us staff were supported to undertake additional qualifications in care and relevant qualifications for staff's role was being rolled out? For example specific training was being provided around provision of activities. The service was also supporting care staff who wanted additional responsibilities to undertake duties which otherwise would be carried out by nurses. They were working towards becoming CHAPS- care home assistant practitioners. Tasks included administering medicines and taking bloods.

The manager told us they had made significant improvements in how they support their staff. Examples given were a senior carer had been nominated for an award and the service went to the care awards in London for the first time. This they told us had inspired and motivated staff and the organisation supported staff to develop further where they wished to. In addition the training and development programme for staff in the provision of good dementia care was being rolled out and due for completion in the first quarter of 2017. This was expected to enhance staffs skills and competencies in providing good dementia care.

Staff confirmed there were regular team meeting and staff meetings. We saw these were organised for the year with a different topic for discussion and for the manager to promote within the service. For example in January the emphasis was on infection control and observation on staff practice was taking place to help ensure staff were following good infection control practices. Staff were supported through regular supervision, annual appraisal of their performance and measures were in place to provide additional support, monitoring and supervision for staff where poor practices had been identified. Supervisions were planned well in advance and appraisal gave staff the opportunity to reflect on their practices and agree any training and, or learning required for the following year. This ensured staff had the support to improve their practice and work in line with expectations and company policy.

Consent for care and treatment was sought in line with people's needs. We reviewed people's records and saw where appropriate Deprivation of Liberty safeguards, (Dols) applications had been made to the Local Authority and there was a best interest decisions in place regarding the use of resuscitation and consent for bedrails when it was in the persons best interest to keep them safe. Staff received training in the Mental capacity Act and Deprivation of Liberties safeguards. Staff acted in line with people's wishes. People's wishes in relation to end of life, resuscitation and day to day decisions were recorded and reviewed.

Requires Improvement

Is the service caring?

Our findings

Staff developed positive, caring relationships with people using the service. Staff were visibly kind and caring to people and we saw regular but brief interactions between staff and people. Overwhelmingly people felt staff were kind. One person told us, "I have lived here about eighteen months it is nice here. Another said, "It is all good here thank goodness, I can't fault the carers. Lovely all of them." Another said, "I can't fault the staff. I have been here a month. When the staff come on duty they shout down the corridor 'morning (name) and at night when leaving goodnight (name) No they don't come in for a chat." Another said, "I am happy here I am well looked after I could not be in any different better place."

We met a number of relatives most of whom reported favourable things about the service. One said, "They are happy here, the carers are very good and kind. " They told us the home was a social place and said their family liked coming here.

The manager told us about the impact they had seen from training rolled out for staff in providing high quality dementia care. They said there had been a marked improvement in the way staff treated people and spoke with them.

Some of the observed interactions during the day were meaningful and helped enhance people's day but we found that some interactions did not focus on the individual's needs. For example we saw one person had started to cry and staff sat with them, talking with them and trying to establish why they were upset. They reassured the person as much as they could. In another less caring observation we observed a carer pushing a person's wheelchair towards to table and accidently banging their knee on the table. The person cried out but this was not acknowledged. The person asked for their glasses which were fetched for them but the staff did not speak to the person or say good bye when leaving. Another person told us , " I want to change my room as the carers keep coming in and the door bangs all the time and I don't want to be disturbed. "

We noted that for a number of staff English was not their first language and this for some people was difficult. One person stated, "There is a language barrier, it is not always easy to understand the staff." Another said "There is a language barrier; I see different staff every day." Another said, "The carers don't come, they take a long time and I have to shout, the carers don't speak the language and don't know what you're on about ". We conversed with staff and found most had very good language skills but several staff did not, making in-depth conversation difficult. We also noted that communication with people was often fleeting and not all staff took the time to maintain contact with the person or give them time to respond to things or speak slowly and clearly. One staff was observed shouting at a person who was hard of hearing. The persons hearing aid was whistling so may not have been working effectively and the staff demonstrated a poor understanding of the needs of the person with a hearing impairment. We observed another person being woken up to receive medical treatment Staff engaged with them briefly before leaving the room, the person was talking to the staff asking for confirmation of the day and time but staff had already left their room.

People's independence was not always promoted. A high number of people using the service had memory problems. We noted in different units that some people's rooms had photos or name labels on their doors to help as a reminder of their room but this was not inclusive. There were no memory boxes or photographs for individual memories. In addition room documentation which was meant to give an introduction to the person did not always do this well.

Across the home we met with people who had in the past been involved with Newmarket races and shared a love of horses. When we asked people if they were able to share experiences with others who had been in the same profession they told us no. However when we spoke with one of the activities coordinators they told us they were planning a visit to the horse racing museum in Newmarket and said a famous and well known artist was going to paint a mural of how Newmarket used to look like years ago on one of the walls in the unit. This would help people stay reconnected with their pasts. Staff told us that when a person moved in they tried to find out about them and then find things they engaged them appropriately.

Staff mostly knew people and their families well which helped staff demonstrate positive relationships with people. We saw people were actively encouraged to participate in the life of the home and there was information around the service to help them do this including a newsletter and scheduled activities. I Pads were used to collate feedback about how people, visitors and professionals found the service. Feedback could be viewed by the manager and regional manager so they could take immediate actions. Resident meetings and care plan reviews were held and consultation took place with relatives.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care according to their needs and wishes and care was sometimes compromised by the numbers of available staff. Staff were busy and there was a risk that care could be omitted because of this. We spoke with people about different aspects of their care needs and how this was met. For example we asked people if they needed assistance with personal care. One person told us: "I can ask for a shower or bath at any time. " One person said "Look in there, (indicating to their toilet.) It's is so small I can't turn around properly with my frame it's just too small." Another person when asked about personal care said, ''the staff do it with me. I say can I have a shower, and if it not convenient then I get it the next day."

Records identifying people's care needs were in their care plans. In people's rooms was some additional information for staff including a one page profile which was meant to serve as an introduction to the persons need's and enable any staff member to know enough about the person to provide them with basic care. The care plans then provided more in-depth information about their needs, risks associated with care and how these should be monitored and addressed. We case tracked people through the day. We found that staff were mostly knowledgeable about people's needs but this was not always the case. We found that records in people's rooms did not give enough information or show how staff were meeting the person's needs. For example we saw a daily journal. This contained gaps. There were entries such as, 'person aggressive today' but there were no further entries to offer any explanation for this or how the person had been supported and if this was effective. We then referred to the main care plan which under cognitive section stated the person got confused and agitated; it stated staff should respect and support the person but did not say how they should do this.

Care plan reviews were completed regularly by the nurses and were comprehensive but changes in people's needs did not always result in the care plan or room documentation being updated. It was therefore difficult to see how care staff would know how to accurately care for a person. For example we observed a person recently admitted to the service with breathing concerns and were observed to be very chesty. They were lying flat in their bed with no instruction for staff about correct positioning to aid their breathing or how symptoms of breathlessness should be managed.

We noted some inconsistencies in recording in people's room records. Staff told us they should record contemporaneously but this was not always the case. For example we viewed a food/fluid chart; nothing had been recorded since the previous evening. We looked at a person's records. They had lost weight and their weight was being monitored and the GP had been notified but there were no instructions for staff as how to support the person with their nutritional needs.

We observed another person whose room smelt strongly of urine. Their television was on but the person was not watching it, their appearance was dishevelled. There were lots of risks associated with their care as documented in their care plan. The room documentation lacked detail about those risks and how staff should manage them. For example repositioning charts started hourly repositioning but the records were not accurate, ie they indicated the person was laying on their side when they were sitting up and so forth.

We checked their care plan which stated they should be repositioned every 3 to 4 hours. They had an air mattress but there was no information for care staff about what the mattress should be set at. The information was recorded in a care plan review but not easily accessible to care staff.

Care plans were not always reviewed and amended on the advice of other health care professionals. For example we saw a letter from the Speech and Language Team which advised that a person they had reviewed had mild dysphagia and it would be safer for them not to drink from a spouted cup or a straw. This had been recorded within their care plan review. The care plan had not been revised accordingly to reflect this information and it was not recorded in the room records. The care plan indicated that they required a pureed diet. The Dysphagia Diet Food Texture Descriptors 2011, produced by the NHS National Patient Safety Agency provides standard terminology to be used to ensure consistent understanding of safe food textures. The descriptors include guidance for a Thin Puree and a Thick Puree. Having things too thick is as dangerous as too thin. Too thick and it may stick in the throat and may cause coughing and choking and too thin it can go into the windpipe.

One person's records stated that they should be encouraged to do exercises and the notes stated staff had been shown how to support the person with this. However there was no information in the care plan or room records to inform staff about the exercises or how or when they were to support the person and therefore we could not be assured the person received the right support and improvements were not being monitored and reviewed.

Care plans for people identified at risk of choking were not personalised and did not identify specific symptoms experienced by the individual in relation to how dysphagia affected them. Therefore care staff did not have sufficient information to guide them on how to monitor and review those people or to recognise when symptoms were worsening and identify an increased of risk of choking.

Another example of care plans not reflecting current needs/risks were we observed a person falling asleep and falling forward in their chair. Their care plan review notes stated that they had lost their ability to weight bear or stand recently. Their care-plan had not been updated to reflect this. The care plan had not been reviewed in line with recent falls. One entry said the person was prone to slipping from their chair but there were no strategies in place to help to prevent the person from falling out of their chair such as a non- slip cushion or a more suitable chair. The room documentation did not contain any information in terms of the person's needs in relation to moving and handling.

Care plans did not always provide adequate guidance or information. For example we reviewed plans for people who had feeds through a percutaneous endoscopic tube and people with indwelling catheters. Care plans and room records did not provide sufficient information to guide staff on the safe maintenance of an indwelling catheter and the prevention of the risk of infection and blockage. Totals of output were not consistently recorded, monitored and reviewed to ensure that output was consistent with fluid intake.

There was not an effective system within the care records to access relevant information quickly. We had to read back through the care plan reviews to identify when the catheter was last changed and a record of size and type of catheter. We noted that instruction for the management of the catheter drainage bag was lost in the care plan as identified in a review dated 14/9/16 and was not repeated again. This important information was not reflected in an active care plan or room records. There was no information for care staff in relation to signs and symptoms to be aware of that would indicate a urine infection or blocked catheter.

The above evidence demonstrates a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 9, 1, 2. 3 a- b. Person centred care.

Activities were provided for people and there was up to eighty hours allocated for this. There were four people providing activities and they work separately across different units over a seven day week according to people's needs. For example one person had the 100 year birthday party the previous Saturday. The activity staff had set activities they said people enjoyed to do and spend time in different units and encouraging people on different floors to join in. We observed activities mostly in the main building but were told that activities in the dementia care unit were not being provided as the activities person was on annual leave and their hours had not been covered.

During the first morning of our inspection 14 people were brought to the lounge in the main building and were encouraged to participate in an activity of a playing card version of bingo. The activity co-ordinator was shouting out different playing cards describing the number, colour and suit. Whilst some people had the ability to participate and were enjoying the game it was evident that some people were not engaged and the game was not meaningful to them. We did not observe any activity in the dementia nursing unit. Staff told inspectors that activity staff took people over to the main building to join in activities about twice a week. A person told us they liked to read but did not enjoy the activities. However their sight was not good and they did not have access to easy read books or audio tapes which might help them pursue their interest.

In some units we identified very little in terms of activity and occupation for people. On the first day of inspection some people were engaged in activity both in the morning and afternoon whilst on other units nothing was offered and people sat around throughout the day. People who were able to spend time in communal areas had more social interaction with staff than those who spent the majority of their time being cared for in their bedrooms. We saw that people who spent their time in their bedrooms had little stimulation, only that from staff assisting them with a care task or when their relatives were visiting. Some people were not in a state of well-being. For example one person was observed to be upset and struggling to put their cardigan on. Their breakfast, soggy cornflakes in front of them untouched. We spoke with this person to ascertain if they were alright and also looked at their records. We saw they had been identified as losing weight but did not get support to eat their breakfast. This was removed untouched and although the person was offered something else this did not materialise.

There was an established procedure in place to enable people to raise concerns or feedback about the service. These were appropriately responded to showing what actions had been implemented as a result of the complaint with timescales showing how quickly the concerns had been dealt with. We were provided with a complaints log which documented a number of alleged omissions in care and incidents where people's health and safety had been compromised. These issues had been addressed with individual members of staff and with staff teams as a whole to help ensure staff learnt from incidents and were aware of what they should do differently in line with company policy.

However a number of relatives told us when they raised concerns these were not actioned. An example given was around replacement carpets being requested because of odours and, before the inspection, concerns about toilet systems being broken were raised with us. Although this had been dealt with there was a considerable delay before the matter was effectively dealt with.

Requires Improvement

Is the service well-led?

Our findings

At the last two inspections we have reported on a breach of regulation 18 relating to insufficient staffing arrangements and have previously taken action to ensure this issue was addressed.. At this inspection we found that the improvements had not been sustained. We found the service was not always well led and people's experiences varied from unit to unit. Evidence from our inspection, and talking to staff, relatives and people using the service helped us conclude that there were not always enough staff to give people the care they needed in a timely way and according to their assessed needs and wishes. We were concerned that an overreliance on a staffing tool was misleading and did not adequately take into account peoples experiences or the experiences of staff and relatives.

Some staff felt morale in the home was low and attributed this to their working conditions stating that their efforts were not always appreciated. Staff told us they picked up extra shifts and worked hard but this was not always recognised. Staff told us they raised concerns but these were not listened to or their concerns actioned. Staff said, 'We do not have a voice.' Another said, "There is no team approach, there is no point in going to the manager as nothing happens." In addition staff told us training was mostly completed through e-learning which did not give them sufficient opportunity to discuss things. Staff commented on how difficult this must be for new carers.

We discussed this with the manager. They told us the nurses were responsible for raising concerns if they felt staffing levels were inadequate then they or the deputy manager would assist staff which we observed happening on the first morning or our inspection. However we also acknowledged that the manager had a lot they were expected to do each day which impacted on their ability to support staff. We found each unit was equally busy which made it difficult to deploy staff effectively. For example at lunch time all units would of benefitted from additional staff but in practice only the main building was seen as having additional staff to assist and after lunch staff numbers dropped as staff went for their own breaks which meant people had to wait.

The manager told us they were supported by a deputy manager who had only recently come back into their post. The deputy manager worked on the floor and had recently been given additional time off the duty rota to complete their other duties. In addition nurses were given time off shift to update and review the care plans. There were plans to appoint two clinical leads who would be managed directly by the deputy manager who would then report to the manager. The clinical leads would have oversight for the two floors in each separate building. We agreed this was a sensible suggestion. There were two registered nurses at any one time on each of the designated nursing floors. However the other floors had a mix of people with a primary nursing or residential need. People in the residential beds had their health care needs overseen by the district nurse team. People with a nursing need on the nursing unit were overseen by nurses employed by Kingfisher staff. On the residential units there was no nurse but they did have people in nursing beds. These floors were managed by care staff with enhanced training and specific training to enable them to carry out some basic nursing duties. We asked about oversight arrangements for these floors and were told the registered nurses would support non nursing staff as required. In practice this meant nurses were supporting more than one floor.

There were systems in place to audit and identify where the service was performing well and where improvements were still required. Most of the audits seen showed a high level of compliance against the agreed targets or areas measured. Audits included night inspections to ensure the service was running effectively over a 24 hour period. However this was inconsistent with our findings and some people's experiences. We found record keeping and the dissemination of information requires improvement. We asked about how information was handed over and told there were handovers at the start and the end of the shift. The handover sheet was out of date with information which was incorrect for example, including people no longer at the service and incorrect information about people's needs.

Information in people's room was limited and did not give a sufficient overview of the person's main needs and in some instances gave incorrect information. For example we saw a person with diabetes being given sugar in their tea and whilst their room documentation recorded they were on a normal diet, their care plan recorded their diabetes. Care staff told us they did not read care plans and it was the nurses writing and reviewing the care plans. The care plan reviews were very insightful but important information was often hidden and not known by care staff delivering the care. This was not picked up by the manager or provider through the quality assurance processes which left this person and others at risk of receiving inappropriate care which did not meet their needs

The above evidence demonstrates a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 17 1, 2, a-c. Clinical Governance.

Despite our concerns we did identify a number of significant improvements which were shaping the service and meant care was being managed more cohesively. For example there were heads of department 11.00 o'clock meetings which were used to disseminate information and establish any immediate risks and concerns. There were regular staff/resident/relative meetings as well as clinical meetings which were used to remind staff about their roles and responsibilities and emphasis on what was going well and what required improvement. In addition the manager was doing daily walk around across the service. We felt given the size and complexity of the service this could take a considerable period of time. In addition the head of each unit was reporting on any risks, accidents and other issues such as cleanliness and staffing. The manager was then compiling a daily report which was sent to regional office. Again we found this was an onerous task. Other examples of improvement included promotion of professional practice and development of staff. The manager had completed My Home Life which was run by the Local Authority and put managers of different homes in touch with each other to discuss and share good practice.

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The service engaged well with others, sharing good practice and trying to ensure people got the care they received. The manager spoke positively about their experience of the home life project and other initiatives run by the local authority. They reported positive audits from other regulators and good support from other managers employed by Four Seasons.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Records were not updated as and when people's needs changed and did not always provide an accurate, contemporaneous record. Staff were not using people's plan of care to help guide them in delivering effective, cohesive care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not fully mitigated because of poor assessment, planning and evaluation of risks

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Not everyone received the support or adequate monitoring of their dietary needs and food/fluid intake.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were in place to measure the effectiveness and quality of the service provided but we found poor record keeping did not support this or show that people were getting the support they needed around their health and welfare. This exposed people to

unnecessary risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not have sufficient numbers of suitably qualified or competent staff who were sufficiently deployed across the service.