HC-One Beamish Limited

Kirkwood Court

Inspection report

Kirkwood Drive
Kenton
Newcastle Upon Tyne
Tyne and Wear
NE3 3AX

Tel: 01912133690
Website: www.hc-one.co.uk

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13 April 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Kirkwood Court 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. Kirkwood Court accommodates up to 72 older people, in one purpose built building. Care is provided over three floors, including one floor, known as the Grace unit, for people living with dementia- related conditions. Nursing care is not provided at the home. At the time of our inspection there were 68 people living at the home.

This unannounced comprehensive inspection took place on 28 and 29 March 2018 and 4 April 2018. This meant that neither the provider nor the staff knew we would be visiting the home on the first day of our visit. Following these visits we requested further information from the provider and contacted relatives and staff by telephone. We concluded these inspection activities on 13 April 2018.

We last inspected this service in October 2015. At that time we found the service was meeting all legal requirements and rated the service as 'Good'. However, during this inspection we found some shortfalls in the delivery of care, and therefore rated the service as 'Requires Improvement'.

A registered manager was not in place at the time of the inspection. The previous registered manager had de-registered shortly before our inspection. The provider had employed a new manager who was in the process of applying to CQC to become registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst processes and procedures were in place for the safe management of medicines, these were not always being followed.

Staffing levels were not consistent. On the days we visited we saw people's needs were well met, however staff, people and relatives we told us there were not always enough staff on duty. Rotas showed staffing levels were regularly below the number we observed during the inspection. The regional manager told us any staff shortage was dealt with by the manager or domestic staff providing care. However feedback from people, relatives and staff was that there were not always enough staff available.

Robust recruitment procedures were in place, and the provider had recently strengthened their agency staff protocol after an incident where someone had mistakenly been assigned to work in the home.

The home continued to monitor accidents and incidents, manage risks and follow infection control processes.

People's needs had been assessed. However, as care plans varied in quality and detail, in some instances

information about how to meet identified needs was missing.

Staff were up to date with training the provider considered mandatory for their roles. They received regular opportunities to discuss their roles and care they provided.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us they enjoyed the food at the home and that it was plentiful. Mealtimes were well organised and an enjoyable experience. Where needed, prompt referrals were made to health and social care professionals, such as speech and language teams, dietitians, specialist nurses and GPs.

People and relatives told us staff were caring. They gave us examples of when they had been touched by the way staff had gone out of their way for people. We saw that staff knew people well and had good relationships.

People were encouraged to be independent, and their right to privacy was respected. Staff supported people to maintain links with people and organisations which were important to them. Relatives told us they were welcome to visit any time, and some people were supported by staff to attend church services.

Information was available to people about the service. People were included in the planning of their care. Relatives told us their input had been valued when plans of care were being written. Most care records included information about people's choices and preferences.

Processes were in place to enable people to be cared for with compassion at the end of their lives. A relative spoke highly of the support both their family member and they received at this important time.

There were a range of activities on offer in the home, and regular trips were planned to places of interest. Staff had worked with people to help them to think of 'Three Wishes', which were personalised activities that they would like to achieve.

The provider followed their complaints policy. Some relatives told us they had complained and received a response.

The quality assurance system included a range of audits carried out regularly by the manager, regional manager and the provider's quality assurance team. However, whilst we saw audits highlighted issues with the standard of record keeping, remedial actions identified had not always been carried out. Medicines audits had not identified issues with 'as required' medicines.

Staff described low morale. However, people, relatives and staff were positive about the change in management structure, and proposed changes which the new manager had committed to make.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to Regulation 17: Good Governance and Regulation 18: Staffing You can see what action we told the provider to take at the back of the full version of the 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 effective.

The provider had identified a programme of training for staff and this was well maintained. Staff met with their supervisors regularly to discuss their development.

People's needs had been assessed. Care plans were in place, although we noted the standard of these varied.

Where decisions had been made in people's 'best interests' the Mental Capacity Act 2005 had been followed.

People's feedback was positive about food on offer in the home.

Is the service effective?

Good

The service was effective.

The provider had identified a programme of training for staff and this was well maintained. Staff met with their supervisors regularly to discuss their development.

Where decisions had been made in people's 'best interests' the Mental Capacity Act 2005 had been followed.

People's feedback was positive about food on offer in the home. Choice was offered at every mealtime.

People's needs had been assessed, and care plans detailed how these should be met.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind.

We saw people were encouraged to be independent. People's dignity and right to privacy was respected.

People's views on the service were sought. Relatives told us they

felt welcome at the home.

Is the service responsive?

Good

The service was responsive.

People had been included in planning their care. Staff knew people well. Records included information about people's choices and preferences.

There were a range of activities planned inside and outside of the home. Staff identified with people personalised wishes they would like to achieve.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance system in place covered a range of areas. However, whilst it had identified some of the shortfalls which we found during this inspection, they had had not been fully addressed.

Staff described low morale in the service. A new manager had recently been appointed. People who used the service and staff were positive about the new management structure.

The home had built links with the local community.

Kirkwood Court

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 unannounced comprehensive inspection took place on 28 and 29 March 2018 and 4 April 2018. This meant that neither the provider nor the staff knew we would be visiting the home on the first day of our visit.

Following these visits we requested further information from the provider and contacted relatives and staff by telephone. We concluded these inspection activities on 13 April 2018.

The inspection team consisted of an inspector, a specialist advisor and an expert-by-experience. Specialist advisors are clinicians and professionals who assist us with inspections. The specialist advisor on this inspection had expertise in governance and leadership. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who supported this inspection had experience of nursing homes.

Prior to our inspection we reviewed the information we held about the service including statutory notifications. Statutory notifications are submitted to the Commission by registered persons in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of deaths and other incidents that have occurred within the service. We used this information to inform the planning of this inspection. We contacted the local Healthwatch service, and spoke with the local authority commissioning and safeguarding teams to gather views of professionals who come into regular contact with the service. Healthwatch are an independent organisation who listen to people's views about local service to help them to improve. We also spoke with the police.

Not everyone who used the service was able to communicate verbally with us. 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 spoke with seven people who used the service and chatted with them about their views on the service. During the course of the inspection we spoke with nine

relatives, including eight relatives who were visiting Kirkwood Court during our visits, and one other relative who we spoke with over the telephone.

We spoke with the provider's regional manager, the manager, and seven care workers. We reviewed a range of documents and records including; eight people's care records in detail, four records of staff employed at the home, complaints records, accidents and incident records, minutes of staff meetings, minutes of meetings with people who used the service and a range of other quality audits and management records.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection, we found the service was safe and rated this key question good. At this inspection, we found some shortfalls relating to staffing levels and medicines and have rated this key question as requires improvement.

Approximately half of the people and relatives we spoke with told us more staff were required. One person said, "They could do with more staff. When staff are ill there is inadequate replacement back up." They told us this meant at times they had to wait for support. One person said, "When people press the buzzer for help, they are helping other people who are calling. Sometimes like last night I had to wait a long time." A relative said, "A few times when [my relative] pressed the buzzer they have had to wait to go to the toilet."

Other people told us staff met their needs promptly. One person said, "When I rang the buzzer the carers come quickly, when I need them." One relative said, "We've heard other relatives who have said they are concerned about staffing levels but I can't say we have had any complaints. Staff are brilliant. There whenever we needed them."

At the time of our inspection 68 people were accommodated at Kirkwood Court. On the days we visited the home there were 10 care staff on duty. We saw people's needs were well met. However, staffing levels were not consistent. Rotas showed, due to staff absence, there were regularly nine staff on duty. For short periods of the day, such as first thing in the morning, or after tea time there were sometimes eight care staff on duty. The regional manager showed us their staffing assessments which were based on people's needs. They told us the home could be run safely with nine care staff during the day, and five overnight.

All but one of the staff we spoke with told us the home was understaffed. One staff member said, "It has been horrendous with staffing. We are short staffed all of the time. Today isn't a reflection of how it normally is. It's unusual for us to be fully staffed like today." Another staff member said, "I can't remember the last time I had my break, it's just too busy. I often work a 13 hours shift without a break. I just have to grab my dinner and get back on the floor."

Night staff reported concerns that overnight staffing levels were not sufficient to meet people's needs. These had reduced from eight staff at the time of our last inspection to five staff. People were accommodated on three floors, so during staff breaks two floors were left with only one member of staff. A number of people required the support of two members of staff for personal care. The provider told us they were actively recruiting staff to enable them to staff the home with six staff overnight in response to feedback. The provider's fire risk assessments was up to date, but following the inspection we contacted the fire service to share information on staffing night staffing levels.

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

The regional manager told us they aimed to minimise the use of agency staff whenever possible, and that

the manager or domestic staff (trained in providing care) would step in to deliver care if required. They told us they were confident there were always enough staff to meet people's needs. However, feedback from staff, people and relatives did not confirm this.

Some people, relatives and staff reported that staffing had improved in the three weeks before the inspection since the new manager had been in post.

People and relatives told us Kirkwood Court was a safe place to live. One person said, "Absolutely safe. It is amazingly good here. I regard it as a four star hotel." Relatives told us they felt their family member was safe, they spoke highly of the security of the home. One relative said, "Yes it's safe. The doors are locked and the lifts are coded." Another relative said, "It is safe. They wouldn't let anyone in who shouldn't be here. They all know who I am and who I am here to see."

We checked medicines management. Information about some types of 'as required' was not available. Some people displayed anxiety and distress due to their needs. Care records included 'Stress and Distress' care plans, intended to detail any triggers which may induce feelings of distress, and explain how staff should support them. However, in some instances these care plans were blank or very brief. This included when people were prescribed medicines to be given 'as required' for distress.

We did not have concerns these medicines had been given inappropriately, and saw their use was infrequent. Staff we spoke with were aware of triggers and successful ways to distract and reassure people. However, care records did not include information to support staff to provide consistent care or to provide guidance about when medicines should be administered. Following our feedback, the regional manager worked with staff during the inspection to write personalised care plans. Records showed timely referrals had been made to the behaviour support service where staff required additional support to meet people's needs.

On the first day of our inspection we found a thickening powder unattended in the dining room on the Grace unit, an area of the home where people with a dementia related condition were cared for. Thickening powder is used to change the consistency of drinks for people at risk of choking. The powder can be dangerous if ingested without being mixed with fluids. We immediately arranged for the thickener to be stored securely. The manager told us this was due to human error, as staff were aware of the risks of thickening powder and it had never been left in a communal area before. reiterated to staff Afterwards we were informed that staff undertook additional medicines training about the safe management of thickening powder.

Staff responsible for administering medicines had received appropriate training and had their competency assessed. The provider had introduced an electronic system when administering medicines which staff told us was working well. Records relating to administered medicines, including creams and ointments, were fully completed which meant we could see medicines were being administered as prescribed.

The provider continued to follow safe recruitment practices for newly employed staff. Pre-employment checks, such as employment references and Disclosure and Barring Service (DBS) checks were in place before staff were employed to work at the home. A DBS check supports safe recruitment decisions by providing information to employers about an applicant's criminal record and whether they have been barred from working with vulnerable adults and children.

Prior to our inspection, we had been informed that a staff member from another service had arrived at Kirkwood Court incorrectly; as they were due to attend a training course being held nearby. Staff expecting

an agency staff member, mistook this person and without checking their name assigned them to work within the home alongside another staff member. The provider carried out an investigation into the incident and identified lessons learned to prevent future incidents, including issuing updated protocols to staff for inducting agency staff including checking their ID.

Information about how people should expect to be treated was displayed around the home, accompanied by the steps people or relatives should take if they had concerns about people's safety or wellbeing. Staff we spoke with continued to have a good understanding of their responsibilities and had undertaken training in recognising and responding to signs of abuse. The service had reported concerns to the local authority safeguarding team, and carried out investigations whenever required.

Risks to people's personal safety continued to be assessed. Measures were in place to reduce identified risks such as moving and handling. Individual plans were also devised to support people in the event of an emergency where they needed to be evacuated from the home.

Accidents and incidents were well monitored. Records showed appropriate action had been taken in response, and prompted staff to reflect on the accident or incident to determine if any changes should be implemented to reduce any future risks. Accidents and incidents had been monitored by the manager to determine if there were any trends ongoing.

The home was clean and tidy. People told us the home was well maintained, one person said, "It is spotlessly clean." A relative commented, "The cleanliness is excellent." We saw staff wore appropriate protective equipment when delivering personal care to minimise the risk of the spread of infection.

The building and any equipment used, were regularly checked to ensure they were safe. Specialist maintenance companies were contracted to monitor that required standards were achieved, for example, relating to asbestos and electrics within the home. The call bells and fire alarms were tested weekly. Equipment such as hoists, boilers, emergency lighting and lifts were serviced regularly so they were kept in good working order.

Good

Is the service effective?

Our findings

At the last comprehensive inspection, we found the service was effective and rated this key question good. At this inspection, we found the service continued to be effective.

People told us they thought the service provided good quality of care. One relative said, "The staff are very good. They help if you need them to." A relative said, the "Staff are lovely, excellent, I can't fault them at all."

Staff had received a training programme designed to provide them with the skills and knowledge to carry out their roles effectively. This included a mixture of both face-to-face and online training modules. Training was monitored so staff skills stayed up-to-date. Staff training in had high levels of completion. Staff told us training met their learning needs and prepared them for their roles.

Induction training for new staff included reading policies, shadowing experienced staff and completing a training package. The induction had been designed to incorporate the Care Certificate. The Care Certificate is a set of minimum standards for care workers.

Staff told us regularly met with their supervisor in one to one supervision sessions and discussed the home, the care they provided and the people they supported. Staff reported these meetings were helpful to them. Appraisals were held annually. Staff were asked to consider their performance and discuss any training needs.

People's physical, mental and emotional needs had been assessed, using a range of evidence based assessment tools. However, assessments were not always linked to care plans. Records varied in quality. Whilst some were detailed and provided staff with information about how to effectively provide consistent care others were less specific or in some cases had been identified but no information was detailed about how staff should meet them. For example, we viewed the care records of two people with epilepsy. One person's care records detailed the frequency of their seizures, timeframes indicating when staff should call an ambulance, and information about how to support the person after a seizure. However, there was no information about the second person's epilepsy. The regional manager told us some information had been archived, following a change in documentation. They told us they were in the process of reviewing records to ensure they met expected standards.

Records completed on a daily basis, such as positional change records for people who needed to be supported to change position to reduce the risk of pressure damage, and food and fluid intake charts were well completed so they provided a full picture of the care people received. Body-maps were completed when people had any injuries to show the action staff had taken and monitor progress.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Kirkwood Court was working within the principles of the MCA. We found conditions on authorisations to deprive a person of their liberty were being met. Where people were assessed as not having capacity to make specific decisions, they were made in their 'best interests'. There was evidence that relevant family members and health and social care professionals had input into 'best interests' decisions.

People were asked for their consent before staff provided care. We saw staff asked people whether they wanted any support and respected their decisions. Care records highlighted to staff the importance of gaining people's consent before delivering care.

People told us they usually enjoyed the meals on offer, and that they were always given a choice. One person said, "You get a choice of three things for example salad or meat. It is nice all the meat here is tender." A relative said, "A carer sat and encouraged my relative to eat. [They] put weight on. The food always looks fabulous."

People enjoyed a pleasant dining experience. Tables were well presented, laid out with napkins and condiments. Specialist plates and cutlery were used where people needed them. These were designed to help people maintain their independence. People were offered choices at each meal and offered drinks and snacks throughout the day.

The home had been designed to meet the needs of the people who used it. It was spacious, well decorated and well maintained. All corridors were wide with places for people to sit and rest on their journey. Visual signage was in place to aid people's independence when moving around the home. Walls and handrails were painted contrasting colours so people could see them easily. A range of tactile items had been placed around the corridors and communal spaces on the Grace unit where people with a dementia related condition were cared for. This provided people with items of interest, such as bags, hats and jewellery to look at and use.

People continued to be supported to access a full range of health care services and information from external professionals was incorporated into their plans of care. A relative said, "They know [my relative] well and if [my relative] feels unwell they call they doctor. Staff have called for the doctor loads of times and called for an ambulance. They phone me to tell me they have called the doctor in or if it is less urgent, they tell me when I come in, as I am here often." A visiting professional we spoke with told us they maintained good communication with the service. They said, "They make appropriate referrals. People seem well looked after. They understand what is expected of them and they will do it."

Good

Is the service caring?

Our findings

At the last comprehensive inspection, we found the service was caring and rated this key question good. At this inspection, we found the service continued to be caring.

People living at the home and their relatives were very complimentary about the staff working in the home. All of the feedback shared with us about staff attitude and manner was positive. One person told us, "They are caring and excellent." A relative said, "We are getting to know them (staff). They are really nice and caring. I notice how kind they are to other people in here and encourage them to come out of their rooms." Another relative commented, "Some of the staff are gorgeous, so caring." A third relative said, "They have all been so supportive of [my relative] and us."

One person told us that staff were "rushed" and therefore had to focus on carrying out their tasks with little time to sit and talk with them. They said, "Staff don't really have time but if I ask most will come and have a word with me." We shared this comment with the manager.

Throughout our inspection, we saw people looked comfortable within the home. One person had come into the home with lots of personal possessions. The provider had assigned them an unoccupied space within the home to be used as their office where they had set up their desk and displayed their items. Another person who enjoyed arts and crafts had been given a large desk space near the activities office to store their equipment. We were told one person, who had been a hairdresser, enjoyed spending time in the home's hairdressing salon and helping where they could.

People told us staff respected their privacy and treated them with dignity. One person said, "The staff are great, they are very good. They respect my privacy." A relative said, "The carers are lovely, very much so. They shut the door when necessary and knock on the door before they enter." During our inspection, we saw this was the case. Staff were polite and respectful of people. They were conscious of people's dignity when asking if they needed support, bending down when people were in wheelchairs so they were on the same level as them, and checking with them quietly when asking people what help they needed.

People's independence was promoted. Over lunch, we saw staff sat with people who needed support and encouragement with their meals. They helped people position their cutlery in a way which meant it was easier for them to feed themselves. People were prompted to pour their own drinks where they were able, and to butter toast and bread themselves. Some people had access to hot water so they could make their own hot drinks whenever they wanted. Staff helped some people to make their own beds. Staff ensured people had access to walking aids so they could move around the home safely on their own.

The regional manager told us they were proud of how dedicated staff were. They told us staff always made a fuss on people's birthday, sending a card, putting a banner on their door, making a cake and singing happy birthday. One person had been evacuated during the war to a village which a member of staff had recently visited. They brought photographs to show the person of what the village looked like now. A relative told us staff did everything they could to make their relative happy. They said, "They couldn't do enough. If [relative]

wanted chips in the middle of the night well they put them in for her. They were always so lovely."

People were supported to maintain links with organisations within the community to meet their cultural needs. A vicar held a monthly church service within the home and staff supported one person to attend a weekly service at their local church.

Information continued to be provided about advocacy services and outside agencies. Such as the Care Quality Commission and Healthwatch. The home's monthly newsletter included details about what was going on in the home and the provider's news and developments.

People's feedback continued to be requested through 'resident and relative' meetings, surveys, and an electronic tablet device in the entrance of the home where people, relatives and visiting professionals could record their views about the service. The home assigned a 'resident of the day' every day. This involved staff from across the home, including care, domestic and kitchen staff, speaking with the 'resident of the day' about their views on the service. This gave people a regular opportunity to discuss their care and the service they received.

Relatives told us they were made to feel very welcome when they visited the home. One person said, "My relative comes twice a day to visit." A relative said, "I visit whenever I want to." There were no formal visiting times, the regional manager said, "This is people's homes we want their relatives to feel at home here. They are welcome anytime they want to come."

Good

Is the service responsive?

Our findings

At the last comprehensive inspection, we found the service was responsive and rated this key question good. At this inspection, we found the service continued to be responsive.

People and relatives told us they thought the service met their or their relative's individual needs. One relative said, "We've been extremely happy with everything at Kirkwood. Staff know [my relative] and what they need. We can't praise them enough."

People and their relatives told us they had been involved in planning their care. Most care records included information about people's preferences, choices, families and their life histories. Some care records were briefer and task based, but the regional manager advised staff were in the process of rewriting these. Staff knew people well. We saw that when they chatted with people they would mention the names of their relatives or hobbies they knew people enjoyed.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found that the provider was meeting this standard. Information about people's communication needs were included within care records. Where people could not always express themselves verbally, records described to staff how they communicated, including how staff could identify if the person was in any pain. Information about the home could be made available in easy read format. Easy read uses simple language and pictures to aid people's understanding. Information was also available in large print when needed.

Records had been signed by people to show they consented to plans of care. Where people were unable to do this, relatives had recorded that they had been consulted. One relative said, "I sat and did the care plan with the staff, it took hours. We went through everything. It was worth it though because it meant staff knew how [my relative] liked things." People and relatives were invited to meetings at least twice a year to review their care.

People we spoke with told us their choices were respected. They told us personal care was provided by staff of their preferred gender. One person preferred the support and company of male members of staff. The manager was aware of this and took it into consideration when planning the rota so they could accommodate this whenever possible.

The service provided end of life care to people with terminal and life limiting illnesses. People had been asked how they would like to be supported at the end of their lives. This meant information when they may no longer be able to communicate those wishes themselves was available. The regional manager told us the service worked closely with the district and specialist nursing team to enable people to stay in the home rather than moving to a nursing home or hospice if that was their wish.

The provider sought to improve people's end of life care experiences through investing in innovative

products. The manager told us about a product they used which could be added to a variety of drinks. An air pump was then used to create a foam. This provided a refreshing alternative to oral care swabs which were used when people were receiving end of life care. We spoke with relatives of one person who received end of life care from the service. They said, "We could not ask for more. Having [my relative] looked after here was the best thing we could have hoped for. Every single one of the staff has treated [my relative] and us with compassion."

People and their relatives told us activities within the home had recently improved. The home had recently employed a new wellbeing coordinator after a period of time without one. The wellbeing coordinator was responsible for planning activities and events in the home. A board displayed the scheduled activities for the upcoming week. One person said, "There is a new activity co-ordinator, the old one didn't tell us what was going on. The new one has the right enthusiasm." During the inspection, we saw people enjoying games, and taking part in singing and reminiscence activities. One of the popular weekly activities was a therapy dog, who visited people in their rooms as well as spending times in the communal areas.

One relative told us that they thought people who stayed in their rooms should have more one on one time with staff for activities. We shared this feedback with the provider who showed us activities records which evidenced that the wellbeing coordinator had spent time with each person in the home, including spending time sitting with people in their rooms or reading to them. They advised us they were in the process of recruiting a second wellbeing coordinator so more dedicated activities time could be provided.

One relative said more trips outside of the home should be arranged. The provider showed us pictures from recent trips to the coast, a local gardening centre and an open air museum. They told us these trips were advertised on the notice board, and that relatives were also invited to accompany people, but that they would consider other ways that they could let people know about upcoming trips.

The home had implemented a 'Three Wishes' project where staff discussed people's interests and hobbies with them to create personalised wishes they would like to achieve. One person had wished to dance so the home held a tea dance for Valentine's Day where the person danced with other people and staff. Staff encouraged this person to have a dance during the musical activities in the home such as a sing-alongs. Another person wanted to see more wildlife so they went on a trip to a country park where staff supported them to identify the different birds they spotted.

All of the people we spoke with told us they knew how to a complaint if they had any concerns. Two relatives told us they had made a complaint, and that they had received a response from the provider. One relative said, "I previously complained to the previous manager about the staffing. The new manager is more approachable." The second relative told us their complaint was still ongoing. They had not been satisfied with the response following the provider's investigation, but had been given information about how they could escalate the complaint further. Complaints had been recorded and the manager had followed the provider's complaints policy in response to formal written complaints.

The provider had received four complaints in the nine months leading up to our inspection. We discussed with the regional manager how informal concerns were managed. They told us the previous registered manager had dealt with them as and when they arose, but told us they would discuss with the new manager how these could be recorded in a way which enabled the provider to monitor any themes.

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection, we found the service was well-led and rated this key question good. At this inspection, we found some shortfalls and omissions with the provider's governance system and have rated this key question as requires improvement.

The provider's quality assurance system involved a schedule of audits and assessments which were carried out by staff of different designations. Daily walk arounds of the home were carried out and monthly audits including health and safety, infection control and people's dining experience were undertaken. The provider's regional manager visited the home frequently, and prepared a monthly report which included checking records and speaking with staff and people who used the service. Representatives from the provider's quality assurance department also carried audits, based on CQC inspections. During our inspection however, we found shortfalls and omissions which had not been fully addressed by the provider's internal quality assurance systems.

Care plan audits were carried out regularly, but had not always driven improvements. We saw one audit, carried out in November 2017 highlighted a number of areas where information was missing from a person's care record. When we checked this person's records four months after the audit, none of the improvement actions identified had been carried out. Medicines audits had been carried out monthly, but had not identified the lack of protocols in place for certain types of 'as required' medicines. In addition, systems were not in place to ensure staffing levels within the home were consistent.

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

We discussed these issues with the regional manager. They told us that they been regional manager of Kirkwood Court for only four weeks prior to our inspection. They told us they had identified care records as an area to focus on, and had detailed the systematic review of records on a 'Home Improvement Plan' which they would closely monitor to ensure improvements were achieved.

At the time of our inspection, a registered manager was not in place. The previous registered manager had formally deregistered with the Care Quality Commission two weeks before our inspection, in March 2018. A new manager was in post and in the process of applying for their CQC registration.

Staff told us they welcomed the change in management. All of the staff we spoke with told us that morale was low. Some staff told us their views were not taken into account and they did not feel valued. A number of staff told us they had raised concerns about staffing levels in the home but had not felt they had received a satisfactory response. There had been a high number of staff who had left the home in the year prior to our inspection. Exit meetings had been held with staff leaving the company. These meetings were initially held by the previous registered manager, but the regional manager told us in recent weeks they had held them to get an understanding about why staff were leaving the home. They told us they had introduced a number of changes to reduce staff turnover and would closely monitor the situation.

Some staff told us they felt the standards within the home had slipped, but were positive about the new manager. One staff member said, "The home isn't what it used to be. I guess we can just hope that [manager] does what they say they will." Another staff member said, "[Manager] hasn't had a chance yet, but it's looking like things are going to definitely improve."

People and relatives we spoke with were similarly positive about the change in management structure. One person said, "I get on with [manager], they are a more approachable person." Another person said, "The last manager was not firm enough with the staff discipline. The new manager is very new. So far so good."

The quality monitoring process included asking people their views on the service. A poster on display called, "You said – we did" showed that the service had acted on comments made by stakeholders. We reviewed questionnaires which people and their relatives had been asked to complete. The most recent responses had been very positive overall. We noted that whilst the questionnaire asked people about how responsive staff were to their needs, it did not specifically ask people's views about staffing levels, which was one of the areas of concern people had told us about. A meeting had been held with people and their relatives the day before our inspection to discuss people's views on the service. We saw feedback had been shared about staffing levels, and the manager had made a commitment to look into their concerns and provide a response.

Staff meetings were held regularly to share information and discuss staff practice. Meetings included opportunities for staff to share their views on the service. Following the feedback we shared about staff morale, the manager and regional manager told us they would look at ways to encourage staff to participate in discussions about how the service was delivered. Staff had access to a rewards scheme which included staff discount. Staff attitude and dedication was recognised through a provider award scheme.

During the inspection, the regional manager and acting manager displayed openness and transparency towards the evidence we presented to them and were proactive in their response to our findings. The manager and regional manager showed a commitment to making changes and improvements within the home.

The home continued to have a clearly defined management and staffing structure and senior care staff were allocated to lead all shifts. There were also 'heads of department' who were accountable for different aspects of the service including housekeeping and catering.

The home had good working relationships with other organisations. The home had strong links with GP practices and district nurses. A healthcare professional we spoke with told the service communicated well and fulfilled any requests made of them. When people had moved to other homes, transition records were provided to enable a smooth transfer to other services. The home's wellbeing coordinator organised events and extended invitations to the local community.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always operated effectively. Although audits and checks on the service were in place they had not been robust enough to address the issues we highlighted at this inspection. Where shortfalls had been identified, they had not been fully addressed. The provider had not ensured that complete records were in place for each person who used the service. Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff to meet people's needs. Regulation 18 (1)