Portsdown Estates Limited

Kinross

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 1 and 4 July 2016. Kinross is registered to provide accommodation for up to 29 older people. The home is a large property and accommodation is arranged over two floors, the ground floor offering dining and lounge areas and bedrooms. The upper floor had most of the accommodation. There was a lift and stairs available to access the upper floor. There were 27 people living in the home at the time of our inspection.

A registered manager was in place. A registered manager is a person who has registered with the care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager and the manager of the service are directors of the provider company; they are referred to as the registered manager and manager throughout the report.

Whilst people felt safe at the home and relatives had no concerns about the safety of people, risk assessments had not always been completed to ensure people received safe and effective care in the home. People's preferences and needs were not always included in their care plans.

Staff at the home had not been guided by the principles of the Mental Capacity Act 2005 (MCA) when working with people who lacked the capacity to make decisions. The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst several people who lived at the home were subject to a DoLS and appropriate actions had been taken to support these people, staff lacked knowledge and understanding of the MCA and DoLS.

People were not always protected by staff that had a good understanding of the risk of abuse against vulnerable people. Whilst staff felt confident to report any concerns they may have through the appropriate channels, they had not received appropriate training in this area. The provider had not identified areas of concern in relation to the safeguarding of people which required further action.

There were not sufficient staff available to meet the needs of people. The provider did not have robust recruitment processes in place to ensure people were cared for safely by staff.

Whilst people found staff to be caring and supportive we observed some staff act in a way which was not caring and did not respect the dignity of people. Staff knew people at the home well.

There was a lack of stimulation in the home to encourage people to participate in activities or any offers of an alternative to people in their rooms.

People were provided with opportunities to express their views on the service through meetings and in

discussion with the provider and nominated individual for the service; however people's views were dismissed.

There was a programme of audits however it was not effective in monitoring the welfare and safety of people. The registered manager and manager did not have a good understanding of the requirements of the Regulations and their responsibility with this.

Staff who worked and people who lived at the home felt able to express any concerns they may have and have these responded to promptly. People had access to health and social care professionals as they were required.

We raised a safeguarding alert with the local authorities following this inspection as we had concerns about some areas of care at the home.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Inadequate

The service was not safe.

Risks associated with the care people required had not always been assessed. Assessments had not been completed to ensure people received care in an environment which was safe.

Whilst medicines were stored safely, the provider did not have effective systems in place for the safe management of all medicines.

Whilst staff understood systems in place to report concerns of abuse they had not received training in the safeguarding of people. The provider did not have a good understanding of their responsibilities in relation to the safeguarding of people.

There was not sufficient numbers of care staff to meet the needs of people.

Recruitment and training processes to ensure staff were safe and had the right skills to be employed in the home were not robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make decisions about the care they received, the registered manager and care staff had not always applied the principles of the Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff had not received effective training to support their role and meet the needs of people.

People were not aware of or offered a choice of meals to meet their preferences and their nutritional needs were not met.

People had access to health and social care professionals to make sure they received effective care and treatment.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had not taken all actions required to ensure people's dignity was respected when receiving care.

Whilst staff knew people well, interactions between people and staff were not always caring.

People did not always have the opportunity to express their views on the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans in place did not always reflect the needs and wishes of people.

Whilst there were activities available in the home these were not always stimulating and people were at risk of being isolated.

People were able to raise any concerns they may have about the service however the responses were not always appropriate.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective systems and processes in place to assess, monitor and improve the quality and safety of the services being provided and the risks associated with the care people received.

We identified serious concerns that were not sufficiently identified or addressed by the service.

Accurate and up to date records were not always kept.

Kinross

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 was 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 1 and 4 July 2016 and was unannounced. Two inspectors carried out the inspection.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and service improvement plans. We reviewed notifications of incidents the manager had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with three people who lived at the home and a visitor to the service, to gain their views of the home. We observed care and support being delivered by staff in communal areas of the home. We spoke with the registered manager and manager who were also the directors of the provider company. They are referred to as the registered manager and manager throughout the report. We spoke with five members of staff including domestic and care staff. We spoke with two health and social care professionals who supported people who lived at Kinross to obtain their views of the home.

We looked at the care plans and associated records for six people and sampled a further three. We looked at a range of records relating to the management of the service including; records of complaints, accidents and incidents, quality assurance documents, three staff recruitment files and policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us they felt safe in the home and thought there were enough staff to meet their needs. One person said, "If I did not like it I would not be here." Another told us they were happy in the home and that "Staff are nice, they deal with difficult residents well". A visitor we spoke with felt their friend was safe in the home. One member of staff told us that "People are safe and staff are kind but there are not enough staff as they have to rush."

At our inspection in January 2015 we found the registered provider had not fully protected people against the risks associated with the unsafe management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection whilst we found some improvements in how medicines were administered there were still concerns about medicines and the information surrounding their use.

For example, medicines that were prescribed on an as required (PRN) basis did not always have a clear protocol in place to guide staff about the administration of the medicine. At times protocols had been implemented but these related to medicines that were not prescribed. For example there was a protocol for PRN for a certain medicine for one person however it was not a medicine that was prescribed for them. Nor did every PRN pain relief medicine that had been prescribed have a protocol for its use

There were no plans of care in place which identified when medicines may be required and any other actions staff may be required to take before the administration of the medicine. For example one person was prescribed a medicine usually used to treat heart failure, but there was no plan in place. This meant staff could not be sure of the medicines they were giving and why, and the results and effects could not be monitored, placing people at risk of not receiving medicines safely

Risks associated with the side effects associated with the administration of medicines had not been identified. For example, where people were prescribed medicines to help with their diabetes, memory loss and mood/behaviours, there were no risk assessments in place to identify risks associated with these medicines and how staff could monitor for and reduce these.

Following the inspection the registered manager sent us information about medicines that were prescribed to be taken as needed, their use and any side effects. However, they did not send us information on medicines that were prescribed to be taken regularly; their use and side effects, for example heart medicines, diabetic medicines, medicines for dementia, pain relief patches, and mood/behaviour medicines. We were not assured that staff would know what to look for if any side effects presented themselves and any further support that people would need as a result of having these medicines.

We saw that several people were prescribed lotions and ointments. Where people had been prescribed lotions for protecting their skin to be used as needed, there were no signatures on the medicine administration records (MAR) to indicate they had been applied.

There were two people who were being given medicines covertly. We saw a letter from the GP for one person giving permission, although there was no support from the pharmacist saying it was safe to crush the medicine. However, a second person was prescribed a medicine to help with the symptoms of dementia, and it was to be crushed to enable administration. There was no agreement from the GP or guidance from a pharmacist regarding this. This meant this medicine may have been administered covertly without proper procedures being in place, and also that the efficacy of the medicine may have been affected.

Staff supported people to take their medicines. People said they received this when they needed it. The provider had a policy and procedure for the management of medicines and staff confirmed they had received training in safe administration. Most records showed the amount of medicines received into the home was recorded. A stock check of controlled medicines took place monthly.

Storage arrangements for medicines were secure and there were no unexplained gaps in the recording of regularly prescribed medicines. We did find three items in another cupboard which the manager told us was locked. There were two creams, one with an unclear label and some eye drops. We asked why they were not kept with the other medicines and the manager did not know.

An audit of medicines which had been carried out by the manager on 8 January 2016 identified actions to be completed to ensure a monthly audit of the medicines was completed. There were no audits available to show medicine records and practices had been audited and reviewed since this date. There was no evidence to show that the actions had been completed.

We found the risks associated with the proper and safe management of medicines including the side effects associated with these medicines had not always been identified, assessed and managed to ensure people's safety and welfare. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care records and associated documents for six people and sampled three others. These records contained a large number of risk assessments for people including those to identify the risks of falls, mobility, mental health needs, nutrition and skin integrity. However, these assessments were ineffective in guiding plans of care, not kept up to date and the registered manager lacked an understanding of the purpose of these. A Malnutrition Universal Screening Tool (MUST) score helps to identify adults who are malnourished or at risk of malnutrition. A MUST was found in six people's care records, although these had not been completed since January 2015. One person's MUST was dated January 2015 and stated that they were a high risk of malnutrition. There were no records of any action taken by staff to address this risk. The registered manager told us they were no longer using these tools. They said they were now using a Waterlow assessment. A Waterlow assessment assesses a person's risk of developing pressure sores and not their nutritional risks. We advised that both tools, a MUST and Waterlow were needed where there are relevant risks.

We saw that for two people they had been weighed regularly between January and June 2016, one person had lost 8.8lb in that time and the other 17.6lb. There was no information for staff on what to do if there were concerns about people's weight and no action had been taken to seek support and guidance.

On care plans we looked at we saw that nutrition risk assessments (MUST) were available. We saw that five people had a pureed diet however we could not see how this decision was made. There was no information on whether advice had been sought from a speech and language therapist or whether people had difficulties eating.
One person's nutrition care plan said they had their own teeth and no problem swallowing, but we saw they

were being given pureed food. The action recorded in their care plans for this person in May 2016 to manage risks was "Bed rest as gets tired after lunch. Is at risk of pressure sores, has dressing on both legs. Pressure relief cushion and mattress. Offered assistance with food and fluid and able to hold beaker." There was no mention of pureed food. Whilst the registered manager told us they had replaced the MUST assessment with a Waterlow assessment, these had not been completed in this person's records since January 2015. Their care records stated that they were at high risk of developing pressures sores. However, it was unclear on what basis this judgement had been made as the assessment had not been reviewed.

This same person had a monthly risk assessment review in place. There were two records for the month of May 2016. The total scores regarding risk were different between the two records in six areas. There were no dates in place to show when the assessments had been reviewed and nothing to say why they had changed. This meant that staff were not given clear information on the risks associated with that person's care.

We saw falls tracker forms in place in the care plans. These were not always accurate and corresponding accident records and body maps were not always completed. Where people sustained injuries these were not investigated and no action was taken to ensure risk assessments were up to date and appropriate plans were in place to prevent further injuries. For example, one person's records showed they had two falls in January 2016, however an accident record had only been completed for one. They had suffered injuries as a result; however the risk assessment and associated care plans had not been reviewed. For a second person their daily care records indicated they had hurt themselves in April and June 2016 however, there were no further records and we could not see that an investigation had taken place. A third person's records showed that they had two large unexplained bruises to their arm. No accident records were in place. No investigation had been undertaken. There was no explanation on how this had occurred. The care plans and risk assessments had not been updated.

We made a referral to the local authority safeguarding team following the inspection with regards to a number of concerns, including the bruises and loss of weight for certain people.

There was information available to people which told them what the meal was that day. However we found whilst most people enjoyed the food which was provided and felt they had sufficient to eat and drink, they were not always aware of the choices available to them. The cook told us that the manager did the shopping and met with them for five to ten minutes each day to tell them what to prepare. They told us the manager told them who had a pureed diet. Records told us five people needed a pureed diet. There was no information as to why they needed this and no information from other professionals advising that people should have a pureed meal. This meant that the manager was making these decisions without consulting others. The cook told us they prepared pureed food separately so that visually there were different colours. However the meals we observed where people were supported to have a pureed meal, were grey and had been mixed together. The cook told us that care staff must have mixed together the separate foods they had prepared. We were not reassured that people's specific risks and needs around diet were properly assessed and actions taken to mitigate such risks.

People may not be receiving sufficient fluids. People were offered drinks at set times of the day, breakfast, mid-morning, lunch mid-afternoon and at supper time. We observed these on the two days of inspection. Those people that remained in the communal areas did not have any other access to fluids. There were no jugs of water or juice available for people to help themselves between set times. People who remained in their rooms had a jug of water available, however this was not always in reach of the person or the person was unable to support themselves with pouring themselves a glass of water.

One person was at a high risk of falls and had pressure areas from a long term problem as well as being

treated for bruises and skin tears. We asked a member of care staff what risks were associated with the care of this person who regularly stayed in their room alone with the door closed. The member of staff was not aware of the risk of falls for this person. Daily records and body maps showed that there had been seven incidents since July 2015, six of them this year 2016. They consisted of bruises and skin tears ranging in size from 2cm to 7cm. There were only three accident forms related to these incidents and no record of an investigation into the accidents/incidents. This meant that incidents/accidents had not been investigated and action taken to prevent further harm.

Following the inspection the registered manager sent us information on accidents, incidents and body maps that they had completed, including copies of any notifications they had sent to us. This included information on a further eight accident records with injuries or bruises that had occurred after our inspection. These had not been reviewed and no action had been taken to lessen any identified risks.

We found the risks associated with the care people received had not always been identified, assessed and managed to ensure their safety and welfare. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from abuse and improper treatment as there were no systems established to investigate accidents and incidents and protect people from further risk or harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us most people required the support of one member of staff with personal care and at other times moving to another area of the home or eating and drinking. The registered manager and manager told us there were two care staff, sometimes three and they (the registered manager and manager) were always available and did support with personal care too.

We looked at staff rotas for the period of two weeks prior to the inspection, the week of the first day of the inspection and the week of the second day of the inspection. We saw that apart from Saturday and Sunday afternoons when the registered manager and manager were not on the rota, there were three care staff on duty. There were three care staff on duty on 12 other occasions, mostly though there were only two care staff on duty during the week and two at night. The rota said that the cooks worked 8am to 3pm, and we asked the manager if the care staff had to make the supper and wash up afterwards. We were told yes, but that the cook prepared the tea. However when we spoke to the cooks they told us they worked from 8am to 5pm. The rotas were not always a clear refection of the staff on duty.

We observed staff were very busy and task orientated in their duties due to the limited number of staff available to support people. They did not have time to spend interacting with people in a way which encouraged them to be independent and calm. For example, people often had their eyes shut and had either the television or radio for company. Staff told us that whilst they were happy giving time to people at meal times that needed support, they said other people then had to wait.

For significant periods of time people were left alone without the opportunity or encouragement to interact with staff and others. For example, in one communal area, four or more people sat for long periods of time, approximately 30 minutes, without a member of staff present. People who remained in their rooms by choice and some who were cared for in their rooms, were not provided with time to interact and socialise with staff as they were busy supporting other people across two floors of the home. For example, one person who remained in bed during the day had music playing in their room but had no other social interaction with people other than when care was being provided for them. For another person who chose to stay in their room, interactions with staff were limited to provision of care.

The registered manager told us that they did not use a dependency tool to determine staffing levels, they "had an equation in their head". However, we were given a policy titled Kinross Care Home Staffing Levels; however this document referred to the Health and Social Care Act 2008 Regulation 22 which was not up to date. The document described how to assess dependency and there was a tool to help calculate the number of staff hours needed. We saw that the registered manager had completed the tool in December 2014 and had determined the number of care staff needed to meet people's needs. The calculation said there were no people with a high level of dependency, six with a medium level of dependency and 22 people with a low level of dependency. It stated that "Due to changes in resident's needs, as well as new admissions, staffing levels are to be assessed on a monthly basis. This will be recorded. As the staffing level ratio changes, this may result in an increase or decrease in required staff. The registered manager should constantly monitor incidents and accidents for trends and if there is unusual high level of incidents or accidents or if they occur during a particular time of day staffing should be reviewed."

The document stated the minimum staffing levels during the day: one person in charge and two or three care staff and for minimum staffing levels during the night two members of care staff on waking duty (one will be a senior position), one member of staff on call.

We found no evidence that these staffing levels had been reviewed monthly or in line with people's changing needs. We found that two people at the home required two members of staff for all personal care and moving, and one member of staff to support them at mealtimes. Other people needed one member of staff for personal care and three more needed help and support with meals.

We were not reassured by the evidence that had been gathered at the inspection and the information we requested that was received after the inspection that there were sufficient staff to support people. For example there were records to show there had been seven falls/incidents since our inspection on the 1 and 4 July 2016, five of which were unwitnessed.

The lack of sufficient staff in the home to meet the needs of people and ensure their safety and welfare was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four recruitment files for information which should be verified before staff started to work at the home. These included; application forms and interview questions, complete employment history without gaps, two references and Disclosure and Barring Service (DBS) checks. These checks help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services.

Recruitment records showed these checks were not always completed prior to staff commencing work in the home. Of the four recruitment records, four held incomplete information including, proof of ID, no interview notes, no health declarations stating they were fit to do the job they were employed for, and two references with no dates of when requested and when received. For one member of staff, their DBS had been obtained but raised some concerns; however the registered manager had not explored this further or undertaken a risk assessment.

We were given a list of DBS numbers and the date staff commenced work. There were 42 records in total. This lacked DBS numbers for nine staff. The administrator told us that the information could not be found.

There were no recruitment records for one member of staff who we were told worked on an adhoc basis in the home. We saw they had been involved in undertaking mental capacity assessments and the completion of documentation for people in relation to the care they received. The manager told us they no longer

worked at the home, although their name was on documentation for April 2016. The registered manager sent us information regarding the member of staff's DBS and safeguarding training.

There were no recruitment records including Disclosure and Barring Service (DBS) checks, for the manager who also worked at the home (not the registered manager). They told us they had been a registered manager elsewhere and had not brought any of that information with them.

Following the inspection, the registered manager sent us information on DBS checks and references for each member of staff. The information sent to us assured us to some extent that the recruitment of the current staff was safe.

People were not always cared for by people who had been appropriately recruited and checked for their suitability to work with people. The lack of established and effective recruitment processes in the home was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who felt they had an understanding of the types of abuse which they may observe and how to report this; they felt confident any concerns they raised would be dealt with appropriately by the provider and knew how to escalate any concerns they may have to the local authority or CQC. Staff told us "I would report safeguarding to the managers as soon as possible, I am confident they would look into it." However we did not see that any concerns had been reported by the registered manager when needed

Requires Improvement

Is the service effective?

Our findings

Staff knew people well and told us they understood their needs. People felt the care they received met their needs. One person said, "The staff will help me when I need it. They are very busy." Another person said, "The girls will help me if I need it." People said they were not aware of choice in the food they had. People told us "The cook comes round and tells us what we are having." "If I do not like it I leave it on the plate." A visitor told us they assumed as there was a menu people had chosen that meal. Health and social care professionals told us people had access to their services as required.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

For people who lacked capacity to make decisions about their care and safety, steps had been taken to assess their ability to make decisions about the care and treatment they received in line with their wishes or best interests. Most records held information regarding people who had been legally appointed as representatives for the person in making decisions about the care they received.

We saw that one person had signed consent forms in 2013 and 2014 to be weighed, receive care and treatment, have their medicines administered and to have their photo taken. Their mental capacity assessment which had been discussed with two people that knew them well stated the person no longer had capacity to make any decisions and a deprivation of liberty safeguard had been authorised in August 2015 to live at the home with 24 hour care but there was no other specific information regarding the conditions of deprivation.

Whilst care staff had received training on the Mental Capacity Act 2005 they had a very poor understanding of how to apply this in the day to day care of people. One member of staff told us the MCA was, "Where you understand their thoughts and thinking and if there was any mental illness or they needed extra attention. If someone was unable to make a decision I would make it for them, do the best we can for them." Another member of staff was unable to tell us about the five principles underpinning the MCA. Staff were not always guided by the MCA when they supported people who were not able to consent to aspects of their care and treatment. Whilst care records held some information to identify what decisions people could make for themselves, best interests' decisions were not evidenced and documentation in place to support people's

ability to make decisions about their care and treatment was incomplete and lacked clarity.

Due to the lack of understanding by staff and the lack of clear information in people's care plans, people were at risk of receiving care and treatment to which they had not consented and which was not in line with their wishes.

Six people were subject to a Deprivation of Liberty Safeguards (DoLS) at the time of our inspection. The manager showed us a list of a further 12 applications and we saw on some files that the local authority had been to the home recently to carry out some assessments and a report was to follow. Staff were unsure about DoLS. One member of staff told us it was "Not to face people, to do anything like abuse them." They told us of two types of abuse and they would look for scars and bruises. Other staff had not heard of DoLS.

Due to the lack of understanding by staff and the lack of clear information in people's care plans, people were at risk of receiving care and treatment to which they had not consented and which was not in line with their wishes. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received training in a way that helped them feel confident to meet the needs of people. We asked the registered manager for copies of certificates or information to demonstrate the training staff had received. We were given copies of records for staff training and a training matrix.

All the training staff received was online with the exception of first aid. Staff told us they would prefer practical manual handling training as it was too easy to pass a computer based test. One said "I do feel like I am not sure if I am doing it correctly, people are so frail. I would prefer practical training." We saw there was training online available for tissue viability and the use of slings (which are used with a hoist to move people) at Kinross, however only one member of staff had completed tissue viability training and two had completed training in the use of slings.

The training matrix we were given showed that 11 out of 12 care staff had undertaken moving and handling theory and an assessment. The manager told us that they were enrolled on a train the trainer moving and handling course which was five days long. They said they had done this training previously but it had lapsed. The registered manager told us the manager had enrolled on the train the trainer's course as they needed someone to train the staff as access to training for care staff was difficult.

Training records showed that 11 of the 12 care staff, the housekeeping and administrative staff had completed online training in the safeguarding of people. Although staff had received training on safeguarding people the staff did not demonstrate this training had been effective as they were unable to relay to us their knowledge and understating of the Mental Capacity Act, Deprivation of Liberty and safeguarding of people. There were no training records for the two staff who had no recruitment records or for the registered manager. We were not assured all staff had received effective training and guidance on the safeguarding of people.

The training records for 18 members of staff gave information on safeguarding adults, mental capacity and deprivation of liberty training and only one member of staff had not completed all three. Staff we spoke with did not know about the Care Certificate. This certificate is an identified set of standards that care staff adhere to in their daily working life and gives people the confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. It is the new minimum standards that should be covered as part of induction training of new care workers. There were two new staff that should have been doing this induction training or have an induction based on its

standards. Staff told us that induction was based on shadowing more experienced staff and having a probationary period. Training records showed that 11 out of 12 staff had completed risk assessment training however we were concerned about risk management which questioned the effectiveness of the training.

Following the inspection the registered manager sent us an updated training matrix, which showed two staff had completed further online training. We were concerned that the registered manager and manager's training needs were not being met through the training plan.

Staff told us about their supervision experiences, they included "I have spoken with [name, manager] they have written things down, I have been asked if I like the job and people." "Managers check on what I am doing, I have had formal one to one with [name]." "Yes I have had supervision it does not take long." We looked at supervision notes for three members of staff. The record had a summary of agenda items discussed and key outcomes or action points with personal objectives and timescales. We saw that whilst the details differed from person to person, they were consistent for each individual. For example, for one member of staff it said, "Task orientated and likes the person they are working with to have similar approach" was written on each of the three records we saw. For another member of staff their supervision record stated, "Knows the routine and follows the process ensuring good time management to complete tasks." The key outcomes again were different for each member of staff but repeated on each of their supervision records a number of times with no timescales or dates when completed.

Staff had not received appropriate support, training, professional development, supervision and appraisal and effective training staff needed to ensure they were suitably qualified, competent, skilled and experienced, and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to some external health and social care professionals and services as they were required. For example, records showed people had access to the GP, chiropody services, dentistry and community nursing and therapy services. Health and social care professionals told us staff always received them in a welcoming way and knew people well and they had no concerns.

Requires Improvement

Is the service caring?

Our findings

People said staff were very caring but were always very busy and this meant they were not always available to interact with them. They said staff were kind and understood their needs. One person told us, "They are all lovely and really very caring." One member of staff told us "Yes I do feel I get time to chat with residents it depends on what is happening." However, another member of staff said "No there is not enough time to spend with people. I would like to have more time with them to talk about their family for example. There are a lot of tasks and not enough time to spend with people. Most do not have any family so who will they talk to?"

Health and social care professionals told us staff knew people well and were always kind and considerate towards people when they visited. A visitor told us that if there was a problem with [their relative] then the managers rang them.

We saw activity sheets in people's daily records. These included bathing, seeing healthcare professionals, listening to the radio, watching TV and just the word "activities". The information boards in the hallway and dining room showed what activity was taking place, this included listening to the radio and afternoon tea. On the records for the calendar months we looked at staff ticked when the person had participated in an activity. We saw ticks where people had had a bath; most people had a daily tick for listening to the radio and/or watching TV. Where people chose to stay in their rooms or stayed in bed due to their care needs, there was only interaction from staff at mealtimes and when drinks were taken round at the set times.

We observed staff knocking doors but they did not wait for a response before going in. We observed staff taking drinks and biscuits to people in the lounges and in their rooms. Choices were limited with staff asking if they would like a biscuit and handing them one biscuit only. People were not offered a choice or the option of another biscuit. We saw the cook on the second day of the inspection going round with a box of chocolates offering people one only. The cook physically handed them a chocolate. Whilst there was a choice of tea or coffee there was only fully pasteurised milk available.

We saw mixed interactions with people which demonstrated not all staff were always caring. We saw one member of staff being polite and courteous when offering tea, they gave appropriate responses to people who said thank you, with "You're welcome." Someone asked for a table and the care staff said they would get one, another person asked for tea with sugar and this was given. However, we observed a mealtime on the first day of the inspection. Staff took a jug of orange round the tables, they occasionally mentioned a person's name to get people's attention, however they poured a drink for everyone and no choice was provided. Someone did ask for a glass of water and this was given. However, staff took the meal around and cut the meal up for two people without asking if they wanted the support.

We observed the registered manager supporting one person who appeared to be asleep. The person was prompted to eat by having the spoon put in their hand rather than with verbal communication. The registered manager told us at the dining table, that "Sometimes they eat well with no support but other times they need help." The registered manager started feeding the person; they stood up to do so at first

then fetched a chair and sat next to the person. They put the spoon of food in the person's mouth with the occasional "Head up [name]" "Wake up [name]" "I have a drink for you", and put a glass to the person's mouth. Throughout this the persons eyes remained shut. We went to one room at 12.39pm to see someone who had been in their room all day, the person was asleep and there was no food. When we returned at 12.52pm we saw that the registered manager was just feeding the person the last spoonful of food. This suggested the person had been assisted with their meal in the 13 minutes between our observations.

We observed staff feeding one person a pureed meal although their care plan stated they could eat finger foods. We saw the person put their hand out to the spoon, the member of staff said "No, no, no." We asked the member of staff what would happen if the person was given the spoon, the member of care staff response was not positive. The carer made an "hmm" sound and said "Not a good idea" .We asked why, what would happen and they smiled and said "I will show you". The inspector enquired if [name] would throw the food if the spoon was given to them and the carer nodded and said "watch". However the person did not throw the spoon or food. The care staff showed the inspector that the person was able to hold the spoon and with guidance they fed themselves. This meant that staff member had made an assumption that did not demonstrate good practice in care.

Staff told us that lunchtimes were a "Push" particularly when people needed support to eat. They said the managers helped but it was still difficult. One member of staff said they "Need to take time with [name] and not rush them. This takes time away from other people".
The lack of an understanding and caring approach to people's needs and abilities meant they did not always receive care and support in a way which demonstrated a respect for their needs. We were not assured people were always treated with the dignity and respect they deserved and this was a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

However, we also observed staff take time to speak with a person who was receiving support with their meal. The member of staff spoke kindly and initiated interaction with the person by talking to them and gently rubbing their arm. The person responded by smiling and looking at the member of staff. The person set the pace for the support and the member of staff responded accordingly. They also offered juice in between spoonful's.

Staff explained to us how they promoted people's privacy and dignity when carrying out personal care, especially in ground floor rooms where there were large windows, or where rooms were shared. They also told us they encouraged independence and dignity by "Allowing people to wash their private areas themselves."

People were encouraged to personalise their room and one person told us how a family member had helped them to settle in by bringing to the home many items of importance to them to decorate their room. Relatives and visitors told us staff were always very courteous and kind to them and their relatives.

People and their relatives /representatives were encouraged to communicate with managers and staff at any time. One visitor told us they were always able to talk with the managers and they had a response from them.

Requires Improvement

Is the service responsive?

Our findings

People said they felt able to raise any concerns they may have about the service with any member of staff, especially the registered manager and manager. People and their relatives were able to identify the managers in the service and said they were approachable.

The cook told us that people were asked once a month what they would like and menus were done weekly. However, they also said the manager met with them daily to tell them what to cook that day. Another member of staff said that "People can choose and there was a resident's meeting two or three weeks ago." We saw records for two residents meetings on the 24 February and 5 May 2016. We were told that relatives had been asked about meetings but there had not been any response and the managers spoke to them when they visited.

The meetings were chaired by the manager. Items for discussion included improvements to the home or people's opinion of the menu and the chef. The minutes confirmed that these two meetings followed each other with no other meetings in between.

Minutes from a February 2016 meeting showed that some requests from people had been actioned. For example, a ramp had been fitted to support access to the garden. However, some discussions with people had not led to changes being made. For example, minutes from a May 2016 meeting showed that the manager had apparently been dismissive of people's reasonable suggestions about how to reduce the likelihood of items including clothes and jewellery getting lost. The manager had suggested it was people and their relative's responsibility to mark items as people's suggestions would make more work for care staff. This indicated a lack of understanding and a lack of willingness to accept people's suggestions.

Comments from people and staff and our observations showed that the service was sometimes responsive; however it was not in a positive way. For example, there was no choice of meals, the menu was available to tell people what was for lunch or supper, but people could refuse the meal. There was no choice of activities but people did not have to participate, there was no choice of drinks at lunchtime unless people asked for something different. Not everyone was able to express themselves, and staff did not take time to find out what people wanted.

People were not aware of their care records. Care records did not show people and/or their representatives were involved in planning care to meet their needs. Care plans did not always reflect the preferences and needs people had expressed. People were not aware they could participate in the planning of their care. Health and social care professionals we spoke with described a service which reacted to people's needs/risks rather than being responsive and alert to needs/risks before they required further intervention.

We found in the medicine record file references to people's medical history. When we checked in people's care plan records, we found in two cases there were no care plans related to the people's mental well-being where this would be important to reflect the needs their medical history presented. There were also no care plans for people who had pace makers, and for people who were prescribed a certain medicine.

The administrator told us the care plans were written on the computer and then printed off for staff. One member of staff told us that they had time to read care plans and that they are accurate and that the managers updated the care plans. However, care plans were not always person centred and did not provide the information staff required to provide safe, effective care in line with people's needs. For example one person had been receiving treatment for an infected toe which also tested positive for an infection that was antibiotic resistant. The care plans were typed but in handwriting someone had written "Toe doesn't require any dressing it is healed." There was no date or signature. Behaviour was described with no information for staff on how staff could manage the behaviour. For example, "disorientated, time, place, people, refers to parents, poor memory and can be quite disruptive."

People gathered in two lounges on the ground floor of the home. A television or radio was on most of the day and the volume was loud. People sat around the room in chairs; there was minimal interaction between people and staff. On the first day of our visit, a singer came in the afternoon, the room was full, but there were no staff in the room to help facilitate the event. One person told us they had been told to go in the room by staff. Their visitor replied "But if you had not wanted to stay you would not have, although I was surprised to find you there."

People who remained in their room throughout the day received no stimulation or support to participate in activities in the home. Throughout our two days at the home we only saw staff enter these rooms when they needed to bring a meal or drinks or support people with their meal.

The provider had a complaints process in place which was clearly available for people. The registered manager told us they had received no formal complaints in the service since our last inspection in January 2015. We looked at the complaints folder and saw there were five recorded complaints in 2014, none for 2015 and a statement regarding a concern dated 14 June but no year. The manager told us it was this year. People were happy to raise any concerns they had with staff or the management of the home and felt sure their concerns would be dealt with promptly. A visitor said "I feel able to say something if I feel there is something wrong." However, staff told us that they felt people would be scared to complain. One member of staff gave us a real example of how people complained and the example given to us was: person: "I would like my cup of tea", staff: "I am going to give you a bath", person: "I do not want a bath, who told you to give me a bath", staff: "The manager", person: "I am going to complain". This showed that this person's choice was not facilitated or respected and they were being told what to do when they clearly wanted to have their drink.

Service users were not treated with dignity and respect and were not supported with dignity and respect to promote their autonomy and independence. This was a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People felt the provider and the manager were very nice people. They told us they were always available in the home to speak with them. One person said, "They are very nice to me." Staff enjoyed working at the home and told us both the provider and the manager were supportive and "hands on." Visitors told us "It is brilliantly run." and "The managers are good and always available and visible."

The directors for the provider Portsdown Estates Limited worked at the home. One was the registered manager, the other was titled manager. They ran the home between them and had a very active role in the home. They knew people who lived at the home very well. They were very visible to people, staff and their relatives as they spent extensive hours each week in the home. This was confirmed by people who lived at the home, their family and friends and professional visitors.

At our inspection in January 2015 we recommended that the provider sought guidance from a reputable source about effective auditing of service provision. At this inspection we found that there were several audits and checks in place including medicines, call bells and health and safety of the environment. The administrator at the home provided support to both the registered manager and manager and assisted in auditing the service; for example we saw them on the first day of our inspection checking the first aid box on the first floor to ensure it was stocked correctly, although they did not sign the first aid box checklist. They also audited some people's monies that the service held for them. It was not always clear if issues identified during audits were acted on and resolved. For example, in April 2016 it was noted that a toilet was not working. There was no record of this having been mended although the manager assured us it had been.

Medicines audits recorded actions as "one service user eye drops", however the information did not say what was needed and if anything had been done. Another example was "Alendronic acid awareness for staff," again there was no date or any record that this action had been completed. Medicine records had protocols for as required medicines however these were sometimes for medicines that were not prescribed, and there was no protocol for the medicine that had been prescribed. Or in some instances there was a protocol when people no longer needed the medicines, or they were prescribed a medicine to be taken as needed and there was no protocol to advise staff. The manager told us it was on their list to review the medicine file to ensure these records were correct. However these had not been identified in the last medicines audit in June 2016.

Following the inspection we received a copy of an audit however, it was generalised and covered the building/environment in addition to mentioning care plans and medicines.

The provider's Business Continuity Plan and Annual Development Plan looked at environmental maintenance and improvements and what to do in the event of an emergency or service failure such as heating or lights. The annual plan referred to training and the investment that had been made in online training and NVQ training for staff who had requested it. It made no reference to practical training or the Care Certificate. This meant that the plans had not taken into account the new best practice information and training that should be undertaken by staff.

There was a system in place to monitor all incidents, accidents or safeguarding concerns however, it did not identify trends or patterns in these events. Records we looked at showed incidents had not always been recorded or reported in a way which ensured the safety of people. For example, for one person we saw an incident form had been completed for an unwitnessed fall which occurred in their room. We could not see that there was an investigation into this incident or any action planned to prevent this from reoccurring.

Information available in some care records and medicine records was not clear, contained conflicting information and was sometimes inaccurate although care plans and records had been reviewed. For example, in two people's assessments we saw they had a history of long term mental ill health. There were no care plans to reflect this or any information to say that they no longer had issues in these areas. The risk assessments for these two people also did not reflect fully their mental ill health as we had seen on other records for them that they had been living with mental health conditions.

Information relating to the nutrition, skin care and weight monitoring for people was not always clear and collated in a way which informed the care which staff gave to people. There was also a lack of action when records indicated concerns, for example weight loss.

One member of staff told us that there was a handover between shifts and they took a book with them to write things down. However, another member of staff told us that there was no handover in the morning, "I just get on and ask people. I have heard handovers happening between the manager and night staff on the late shift." This meant staff did not have clear guidance in the form of person centred care planning or verbal handovers as to the needs and wishes of people they supported.

There was concern about the registered managers and manager's lack of knowledge. for example the lack of appropriate assessments and knowledge of those assessments, for example no appropriate nutritional screening was in place and the use of a Waterlow assessment which does not assess nutritional needs. The management approach to residents meetings appeared to be dismissive in some contexts and they did not treat people with dignity and respect at meal times, and given the visibility of them in the service, them not identifying issues was a concern.

There was no information available on the training the registered manager and manager had undertaken to ensure that they understood their roles and responsibilities in overviewing the service and ensuring that the care staff were providing was safe and appropriate. Our inspection had identified a number of serious and significant concerns that had not been identified or addressed by the registered manager or provider, including investigations into incidents, accidents and safeguarding concerns, staffing levels and the effectiveness of training were also causes for concern.

The systems and processes in place had not enabled the service to assess, monitor and improve the quality and safety of care being provided or mitigate risks associated with the care people received. There was a lack of contemporaneous records in respect of each service user and each member of staff employed at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had requested people and their relatives to complete quality assurance surveys for the service at the end of 2015. The results were collated in December 2015 and these surveys showed people were very happy with the quality of care at the home, and that the results showed there had been improvements since the last survey. Examples included improvements to privacy in shared rooms and the installation of a second bath which enabled people to have a bath with more dignity. The feedback also examined some of the improvements which were planned for 2016 such as improvements in the flooring to reduce trips and

wheelchair access at the entrance. We saw that this had already been actioned.

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 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 1 We were not assured people were always treated with the dignity and respect they deserved particularly at mealtimes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 Due to the lack of understanding by staff and the lack of clear information in people's care plans, people were at risk of receiving care and treatment to which they had not consented and which was not in line with their wishes. People were at risk of being deprived of their liberty. This was a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 1, 2 3 The lack of training to recognise, report and record allegations and investigations into abuse meant people using the service were at risk.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Regulation 19 HSCA RA Regulations 2014 Staffing
People were not always cared for by staff who had been appropriately recruited and checked for their suitability to work with people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 1, 2 a,b,c,i We found the risks associated with the care people received had not always been identified, assessed and managed to ensure their safety and welfare. Regulation 12 1, 2 g We found the risks associated with the administration of medicine's and the side effects associated with these medicines had not always been identified, assessed and managed to ensure people's safety and welfare.

The enforcement action we took:

We served a warning notice requiring the provider and registered manager to be compliant by 7 October 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 171, 2 a,b,f, There was a lack of effective systems and processes in place to assess, monitor and improve the quality and safety of the services being provided and the risks associated with the care people receive. There was a lack of records to demonstrate the registered provider managed the Regulated Activities at the service.

The enforcement action we took:

We served a warning notice requiring the provider and registered manager to be compliant by 2 December 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 1,2 a,b The was a lack of appropriate and effective

training staff needed to ensure they were confident and competent to care for people living at the service.

The was a lack of sufficient staff in the home to meet the needs of people and ensure their safety and welfare.

The enforcement action we took:

We served a warning notice requiring the provider and registered manager to be compliant by 2 December 2016.