Portsdown Estates Limited

Kinross

Inspection report

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Date of inspection visit:
14 November 2017
15 November 2017

Date of publication:
05 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 14 and 15 November 2017 and was unannounced. Two inspectors and an expert by experience in the care of older people carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Kinross is registered to provide accommodation for up to 29 older people. There were 27 people living at the home at the time of the inspection. 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 bedroom accommodation. Bathrooms and toilets were provided on both floors. There was a lift and stairs available to access the upper floor.

Kinross is a 'care home'. People in care homes receive accommodation and 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. We found the home to be clean and tidy throughout the 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.

Previous inspections of the service in July 2016 and December 2016 had identified that the service had needed to make improvements to ensure people received safe effective care and that the service was well led. Whilst improvements had been made these have not been sustained over the longer term and there continues to be further improvements required.

A quality assurance process was in place. However, this had not identified the areas of concern we found during this inspection and ensured that improvements were sustained over time.

There were not always sufficient staff provided. In the late evening and overnight there would not be sufficient staff should an emergency occur.

Records of the assessment of people's ability to make decisions about various aspects of their care had been undertaken and best interest decisions recorded. However, the recording did not clearly show discussions with other professionals involved with the person, or their family members and when these happened.

Although medicines were usually managed safely, systems were not in place to ensure times of administration were recorded where medicines needed to be taken at regular intervals.

Systems to ensure prescribed topical creams were used safely, to ensure medicines were only given with

informed consent and individual information as to when 'as required' medicines should be administered required improvement.

Although staff felt supported they were not all receiving regular formal supervision.

We discussed these issues and some other minor issues with the clinical lead and registered manager who were responsive to the issues raised and undertook to take action.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home although full information about applicant's previous employment was not always known. Staff were suitably trained and although they felt supported in their work.

Where necessary Deprivation of Liberty Safeguards (DoLS) applications had been made. Equality and diversity was seen to be actively supported with people being able to express themselves.

People received the personal care they required and were supported to access other healthcare services when needed. Staff worked well as a team and with external professionals.

People received a varied diet of their choosing and meal times were sociable unrushed occasions. Infection control procedures were followed and the home was clean.

People felt safe and staff knew how to identify, prevent and report abuse. Staff offered people choices and respected their decisions. Risks to people were managed safely with plans in place to minimise risks where possible. People were supported and encouraged to be as independent as possible and their dignity was promoted. People were encouraged to maintain relationships that were important to them.

Staff were ware of people's individual care needs and preferences although these were not always documented in care plans. People had access to healthcare services and were referred to doctors and specialists when needed.

People and external health professionals were positive about the service people received.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The times of administration of regular medicines were not recorded and people could have received these without an adequate gap between doses. Systems to ensure the safe use of prescribed topical creams, to ensure medicines were only given with informed consent and individual information as to when 'as required' medicines should be administered required improvement.

In the late evening and overnight there were not always enough staff to meet people's needs.

Risks to people were managed safely with plans in place to minimise risks where possible.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home although full information about applicant's previous employment was not always known.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency.

Infection control procedures were followed and the home was clean.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked the ability to make decisions, such as those relating to medicines and care, best interest meetings or discussions had not always occurred. Where necessary Deprivation of Liberty Safeguards (DoLS) applications had been made.

People received the personal care they required and were supported to access other healthcare services when needed. Staff worked well as a team and with external professionals.

People received a varied diet of their choosing and meal times were sociable unrushed occasions.

Staff were suitably trained and felt supported in their work.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to maintain valued relationships.

People and their relatives were positive about the way staff treated them. People were treated with respect, provided with information about the home and their choices were met. Dignity and independence were promoted.

Is the service responsive?

Good

The service was responsive.

People were receiving personalised care that met their needs.

People received mental and physical stimulation in the form of organised and ad hoc activities.

People and relatives knew how to raise concerns and felt these would be addressed.

Is the service well-led?

Inadequate

The service was not well led.

A quality assurance process was in place, however, this had not identified the areas of concerns we found. The provider had failed to ensure improvements were sustained over time.

People and their relatives felt the home was well organised. They were asked for their views about the service which were considered by the registered manager.

Staff understood their roles, were motivated, worked well as a team and felt valued by the registered manager.

External professionals were welcomed and the registered manager consulted with them when required.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 15 November 2017 and was unannounced. The inspection was prompted in part by concerns which were raised to us about the availability of staff at night and the way this affected the care people were receiving. Part of the inspection was completed during the evening on the 14 November 2017.

The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 14 people living at the home and four visitors. We spoke with the registered manager, clinical lead, four care staff and ancillary staff including, the cook and housekeeping staff. We also spoke with two visiting healthcare professionals including a care consultant who supported the home. We looked at care plans and associated records for seven people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance. We observed care, support and activities being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in October 2016 we identified that some people did not have access to their call bells. At this inspection we saw that people in their bedrooms had access to call bells. We heard call bells being used and they were answered quickly. One person told us "They [the staff] come and help me if I buzz, you never wait too long". However, we saw that some call bells in people's bedroom were not easily accessible as they were not located near their beds meaning they could not call for assistance if unable to rise from their beds at night. The registered manager explained that when necessary longer leads to call bells were available to ensure people could have furniture in their bedrooms organised to best meet their needs. Care staff told us that where a person who was cared for in bed was unable to use their call bell due to cognitive disability they checked the person regularly. Records for this person showed staff attended them on a regular basis.

We identified some additional areas where improvements could be made to ensure the safety of medicines management. When people were prescribed medicines, which were required to be administered up to four times per day, there was no system in place to record the exact time of administration. This included medicines, such as paracetamol, which should be given at least four hours apart. This placed people at risk of overdose and complications resulting from their medicines. Improvements were also needed in respect of prescribed topical creams. Dates when containers of topical creams had been opened had not been recorded and there was no system to replace these on a regular basis. This meant staff would not be aware of the expiration of the item when the topical cream would no longer be safe to use.

We saw for one person the registered manager gave prescribed tablets and liquid medicine to a care staff member to give to the person by adding it to their food. The registered manager told us they had not sought confirmation from the pharmacist that it was safe to give these medicines with food. The care staff member had not been involved in the checking of the person's MAR and selecting the correct medicines to be administered. They therefore could not be sure that they were giving the correct medicine as prescribed for the person.

Where people were prescribed 'as required' medicines best practice guidance was not being followed. This states 'Care home providers should ensure that a process for administering 'when required' medicines is included in the care home medicines policy. The following information should be included: the reasons for giving the 'when required' medicine, how much to give if a variable dose has been prescribed, what the medicine is expected to do, the minimum time between doses if the first dose has not worked, offering the medicine when needed and not just during 'medication rounds' and when to check with the prescriber any confusion about which medicines or doses are to be given recording 'when required' medicines in the resident's care plan.' One person was prescribed an 'as required' (PRN) medicine for agitation. The prescription stated to 'take when needed' however, there was no additional guidance as to when this should be administered or information about other actions staff should take to calm the person before administering medicine. For a second person also prescribed a PRN medicine for agitation there was some guidance for staff as to what actions they should take if the person became distressed. However this did not specify when the PRN medicines should be administered. The registered manager understood the need for

clearer information and undertook to provide this for staff. We discussed these areas for improvement with the registered manager who told us they would take action to address them.

The failure to ensure the proper and safe management of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with told us care staff administered their tablets. One person said "The carers give them to me." Another person said "If you have a headache or something you just ask for some tablets and they'll get them for you." Most people who were prescribed 'as required' medicines were able to say if they needed these. A recognised pain assessment tool was available if required to enable staff to assess if people unable to say required PRN medicines.

All medicines were stored securely and appropriate arrangements were in place for obtaining, recording and disposing of prescribed medicines. A lockable medicines refrigerator was available should any medicines require to be kept at cooler temperatures and records showed medicine refrigerator temperatures were monitored although this did not record the daily maximum/minimum temperature, only that at the time of recording. The registered manager told us they would explore how this could be addressed. The medicines storage room temperature was also monitored to ensure all medicines were kept at safe temperatures. Medicine administration records (MAR) documented that people had received their medicines as prescribed. Although the registered manager was primarily responsible for the administration of medicines, training records showed other staff were suitably trained and had been assessed as competent to administer medicines. When medicines were administered we saw people were not rushed and were informed about their medicines. There were systems in place to ensure that medicines prescribed 'out of hours' could be promptly obtained meaning there would be no delay in treatment being commenced.

We received mixed views about the availability of care staff. When asked if they thought there were enough staff, one person told us "They (the staff) come and help me if I buzz, you never wait too long". However, another person told us that on occasions no staff were available meaning they would walk unaided upstairs as they preferred to use the ensuite toilet in their bedroom. A visitor told us they felt there were staff available when required and that they did not usually have to wait long for the front door bell to be answered. However, another visitor who told us they often visited in the evening said "There are only two night staff who may be upstairs with people and I have sometimes had to go and find staff as people are walking around and I'm worried about them". Whilst at the home during the evening we saw there were periods of time when both care staff were supporting people and not immediately available for those in the communal lounges.

The registered manager told us staffing levels were determined by the needs of service users living at the home. They provided us with copies of the staffing needs assessment which we were told was last updated on 6 November 2017 and they stated this represented an accurate needs dependency assessment at the time of the inspection on 15 November 2017. This stated twenty-six people however there were twenty-seven people at the time of the inspection. Therefore the dependency assessment had not been updated when an additional person had been admitted to the home and did not accurately reflect the staffing needs of people. We reviewed the dependency staffing level calculator and found that it did not include an allowance for time staff would need to complete all care and related tasks. For example, there was no allowance of emotional support that may be required by people living with dementia or the additional time they may need for explanations prior to care being provided. The assessment calculated the total number of care staff hours required each week however this did not show how these hours should be provided over a twenty four hour day to ensure adequate staff were available to meet people's needs. Many of the people living at Kinross were either independent in most of their daily care needs or required the support of one

care staff member. We were told two people required the support of two care staff for personal care and changing their position. Overnight two care staff were employed. The dependency assessment tool recorded that they should each have one hour break. The registered manager told us that care staff on breaks were expected to respond to people should the need arise. If there was a medical or other emergency there would be insufficient staff to take urgent action and continue to support other people. One senior member of the staff (the registered manager, clinical lead, or a senior carer) was on call each night and would always attend to any emergencies that may occur during the night. However, there would be a delay in adequate staff being available as these staff were not at the home overnight. One care staff member was scheduled to commence work at 7am to supplement the two overnight care staff until the remainder of the day staff arrived at 8am.

The registered manager and clinical lead told us they were working long hours to ensure people's needs were met. Medicines administration records showed that the registered manager had worked at the home every day for the previous two weeks covering all medicines administration. This confirmed that there were inadequate staff available as the registered manager was having to work excessive hours to ensure the home was covered. A deputy manager had recently commenced employment and the registered manager and clinical lead identified that they would be able to reduce some of their hours once the new deputy manager was familiar with the home.

The failure to ensure there were sufficient numbers of staff at all times to make sure people's care needs can be promptly met was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a duty roster system, which detailed the planned cover for the home. When required agency staff were used to ensure adequate numbers of staff were available. The registered manager told us they had recently recruited new staff and were waiting for pre-employment checks to be completed before staff commenced employment. Separate activities, kitchen and cleaning staff were also employed meaning care staff could focus on their care duties. During the inspection call bells were heard ringing for only a very short time before being answered. Care staff told us they thought there were usually enough staff.

Documentation, such as individual risk assessments, were up to date and were amended when the person's needs and risks changed. We saw risk assessments that used a scoring system to identify how high the risk was. An example of this was a falls risk assessment when a person was identified through a scoring system as being 'very high risk of falls'. There was a detailed risk assessment about how to support the person to reduce the risk of falls. The person had not had a fall since moving to Kinross earlier this year.

Where people required support to mobilise or change their position we saw staff supported them in line with national guidance, which would indicate training was being put into practice. We observed care staff supporting people using wheelchairs. The care staff were using the equipment appropriately and had put footplates on the wheelchairs before moving people. We looked at equipment used to support people when moving and we saw evidence that the equipment was well maintained and serviced regularly.

People were supported to maintain a level of independence by continuing to undertake some activities where there may be a risk. Where people were at risk of falls and may not remember to request care staff support before mobilising, movement alert systems were seen to be in use. One person explained to us the reasons for these and recognised they were for their own safety. They told us staff came quickly if the movement monitor was activated.

Overall infection risks were managed safely although we identified a few areas where improvements could

be made. Some people were accommodated in companion rooms. We saw in one companion room ensuite bathroom two bars of in use soap were on the wash basin. There was no way to identify which soap belonged to and should be used for, which person accommodated in the bedroom. This presented a risk as the home used agency staff on a regular basis and they would not be aware of which soap should be used for which person. We also identified a rusty toilet frame which could not be thoroughly cleaned. We discussed these concerns with the registered manager who immediately purchased a new toilet frame and undertook to take action to identify toiletries in companion rooms.

The home was clean. A cleaner was employed. They had cleaning schedules and told us they had time to complete all cleaning. Night staff were also allocated some cleaning tasks to complete. A handyman was employed who assisted the cleaner when necessary. Shortly before this inspection the local environmental health team had undertaken a food hygiene inspection. The registered manager told us this had resulted in a five star (the highest) rating. Staff had completed infection control training and had access to equipment, such as disposable gloves and aprons to protect themselves and people from the risk of the spread of infection. A care staff member told us and we saw that when people required equipment, such as for repositioning in bed individual equipment was available. People had been supported to receive the annual flue immunisation, which would help prevent the spread of this disease and antibacterial hand gel was available at the entrance of the home.

Systems were in place to ensure that when adverse incidents occurred lessons would be learnt to reduce the potential for repeat incidents. The registered manager reviewed all accidents and incident, such as where people had fallen and considered additional measures that could be taken to protect the person. Within individual care files we saw falls records and risk assessments which had been reviewed following any incidents. One person told us they had fallen shortly before the inspection. Their file contained the record of the fall and the registered manager was able to describe how the incident occurred and action taken to reduce the risk of recurrence.

Environmental risks were assessed and managed appropriately. The registered manager had assessed the risks associated with the environment and the running of the home; these were recorded along with actions identified to reduce those risks. They included the use of electrical equipment and fire risks. Cleaning chemicals and other substances hazardous to health (COSHH) were stored securely. Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, and had been trained in fire safety and the use of evacuation equipment. People had individualised evacuation plans in case of an emergency, which identified the support and equipment they needed to leave the building in an emergency situation. Records showed fire detection and firefighting equipment was regularly checked. Arrangements had been made should people need to be evacuated and require a safe, warm place to wait until they could return to the home or be moved to alternative accommodation. Essential emergency equipment such as 'foil blankets' and a torch was available should these be required. Staff had been trained to administer first aid.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. Staff completed an application form, which requested information for previous employment, as is required to identify and explain any gaps in employment. This had been completed but did not provide full information of past employment. We spoke to the clinical lead about this and they informed us they will be ensuring this was included in future applications and would be seeking this information from existing staff members. Otherwise appropriate pre-employment checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home.

People told us they felt safe. One person said "It's comforting to know someone is always there, they [staff] give you a lot of comfort when you are down, and they are helpful." A visitor said they felt their relative was safe. They told us "I don't worry anymore – I used to when they were living on their own".

There were appropriate policies in place to protect people from abuse. Staff said they would have no hesitation in reporting abuse. One staff member told us, "I'm in this job because I care, I would always report abuse." The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them. They described the actions they had taken when this had been necessary. For example, when a concern was raised to the CQC and local safeguarding team in October 2017 they undertook the investigation requested by the local safeguarding team. However, the concerns had been around the care provided at night and the investigation had not included specific observations overnight. All staff were confident the registered manager would take the necessary action if they raised any concerns and they knew how to contact the local safeguarding team if required. Safeguarding information was available on the walls in the hallway and entrance area of the home and in the care office.

Requires Improvement

Is the service effective?

Our findings

The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people had a cognitive impairment and were not able to make certain informed decisions. These included decisions around the delivery of personal care, the use of bed rails, the use of alarms to alert staff they were moving about the home, and the administration of medicines. Assessment of people's inability to make these decisions had been undertaken and best interest decisions recorded. Although the registered manager told us family members and professionals had been involved in best interest discussions these had not always been recorded.

A care staff member told us they added tablets to the last spoonful of a person's breakfast as if they gave them without food the person would push them out of their mouth. There was no covert medicines assessment or best interest decision to show that this was how the person who lacked capacity should receive their medicines. Their care plan also did not detail this method of administration. We discussed this with the registered manager who agreed this was covert administration and undertook to complete a best interest assessment and update the person's care plan. The registered manager had therefore failed to ensure the MCA was followed and people's legal rights were upheld when decisions about their care were made. We spoke to care staff and they were able to explain what Mental Capacity and DoLS meant. However, as detailed above they were unable to demonstrate that they were following the MCA in practice.

The failure to ensure the MCA is followed and peoples legal rights ensured was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff member said, "We always give people choices/options, even if they lack capacity in one area they may still be able to make choices in others". Another care staff member said "We show people objects to help them make choices where possible, such as showing two different tops so they can make a choice. We also use pictures to help people make choices about the food they want to eat". When people had DoLs or best interest decisions in place care plans still promoted choice and involvement in decision making where 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 Mental Capacity Act 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether DoLS applications had been made appropriately. We found the provider was following the necessary requirements and where appropriate, DoLS applications had been made. Staff had been trained in DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. There were systems in place to ensure that DoLS were reapplied for when necessary

Staff felt supported and told us they had supervisions but the records showed that these were not always regular. One staff member had two supervisions in a year and another had worked at the home for a few months and told us they had not yet had formal supervision. The registered manager and clinical lead work closely with care staff and therefore informal supervision was happening but was not being recorded. Supervisions provided an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff who had been employed for in excess of a year had received a formal annual appraisal, with the registered manager, to assess their performance and identify development objectives. We spoke with four care staff and they all told us that they felt confident to talk to the registered manager or clinical lead at any time if they felt they needed support or guidance. Staff said they felt supported by the management team. There was an open door policy and they could raise any concerns straight away.

People were supported by staff who had received an effective induction into their role. This enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff. Kinross employed a training consultant to deliver some of the essential training required by the staff. Care staff had completed the Care Certificate or were working towards gaining this. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. New staff confirmed they were receiving an appropriate induction including shadowing and formal training.

Staff were supported to undertake vocational qualifications and had access to other training focused on the specific needs of people using the service, such as, experiential dementia awareness. Care staff were positive about the training they received, which was a mixture of electronic work books, in-house practical classroom based training, such as for moving and handling and first aid. They were also able to access external training if needed. We observed them applying the training they had received. For example, we saw staff supporting a person appropriately to transfer from their chair into a wheelchair. The equipment was used correctly. Staff worked collaboratively for the benefit of people. We spoke with an ancillary staff member who told us they had completed the same basic training as care staff including emergency training meaning that they would be able to assist other staff if required, such as during a fire. We saw them responding to a call bell. They told us that if they were close by they would always do this especially if the alarm was from falls alert equipment. We saw the registered manager and clinical lead led by example and undertook all tasks that required doing.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. Doctors and district nurses visits were recorded in people's care files. We were told that the district nurse visited daily to attend to any medical needs for people. The registered manager was aware of how to contact health professionals including home visiting opticians and dentists should these be required for people not be able to go out to clinics or surgeries. We spoke with a visiting health professional who told us referrals were made appropriately. Arrangements had been made with a visiting optician to attend the home and the registered manager was aware of how to arrange a community dentist should a person not be able to attend a dental surgery. We saw in one person care file recorded they had had lost weight over a few months. Although they remained within a healthy weight, the dietician had been contacted and was monitoring monthly.

Prior to admission to the home the registered manager or clinical undertook an assessment of the person's needs to ensure these could be met at Kinross. This was confirmed by a person and by two relatives. We saw copies of assessments in care files and these showed that there had been consultation with family members and others such as hospital staff when these pre-admission assessments were undertaken. We also saw that a request was made to the person's GP for medical information and copies of this and hospital discharge

documents were kept within care files. This would help ensure all needs were known and met on admission. Care files held 'hospital transfer forms', so that if people needed to go to hospital all the relevant information about them, including any medication they were prescribed, would be passed over to the hospital to ensure a continuity of care.

Where people had specific needs in relation to their lifestyle choices we saw through interactions with care staff and care records that their needs were being considered and met. Care staff demonstrated a good understanding of people's needs and wishes. For example, they told us how they support people's human rights, how individual people like to be supported and what was important to them.

Overall the home was suitable for the number and needs of the people living there. However, some aspects had not been adapted to meet the needs of some older people. For example, handrails in the corridors were painted the same colour as the walls. This would make it difficult for someone living with dementia or a visual impairment to recognise the handrail and use it to aid safer walking. This was discussed with the registered manager who recognised the need for adaptations to meet the specific needs of the people living at Kinross. He told us they had engaged a sensory specialist who had given them advice about changes they could make to adapt the environment to better meet the needs of the people living there. People's bedrooms were personalised with their belongings. A passenger lift was provided for people and where necessary ramps had been provided to enable people to better enter or leave the home and move around within the home. Suitable bathing facilities were provided.

Mealtimes were relaxed, and people were encouraged to attend the dining room, which provided an opportunity to socially engage with each other. People were offered a choice of meals and different diets were catered for. When people required support, this was done in a respectful and dignified manner by care staff. One person said, "The food is good they make it just like my grandmother used to make, lovely and warming." Another person told us "The foods alright, but I can have something else if I don't like what is on offer." Care files had clear information about any special dietary needs people had and if they required a soft diet or needed support to eat. There was also clear information about the food and drinks that people liked and did not like.

People had a choice of what they wanted to eat each day. There were usually two choices but the cook told us they would make an alternative if someone requested something or did not like the options offered. Meal times were spaced evenly throughout the day but people told us they could get food when they wanted it if they asked the care staff. Fruit, cake and biscuits were readily available at all times. People who had lifestyle and religious choices about the food they ate were respected and their choices adhered to.

Kinross had a cooks who worked every day of the week. The kitchen was well organised and had information about what each person liked and did not like to eat, if they had any dietary requirements such as being Diabetic, or if they needed their meals prepared in a particular way.

Good

Is the service caring?

Our findings

People and visitors spoke warmly about all the staff at Kinross. When asked if they liked living at the home one person told us "I've been here a while and I've been to a few homes but ended up here. It is very good, the staff are good and everyone is jolly". A visitor told us, "The staff show respect at all times to my [family member]." Another visitor said "My [relative] is happy, and they [care staff] take good care of him, they treat us as family." Whilst a third visitor said "The staff are very caring." These comments were echoed by other people and visitors we spoke with, including a visiting health professional who told us, "Staff always show me to the patient and will stay if they [the person] want this."

The majority of interactions between staff and people were positive. However, we heard a care staff member ask a person if they were ready for their evening alcoholic drink. The person responded "Oh yes please ready now". The care staff member left the communal room however they did not return with the offered drink. Approximately 45 minutes later the person was supported to go to bed and had not received the drink. We also noted that the television was very loud in one of the communal lounges and the people did not appear to be watching it. Staff had failed to notice that it was very loud or that the content of a film being shown contained a high level of violence. We told the registered manager about our concerns regarding the volume and content of the film. They had been unaware of this and said they would remind staff of the need to ensure people are happy with television programmes they were watching.

We observed positive relationships between the people who live at Kinross and the staff team. The staff knew the people well and were able to communicate with them, adapting their conversation to the individual needs of the person. For example, care staff members recognised when someone needed time to process the information being given before they answered. Conversations between people and care staff were not rushed and were respectful. We also observed humour between people and the care staff. We saw staff playing a game with a person who was unsettled. This demonstrated they were able to support people in a professional and respectful way and ensured the person was given the time and care they needed.

We observed a handover between the staff from one shift to another. The language used when describing people was kind, respectful and person centred. "[Person] got mixed up today and thought it was her hairdresser day, she wanted a bath so we supported her and also washed her hair and made it look nice for her". All care staff at the handover meeting knew people well and showed care and compassion when discussing their needs.

People's lifestyle choices were respected and details of how they liked to be supported were contained in their care plans. Support to attend religious services and celebrations or watch them on television, was also recognised, with details in people's care plans about how their particular needs and wishes should be met. Staff told us about people's needs and were aware of their rights under the Equality Act. When talking about people staff demonstrated they respected diversity and treated people in a kind and caring way, whilst adhering to any individual needs or wishes people had about their lifestyle choices. People were supported to stay in their rooms or attend the home's communal areas if they wished to do so. One person told us "I do what I want, when I want" and another said "It's very good here they look after you well".

Staff treated people with dignity and maintained individual's privacy throughout the home when carrying out personal care, doors were closed, and staff could be seen knocking on doors and waiting to be invited into a person's room or supporting individuals to use the toilet in a sensitive manner. Most bedrooms were for single occupancy and many had ensuite facilities. Where bedrooms were shared we saw privacy screens were available to use when personal care was being provided. This meant personal care could be provided in private. One person said, "Staff here are particularly nice, you only have to lift an eyebrow and they [care staff] are there". Another person told us "They [care staff] are helpful" whilst a third said, "The staff are good as gold, no problems here." Care staff used respectful language when describing to us how people like to be supported and understood the individual needs of each person. People were observed in communal areas and in their rooms and they appeared to be content and were supported when required.

Independence was promoted. People's care plans were detailed and contained information about how they like to be supported and what help they required to complete different tasks. Care plans identified where people could do things for themselves and where they may need some minimal support, as well as when they needed full support. We saw walking aids were left conveniently for people who required these. This would both ensure their safety should they wish to move about the home and promote their independence as they would be able to do so without waiting for care staff. One person told us "The staff try to get you to do things for yourself, but will help you if you need it".

People who may have sensory or communication difficulties needed to be given information in a way that is accessible for them. Care staff told us they provided information for new people to the home within welcome packs. Care staff told us that they could enlarge the writing for people who may have sight problems and they spent time with new people slowly read things through to try and help them to understand. They said this was sometimes done over a few days to enable people to process the information in the best way for them to understand. The staff also told us that they encouraged families of people to look though the welcome packs and to ask any questions should they want to. Care staff gave an example of supporting people to make choices and understand the information being presented to them by using visual aids, such as items of clothing when offering choice about what to wear. People were supported to make choices about meals using large laminated pictures of food where necessary. Care staff identified this can be effective for supporting people who may have difficulty verbalising their choices, but are able to point to the item they want.

People were supported to maintain relationships and to be part of the local community. We observed visitors coming into the home throughout our inspection. One person told us "Visitors can come whenever they want, a friend of mine comes a lot and she takes me out as well." One visitor told us they were able to bring in their pet dog which their relative loved seeing. There was information about local community events and people were supported to go to local shops should they want to make small purchases.

Good

Is the service responsive?

Our findings

People and their relatives were happy with the way Kinross met people's personal and other care needs and told us care staff knew their preferences and respected their wishes. One person said, "The staff help me when I need help." A visitor told us the registered manager had met with them to discuss their relatives needs prior to their moving into the home.

Initial assessments of people's needs were completed using information from a range of sources, including the person, their family and other health or care professionals. Care plans were then developed, which contained information about people's life history, preferences and medical conditions. Care files had details about people's lives, such as where they lived, what they had done for a job, if they were married, had children and what interests and hobbies they had. They also contained specific information about things the person liked, what their usual routine was, the care people required, such as washing, dressing, bathing, continence and nutrition and any medical conditions. However, we found not all care plans reflected the care the person was receiving. One person's care file did not clearly identify recent changes to their needs. The moving and handling plan had not been updated to identify the changes to how they were being supported. This was discussed with the clinical lead and resolved immediately. Another person's care plan did not detail how they should receive their medicines and a third person's care plan did not contain specific information as to how the person's agitation should be managed and when 'as needed' medicines should be given. The registered manager arranged for these care plans to be updated with this information.

The management team conducted reviews of care needs and risk assessments regularly. Care staff had access to care files should they need to refer to these. Records of the care people had received reflected the information within care files.

Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about changes to the needs of the people they were supporting. We saw that relevant individual information was provided to staff at the start of their shift, including, information about the personal care people had received and if they had eaten and drunk well.

Care staff were aware of the specific needs of people and followed their care plans to ensure they were maintaining people's individual needs and wishes about how they lived their life. A health professional told us, "The staff seem to know the residents well." One staff member told us "We treat people here like they are our family, with dignity and respect. If I had to put my grandfather somewhere, I would like him to live somewhere like here."

People were supported to take part in activities providing both mental and physical stimulation. On the day of this inspection we saw people enjoying 'arm chair exercises' and were actively engaged. People told us about the homes activities organiser. One person said "He's a people person [The activities man], we all love him". Another person said "We have a man who comes in five days a week and we do exercises and have a laugh; he has a great sense of humour". They added "There is so much going on, music, exercise and we have a big party at Christmas". We saw posters in the hallway at Kinross, which had details of the activities

and entertainment that was going to be happening.

People were supported to make choices about their preferences for end of life care. At the time of this inspection nobody was receiving specific end of life care. Care files had information about people's next of kin and end of life details, such as the funeral provider people would want. Care files also contained other individual information, such as a person religious or spiritual needs and information about people and things which were important to them. The district nurse visited the home regularly and we were told they would be consulted about anyone who was being supported at the end of their life. The clinical lead said that relatives were able to stay with people approaching the end of life and where possible people would be supported to remain at the home as long as their needs could be met.

People and visitors said they would make any complaints to the registered manager, who many knew by name. Everyone we spoke with said they would feel able to raise a complaint. A relative told us, "I understand how to make a complaint should I wish to do so, however, all I've had to do is speak with one of the staff and any issue gets dealt with." One person told us if they had a complaint "I would speak to the boss man [registered manager] or the boss man's wife [clinical lead]." We looked at complaint records and how these had been responded to. There had been no formal complaints made in the last year. When people or relatives raised informal complaints or issues these were addressed. For example, the clinical lead told us a concern was raised regarding the curtains in a person's bedroom. The clinical lead said they discussed this with the person and their family. The family wished to choose new curtains so it was agreed that they purchase new curtains and light fittings that the person would like. Kinross reimbursed the family for this and everyone was pleased with the outcome. The clinical lead told us that when they picked up any concerns through their quality audit process they would act on them straight away. They said they would talk to the person who had raised a concern and try to improve things for a satisfactory outcome.

Inadequate

Is the service well-led?

Our findings

Although people and visitors were happy with the care provided we identified areas where improvements were required. Although medicines were usually managed safely systems were not in place to ensure times of administration were recorded where medicines needed to be taken at regular intervals. Systems to ensure prescribed topical creams were used safely, to ensure medicines were only given with informed consent and individual information as to when 'as required' medicines should be administered required improvement. Not all individual risks to people were minimised through the use of effective risk assessments as care staff were not always following these. Staff felt supported although they were not receiving regular formal supervision. Records of the assessment of people's ability to make decisions about various aspects of their care had been undertaken and best interest decisions recorded. However, the recording did not clearly show discussions with other professionals involved with the person, or their family members and when these happened. We discussed these issues and some other minor issues with the clinical lead and registered manager who were responsive to the issues raised and undertook to take action.

There were a variety of audits undertaken by the registered manager and clinical lead. However these had not identified the issues we found. For example, the medicines audit did not include checking prescribed topical creams and dates these should no longer be used by. The medicines audit also did not include checking stock levels of packet medicine to ensure this had been administered as prescribed and as recorded on the Medicine Administration Records (MARS). Infection control audits had failed to identify the need to replace a rusted toilet frame or that care staff had no way of knowing which toiletries belonged to who in shared rooms.

At no point has the service been rated higher than requires improvement. In January 2015 we undertook an inspection and breaches of regulations were identified. The service was rated Requires Improvement and the provider was told to take action to make improvements. The subsequent inspection in July 2016 resulted in an overall rating of Inadequate and breaches of regulations made at the previous inspection had not been complied with and additional breaches were also identified.

At the next inspection in December 2016 we identified some improvements and the service was rated as Requires Improvement. However, at this inspection we found that improvements had not been sustained and embedded into practice and we again found areas that required improvement. These areas included those which had been a concern at the inspection in July 2016 and at previous inspections before we had commenced providing ratings for services. This demonstrated that whilst in the short term the provider had been able to improve the service they had not been able to sustain this improvement in the long term.

The failure to ensure that systems have been developed and operated effectively to ensure compliance with regulations and to monitor and improve the quality of the service provided is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views about the service were sought both via meetings and thorough an annual survey. Meetings

were held with people several times a year to discuss their views about the service and see if there were any changes they would like to be made. The registered manager told us that they also talked with people all the time and asked them if they want anything. They involved them in menu choices and asked people's views when there were new activities or changes to the home were planned. In July 2017 a questionnaire had been sent to people and their relatives. The results of this were available in the entrance area of the home and had largely been positive. Relatives had identified they would like improvements made to the wheelchair access to the garden and the registered manager told us about how they planned to achieve this.

The registered provider had employed a care consultant to provide additional support and guidance. The care consultant was still employed and attended the home during the inspection. They were involved in providing training for staff and in supporting the registered manager and clinical lead as well as undertaking some specific quality assurance work. For example, when a concern was raised to the CQC and local safeguarding team in October 2017 they undertook the investigation requested by the local safeguarding team. The concerns had been around the care provided at night however the investigation had not included specific observations overnight. The care consultant told us they were always available to the registered manager for guidance and support should this be required.

People and relatives were positive about the service and the way it was managed. One relative told us "The staff here are fantastic; I could not have chosen a better home". Another visitor said "We are so lucky to have got my relative in this home; it's wonderful we are very impressed". People told us they enjoy living at Kinross. The home aimed to involve people in the local community as far as possible. The clinical lead told us about links with the local school and people had been invited to attend a performance by the children at Christmas.

Although a limited company the home was owned by the registered manager and clinical lead who people were very positive about. One person told us "The owners are very good, they do make you comfortable, they do their best." Another person who had a second language said, "They [The registered manager and clinical lead] are open to suggestions and he [registered manager] comes in every morning and says good morning in French to help me brush up on my language." One staff member said of the registered manager, "The owners are lovely, they talk to the staff. I worked at a previous home they owned and followed them here." Staff meeting minutes showed that best practice was discussed with the staff team.

The service ensured people, visitors and staff were kept informed about the service. Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The registered manager understood their responsibilities in respect of this although they had not needed to follow the procedure as no significant incidents had occurred. Visitors told us they were kept informed verbally of minor incidents and changes in their relative's health. Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection were displayed both in the home and on the provider's website. We saw information on the office noticeboard about how to contact the registered manager and clinical lead when they were not at the home. The staff were aware that they should contact the registered manager in the first instance if they were concerned or needed to report an incident/accident, but they also knew what to do if they were not available or they needed to go 'above their heads'. There was a list of phone numbers including the local safeguarding team and CQC for staff to use should they need to contact them.

The registered manager described their goal for the home as being to provide, "A happy place where people

could live and enjoy their lives." They added they wanted people to be "Treated like I would want my own mother to be treated". The registered manager and clinical lead said they aimed to lead by example and role modelling, and would undertake any tasks that needed doing. They identified this also helped them ensure the quality of the service and would not hesitate to take action if staff were not treating people appropriately. Staff also described their goal as being to make people as happy as possible. Care staff said they all worked well together as a team. For example, the housekeeper said they would respond to call bells if they were in the area. All staff members said they would be happy for a member of their own family to receive care at the home.

The registered manager told us they had developed links with the managers of other local care homes through their membership of a local care homes association and attended meetings and conferences where appropriate. They identified this helped keep them up to date with current best practice and to develop the service for the benefit of people. When we identified areas, which could be improved the registered manager was receptive to these and where necessary took immediate action. This showed they were willing to listen to others opinions and views about the service.

Policies and procedures were supplied via an external company and had been adapted to the home and service provided. We were told policies were reviewed yearly or when changes were required and updates were received from the external company when legislation or best practice guidance changed. We saw these were available for staff in the office and ensured that staff had access to appropriate and up to date information about how the service should be run.