Barchester Healthcare Homes Limited

Kingsland House

Inspection report

Kingsland Close
Off Middle Road
Shoreham By Sea
West Sussex
BN43 6LT

Tel: 01273440019
Website: www.barchester.com

Date of inspection visit:
02 March 2016

Date of publication:
28 April 2016

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Kingsland House on the 2 March 2016. We previously carried out a focussed inspected at Kingsland House on 12 and 13 August 2015, in order to look at specific areas of concern. We found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect to people not receiving person centred care, people not being treated with dignity and respect, people's consent to care and treatment not being sought , people not receiving adequate amounts of food and drink, quality monitoring and inadequate staffing levels. The service received and overall rating of 'Inadequate' from the focussed inspection on 12 and 13 August 2015. After this inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

Kingsland House is a purpose built home that provides nursing care and accommodation for up to 71 older people with a physical disability, dementia and/or related mental health conditions. The home includes 'Memory Lane Community', a dedicated part of the home that accommodates people living with a dementia and 'Bluebell Community', part of the home where people with complex and general nursing needs reside. Services offered at the home include nursing care, end of life care, respite care and short breaks. At the time of this inspection, there were 41 people living at the home. Kingsland House belongs to a large corporate organisation called Barchester Healthcare Homes Limited. Barchester Healthcare Homes Limited provides residential and nursing care in a large number of services across the United Kingdom.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had followed their action plan, and confirm that the service now met legal requirements. We found improvements had been made in many areas. However, further areas were identified in order to improve some practices in relation to the need embed and sustain improvements in relation to staffing levels and increased occupancy, the need to obtain consent and there being no registered manager in post.

The overall rating for Kingsland House has been revised to requires improvement. We will review the overall rating of requires improvement at the next comprehensive inspection, where we will look at all aspects of the service and to ensure the improvements have been sustained.

There was a manager in post, however they had not currently registered with the CQC. The service had been without a registered manager for approximately ten months. 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.

Despite the improvements that we identified in relation to staffing levels and the planning and delivery of personalised care, we were unable at this inspection to determine whether the current service provision had been fully embedded and could be sustained over time, should the number of people living at the service increase.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the provider was meeting the requirements of the Deprivation of Liberty Safeguards. However, several MCA assessments did not record the steps taken to reach a decision about a person's capacity. Capacity enables people to make their own decisions about their care and support. Assessing capacity in the right way at the right time is vital in care planning. A senior manager told us, "It is a work in progress with the MCA assessments, it is not consistent across the home".

The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement. The service had an ongoing action plan for improvement and the manager was required to feedback progress weekly to senior management. This information was then fed into a central action plan to monitor progress. Significant improvements had been made, however the delivery of the action plan would need to be monitored over time to ensure that the improvements identified could be fully implemented and sustained.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. One person told us, "Yes we are very safe here". When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. One person told us, "The nurses are nice. They give me my medicines every day, I would forget otherwise".

Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including treating people with dignity and the care of people with dementia. Staff had received supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place. One member of staff told us, "Brilliant training, lots of opportunities".

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. One person told us, "The food is marvellous and we get to choose what we have. It's lovely". Special dietary requirements were met, and people's weight was monitored, with their permission. Health care was accessible for people and appointments were made for regular check-ups as needed.

People chose how to spend their day and they took part in activities in the service and the community. People told us they enjoyed the activities, which included quizzes, singing, exercises, films, arts and crafts and themed events, such as reminiscence sessions. One person told us, "There are lots of activities, singing, memory games and quizzes. They are all good". People were also encouraged to stay in touch with their families and receive visitors.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. One person told us, "I have been here a long time. I am very lucky. People are

very kind to me". Care plans described people's needs and preferences and they were encouraged to be as independent as possible.

People were encouraged to express their views and had completed surveys. Feedback received showed people were satisfied overall, and felt staff were friendly and helpful. People also said they felt listened to and any concerns or issues they raised were addressed. Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns.

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 consistently safe.

There were enough skilled and experienced staff to ensure current number of people living at the service were safe and cared for. However, we were unable to determine whether the current service provision could be sustained over time, should the number of people increase.

The provider used safe recruitment practices. Staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. Medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the service was meeting the requirements of the Deprivation of Liberty Safeguards. However, several MCA assessments did not record the steps taken to reach a decision about a person's capacity to make choices.

People spoke highly of staff members and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes. However, we were unable to determine whether the current service provision could be sustained over time, should the number of people increase.

People were supported to take part in meaningful activities. They were supported to maintain relationships with people important to them.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had not had a registered manager in post for approximately 10 months.

The provider promoted an inclusive and open culture and recognised the importance of effective communication.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided. Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

Kingsland House

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

The inspection took place on 2 March 2016. This visit was unannounced, which meant the provider and staff did not know we were coming. Kingsland House was previously inspected on 12 and 13 August 2015, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect to people receiving person centred care, people being treated with dignity and respect, people's consent to care and treatment, people not receiving adequate amounts of food and drink, quality monitoring and staffing levels. The service received an overall rating of 'Inadequate' after our inspection of 12 and 13 August 2015, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

Six inspectors undertook this inspection. Before our inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and clinical commissioning group, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We observed care in the communal areas of the service. We spoke with people and staff, and saw how people were supported during their lunch. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including nine people's care records, six staff files and other records relating to the management of the service, such as training records, food and fluid recording charts, accident/incident recording and audit documentation.

During our inspection, we spoke with 10 people living at the service, one visiting relative, a visiting professional, six care staff, the divisional director, the regional director, the operations manager, the director

of regulation, the training co-ordinator, two maintenance staff, two ancillary staff, the administrator, two nurses and the chef. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 12 and 13 August 2015, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that there were not always sufficient numbers of staff to safely support people's care needs. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to staffing. Improvements had been made and the provider was now meeting the legal requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they considered themselves to be safe living at Kingsland House. The care was good, there were enough staff and the environment was safe and suitable for their individual needs. One person told us, "I feel quite safe here". Another person said, "I feel very safe here".

At the last inspection we found the staffing levels to be inadequate and this had placed people at risk. At this inspection the staffing levels had remained the same, however, the number of people living at the service had reduced from 61 to 41 since the previous inspection. The provider calculated staffing levels using a dependency tool the dependency indicator care equation (DICE).This tool looked at each person's level of dependency (care needs) and calculated the required staffing numbers. The information to aid the DICE tool was based on individual care plans and the assessed level of need documented. The current assessment was up to date and we saw that staffing levels were greater than what would normally be implemented for the 41 people living at the service. A senior manager told us that the service was currently "overstaffed", and a decision to keep staffing levels the same, despite the reduction in people living at the service had been made to assist with improving the safety of the care being delivered. We saw that this was the case.

Feedback from people indicated they felt the service had enough staff and our own observations supported this. One person told us, "There are always enough staff around if I need anything". Another person said, "If I call, the staff come to me. If I need the toilet or help, they come". A further person added, "I push my bell and they come, they are nice". Other comments included, "I call for them if I need them and they come".

Staff also told us that they felt the current staffing levels were sufficient. One member of staff told us, "We have less residents now, so there is more time for everyone". Another said, "It's a big home, but staffing was split between the two units. We had a big change around of staff, so we work over both units, so we now work as one big team. As there are less residents, it feels easier at the moment. We can spend a lot more time with the residents that are here, but to be fair changing the routines and practices really helped". A further member of staff added, "We have more time now, the residents can have more showers and more attention from us, it's good". Other comments included, "Staffing has improved tremendously since the last visit" and "We have enough staff now, which is so much better".

At the last inspection people told us, and we saw records that showed call bells were not always answered in a timely way. We saw that improvements had been made. At this inspection, we were shown records and analysis of the time taken across a 27 day period for staff to attend to someone once they had pressed their call bell. The analysis of the records was calculated over the three daily staff shifts in the service. The records

showed that on average call bells were answered within four minutes and twenty eight seconds on the first shift, three minutes and ten seconds on the second shift and one minute and five seconds on the third shift. Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told agency staff were used as required and existing staff would also be contacted to cover shifts in circumstances such as sickness and annual leave.

However, despite the improvements identified in relation to staffing levels, we were unable at this inspection to determine whether the current service provision could be sustained over time, should the number of people living at the service increase. The service is approximately 60% full, and is "overstaffed" for the amount of care that is being delivered. Whilst it is acknowledged that the current staffing levels improved the safety of people, we cannot at this stage determine an accurate representation of the care delivery with increased occupancy. The service would need to demonstrate appropriate staffing arrangements over a defined period of time, to ensure that the sustainability of good care could be achieved for people. We have therefore identified this is an area of practice that needs improvement.

Suitable measures had been taken to ensure that people were safe, but their freedom was not restricted. Positive risk taking involves looking at measuring and balancing the risk and the positive benefits from taking risks against the negative effects of attempting to avoid risk altogether. People were supported to undertake positive risks, we observed people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Risk assessments were in place which considered the identified risks and the measures required to minimise any harm whilst empowering the person to undertake the activity. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. Staff confirmed that they found risk assessments and information within people's care plans useful as it provided them with guidance about how to support people in a safe manner. We also saw safe care practices taking place, such as staff supporting people to mobilise around the service.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. The provider employed two dedicated maintenance staff who carried out day-to-day repairs and maintenance, and staff said these were attended to promptly. Regular fire alarm tests took place along with water temperature tests and regular fire drills were taking place to ensure that people and staff knew what action to take in the event of a fire. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan. Generic and individual health and safety risk assessments were in place to make sure staff worked in as safe a way as possible.

Staff had a good understanding of what to do if they suspected people were at risk of abuse or harm, or if they had any concerns about the care or treatment that people received in the home. They had a clear understanding of who to contact to report any safety concerns and staff had received up to date safeguarding training. They told us this helped them to understand the importance of reporting if people were at risk, and they understood their responsibility for reporting concerns if they needed to do so. There was information displayed in the home so that people, visitors and staff would know who to contact to raise any concerns if they needed to. There were clear policies and procedures available for staff to refer to if needed.

We looked at the management of medicines. The registered nurses were trained in the administration of medicines. A registered nurse described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks and cleaning of the medicines fridge. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed.

We observed a nurse administering medicines sensitively and appropriately. Nobody we spoke with expressed any concerns around their medicines. One person told us, "The nurses are nice. They give me my medicines every day, I would forget otherwise". Another person said, "They are pretty good here. They do the medication regularly and it's on time. There's been no problem so far". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of.

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The provider had obtained proof of identity, employment references and employment histories. Nursing staff were registered with the Nursing Midwifery Council and had up to date registrations.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 12 and 13 August 2015, the provider was in breach of Regulations 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect to the recording and assessment of consent and that people had been placed at significant risk of malnutrition and dehydration. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the need for consent and meeting peoples nutritional and hydration needs. Improvements had been made and the provider was now meeting the legal requirements of Regulations 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received effective care and their individual needs were met. One person told us, "Very good staff, very good qualifications". Another person said, "You can't fault the food, I have a choice and they check if you have any allergies". A further person added, "The care staff are good and they help me when I need them". However, despite the positive feedback, we saw areas of practice that needed improvement.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had knowledge of the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. Staff told us they explained the person's care to them and gained consent before carrying out care. Throughout the inspection, we saw staff speaking clearly and gently and waiting for responses. One member of staff told us, "I always ask first and always assume people are capable". Staff recognised that people had the right to refuse consent. The manager and staff understood the principles of DoLS and how to keep people safe from being restricted unlawfully. They also knew how to make an application for consideration to deprive a person of their liberty, and we saw appropriate paperwork that supported this.

At the last inspection we saw that where required people had a mental capacity assessment completed. However, in the mental capacity assessments we viewed, it was not clear what decision was being made, in particular around the use of bed rails. We saw that this had improved and capacity was assessed and recorded appropriately in five of the care plans we looked at. However, in four care plans, mental capacity assessments did not record the steps taken to reach a decision about a person's capacity, including around the use of bed rails. We spoke with a registered nurse about what we had seen. They told us, "This is an area that needs to be addressed". Additionally, a senior manager added, "It is a work in progress with the MCA assessments, it is not consistent across the home". Determining whether or not someone has capacity to make a decision may have significant consequences. Capacity enables people to make their own decisions

about their care and support. Assessing capacity in the right way at the right time is vital in care planning. A person assessed as lacking capacity may be denied their rights, or could be put at risk if they are making decisions that they do not really understand. We have identified this as an area of practice that needs improvement.

At the last inspection we identified significant concerns around the mealtime experience, people being supported to eat and drink appropriate amounts and the monitoring of people's food and fluid intake, which had placed people at risk. The manager told us that improvements had been made, and that changes to the planning of the mealtime experience and the deployment of staff at these times had been implemented. We saw that this was the case.

Feedback from staff was that they felt that improvements had been made to the way they provided people with food and drink. One member of staff told us, "We've changed the mealtime routine and it's got a lot easier. We co-ordinate the food service, so that staff can have delegated tasks. This frees us up to assist with people. We discussed it all with the manager and it's worked really well. People have eaten and they are happy". Another said, "We get the time now to sit and support people. Some residents won't eat if you leave the food in front of them, but if you sit with them they will". A further member of staff added, "I think things are much better at mealtimes". The chef told us, "The issue was never with the standard of food. There has been a lot of focus on how we deliver the food and the mealtime experience. Attitudes have changed and we are all working together to support the care staff at mealtimes". They added, "We make sure that everything is ready for them, so that they don't need to look for anything, like jugs or cups. We ensure everything they need is set up in the fridges, to save time for the carers. We've looked at the layouts of the dining rooms, to give people quiet areas to eat and have a pleasurable meal".

We saw that nutrition meetings took place monthly for care workers, nursing staff and catering staff, to discuss the nutritional status of people and to feedback around the mealtime experience. Topics discussed included the need for staff to take responsibility for filling in all charts accurately and feedback about the changes to the mealtime routines that had been implemented. The feedback was positive, however the manager reminded staff to be mindful of the views of people and information should be shared and documented. Additionally, we saw that regular observational checks by management took place monitor and improve the mealtime experience.

People were complimentary about the food and drink. One person told us, "They feed me so much. I like the choice, I have a menu. I like prawns and smoked salmon". Another person said, "Food is good. Yes I get a choice of two things". A further person told, "The food is lovely. Lovely breakfasts". People were involved in making their own decisions about the food they ate and special diets were catered for. For breakfast, lunch and supper, people were provided with options of what they would like to eat. The chef told us, "We get feedback from professionals, staff and residents about the food and always have second choices for people". The chef confirmed that if relatives wanted to eat with their loved one, a meal would be prepared for them. The menu showed that fresh vegetables were used daily, as well as fresh fish and fresh meats.

We observed lunch in all the dining rooms and lounges. It was relaxed and people were considerately supported to move to the dining areas, or could choose to eat in their room or the lounge. The food was presented in an appetising manner and people spoke highly of the lunchtime meal. The atmosphere was calming and relaxing for people. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or additional choices. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. All the time staff chatted socially with people, encouraged them to eat and were checking that people liked their food.

We saw that in between meals people were offered hot drinks and snacks. We saw staff offering people cakes, buns, custard, mousse, sausage rolls, smoothies and stewed fruit. A member of staff told us, "There are loads of snacks for people, even those on pureed diets, so much variety". The chef added, "Staff breaks have been changed so that there is protected time for staff to get the tea trolleys out".

Staff understood the importance of monitoring people's food and drink intake and monitored for any signs of dehydration or weight loss. Where people had been identified at risk of weight loss, food and fluid charts were in place which enabled staff to monitor people's nutritional intake. We saw that food and fluid charts were completed accurately. A member of staff told us, "There has been so much improvement with paperwork, especially with food and fluid". Another member of staff said, "Definite improvement around the recording of food and fluids. It's been explained how to do it". People's weights were recorded regularly, with permission by the individual. The manager held regular meetings in relation to nutrition, and kept updated records to monitor people's weight over time, and where people had lost weight, we saw that advice was sought from the GP, dietician and speech and language therapist. They told us, "All nutrition care plans have been revisited and we have put charts together for people at medium and high risk".

Staff told us the training they received was thorough and they felt they had the skills they needed to carry out their roles effectively. We saw that staff were supported by an in-house training co-ordinator. The divisional director told us that clinical development nurses had also been working alongside both nurses and care staff on a daily basis since January 2016, to ensure that all staff understood how to support people as individuals. As well as providing training, the training co-ordinator carried out regular observations of the practice of all staff and checked their knowledge and understanding of topics such as the mental capacity act or infection control. They told us that where required, staff were offered additional one to one support and training.

Training schedules confirmed staff received essential training on areas such as, moving and handling, equality and diversity and infection control. In light of the concerns identified at the previous inspection, staff had also received training that was specific to the needs of the people living at the service. This included caring for people with dementia, diabetes, nutrition and tissue viability. Training had also been sought around the use of syringe drivers. A syringe driver is a small, portable pump that can be used to give a continuous dose of painkiller and other medicines through a syringe. Staff spoke highly of the opportunities for training. One staff member told us, "We get mini training sessions from nurses around nutrition and diet. We are all trained very well. The training is good and there is lots of development for growth". Another said, "Brilliant training, lots of opportunities". The manager added, "The home trainer has done a lot of work around training for staff for dignity, dementia and person centred care". We also saw that the provider's hospitality manager had been regularly visiting the service. They had been working closely with the chef and training co-ordinator to develop specific training for staff on how best to support people to eat and drink appropriately.

There was an on-going programme of supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. A senior manager told us that since the previous inspection their priority had been to improve the training and supervision of the staff, and they aimed to complete all appraisals by April 2016. Staff members commented they found the forum of supervision useful and felt able to approach the manager with any concerns or queries.

People commented that their healthcare needs were effectively managed and met. One person told us how if they felt unwell, staff always acted upon their concerns and sought advice from their GP. People felt confident in the skills of the staff meeting their healthcare needs. Staff were committed to providing high quality, effective care. One member of staff told us, "We need to have continuity for the residents. At all times

there is a nurse on duty. This gives a good overview of people and their health needs". People's health and wellbeing was monitored on a day to day basis. Where required, people were supported to access routine medical support, for example, from an optician to check their eyesight. In addition, people had input into their care from healthcare professionals such as doctors, occupational therapists, speech and language therapists and dieticians whenever necessary.

Good

Is the service caring?

Our findings

At the last inspection on 12 and 13 August 2015, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that people's care and treatment was not delivered in a way that supported their independence, ensured their dignity and treated them with respect at all times. After this, the provider wrote to us to say what they would do to meet legal requirements in relation to dignity and respect. Improvements had been made and the provider was now meeting the legal requirements of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found the principles of privacy and dignity were not embedded into every day care practice, especially around supporting people with their continence and people having their choices and independence supported. We saw at this inspection, that people were supported with kindness and compassion. They told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "The male and female staff are very caring. I wouldn't want to be anywhere else". Another person said, "The staff are all very kind". A further person added, "The staff are excellent. Always helpful". A member of staff told us, "We get the time to take people to the toilet now. We listen to them, if they want to go, we take them".

Positive relationships had developed with people. A visiting relative told us, "The staff that I know are brilliant". Staff showed kindness when speaking with people. Staff took their time to talk with them and showed them that they were important. For example, we saw a person become upset and stated that they felt lonely. A member of staff sat with them and said, "I'm here for you". Staff always approached people face on and at eye level, they demonstrated empathy and compassion for the people they supported. We saw a member of staff bring some tea and a sausage roll to a person. The member of staff said, "I've made your tea, just how you like it". They then sat together and discussed the person's family. There was a lot of laughter and after the member of staff left, the person told us, "She's lovely. She knows what I like. Such a charming young girl, we do have a laugh together". We also observed a member of staff assisting a person in a wheelchair to go to one of the communal lounges. The person told us, "She is a darling, she helps me around the home. God bless her, one of a kind I say".

Kingsland House had a calm, relaxing and homely feel. Throughout the inspection, people were observed freely moving around the service and spending time in the various lounges. People's rooms were personalised with their belongings and memorabilia. People showed us their photographs and other items that were important to them. People were supported to maintain their personal and physical appearance. They appeared well dressed and had their individual styles respected. For example, ladies had their handbags to hand and were seen wearing jewellery and makeup. A member of staff told us, "I try to make all the ladies look pretty. We talk about what clothes match, so they look nice". We observed a member of staff talking with a lady, they said, "Your hair looks pretty today", and the person responded with a smile and a thank you.

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do, what they would like to eat or drink and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do very much what they wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. One person told us, "Staff are thoughtful and always ask what I want". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "We ask people what they want and give them choice. Whatever they want to do".

We looked at the arrangements in place to protect and uphold people's confidentiality, privacy and dignity. Staff members had a firm understanding of the principles of privacy and dignity. In light of the issues identified at the previous inspection, staff had been given specific training and support around treating people with dignity respect and allowing choice and privacy. They were able to describe how they worked in a way that protected people's privacy and dignity. People confirmed this was the case. One person told us, "They respect my privacy and dignity. They close the bathroom door, and they will help if I need it. We saw that a member of staff had been selected to be a 'Dignity Champion' and that a 'Dignity Promise' had been written, that staff had signed. The promise included a commitment for staff to respect the personal space of people and to speak to them with sensitivity, patience, empathy and interest.

Staff supported people and encouraged them, where they were able, to be as independent as possible. One member of staff told us, "I encourage people to do things for themselves, like eating their cornflakes. Even if they make a mess, I don't care, as it's the best thing to do". Care staff informed us that they always encouraged people to carry out personal care tasks for themselves, such as brushing their teeth and hair. A member of staff said, "We have one resident who stays in bed. We encouraged them to have a shower and wash their hair. It took a long while and a lot of encouragement, but they were so happy afterwards".

People were able to maintain relationships with those who mattered to them. Visiting was not restricted and guests were welcome at any time. People could see their visitors in the communal areas or in their own room. One person told us, "My relatives come and visit any time". Another person said, "My daughter comes to see me at the weekends". We also saw that there was a guest room available and areas could be hired for special events like birthday parties.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 12 and 13 August 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that people did not receive the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. After this inspection the provider wrote to us to say what they would do to meet legal requirements in relation to person centred care. Improvements had been made and the provider was now meeting the legal requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were listened to and the provider responded to their needs and concerns. People had access to a range of activities and could choose what they wanted to do. One person told us, "There are lots of activities, singing, memory games and quizzes. They are all good". Another person said, "If there are any problems, there is always someone to go to". A relative added, "I've never had a lot of complaints, but I'd go to the staff and get things sorted". A member of staff told us, "To care for someone, you must know who they are".

At the last inspection, the care received by people was not personalised to the individual. Additionally, the recording of people's care was not accurate and people's levels of need were inaccurately assessed. We saw at this inspection that people's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. People confirmed they were involved in the formation of the initial care plans and were subsequently asked if they would like to be involved in any care plan reviews. One person told us, "We write the care plan together, I get what I need". Care plans contained personal information, which recorded details about people and their lives. Staff told us they knew people well and had a good understanding of their family history, individual personality and interests, which enabled them to engage effectively and provide meaningful, person centred care. One member of staff told us, "Care plans are detailed and they have been updated with people's likes and dislikes". Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required meeting those needs, for example about the care of people with pressure wounds or diabetes. We pathway tracked several people and saw that staff were aware of the care that people needed and followed agreed plans of care.

Care plans also contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. For example, one care plan stated that staff should be vigilant if a person became distressed, as this may indicate that they are in pain. Another care plan stated that a person was to be encouraged to eat snacks between meals, and listed their favourite snack foods. We saw that these specific snacks were offered throughout the day to this person. The manager told us that staff ensured that they read peoples care plans in order to know more about them. We spoke with staff who confirmed this was the case and gave us examples of people's individual personalities and character traits that were reflected in peoples care plans. One member of staff said, "One resident gets stressed and clenches up so tight. I've found that if I speak clearly, calmly and slowly, she relaxes and lets me help her to

get dressed and bathed". Another added, that through getting to know a person, they found out they preferred to use handkerchiefs, rather than tissues. They told us, "I'm a big believer in person centred care and getting people the things that they want. He preferred to use handkerchiefs, so we got him some".

However, despite the improvements identified in relation to the planning and delivery of personalised care, we were unable at this inspection to determine that the systems of care planning had been fully embedded and could be sustained over time, should the number of people living at the service increase. The service is approximately 60% full and has been through an extensive period of review, involvement and support from the provider. Whilst it is acknowledged that the current care plans and delivery of care from staff improved outcomes for people, we cannot at this stage determine an accurate representation of the care delivery. The service would need to demonstrate appropriate planning and delivery of person centred care over a defined period of time with increased occupancy, to ensure that the sustainability of good care could be achieved for people. We have therefore identified this is an area of practice that needs improvement.

There was regular involvement in activities and the service employed specific activity co-ordinators. Keeping occupied and stimulated can improve the quality of life for a person, including those living with dementia. There was a range of activities throughout the week, including weekends. Activities on offer included singing, exercises, films, arts and crafts and themed events, such as reminiscence sessions. One person told us, "There are lots of activities in the lounge. Music, games and professionals come in. I like the quizzes, they are fun. There's plenty to see and do here". A further person said, "There's a reminiscence session today in the afternoon". Feedback was received from people to gather their ideas, personal choices and preferences on how to spend their leisure time.

On the day of the inspection, we saw activities taking place for people. A number of people had been on a minibus outing in the morning and in the afternoon a volunteer held a reminiscence session with people and their guests. We saw people watching films together in various lounges and discussing current affairs with staff. We saw people spent time in the communal areas talking with each other, or meeting friends or family. One person told us, "There are enjoyable trips out, like trips to Brighton".

The staff ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. There was an individual one to one activities programme for people who were bedbound or preferred to remain in their rooms. One person told us, "I like peace and quiet and like my own company. I'll go out for a walk in the garden depending on the weather". We saw that staff set aside time to sit with people on a one to one basis. The staff also supported people to maintain their hobbies and interests, for example one person used to be a carpenter and a member of staff had bought them a tool box which they enjoyed using and talking about. A member of staff additionally told us how they had found out that several people enjoyed the film 'Oliver' and they had organised a showing of the film and provided people with pick and mix sweets in individual bags. Religious services were also made available for people, such as Holy Communion.

There were systems and processes in place to consult with people, relatives, staff and healthcare professionals. There was a box in the reception area for people to make comments or suggestions about how the service was run. Satisfaction surveys were carried out, providing the manager with a mechanism for monitoring people's satisfaction with the service provided. Feedback from the most recent survey was on the whole positive, and changes were made in light of peoples' suggestions, for example around the mealtime experience.

People and relatives were aware of how to make a complaint and all felt they would have no problem raising any issues. The complaints procedure and policy were accessible and displayed around the service.

Complaints made were recorded and addressed in line with the policy with a detailed response. Most people we spoke with told us they had not needed to complain and that any minor issues were dealt with informally.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 12 and 13 August 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that people were placed at risk as the provider did not have effective systems to monitor and improve the service. Additionally, several improvement plans for concerns previously identified had not been put in place. After this inspection the provider wrote to us to say what they would do to meet legal requirements in relation to good governance. Improvements had been made and the provider was now meeting the legal requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a manager was in post, however they had not currently registered with the CQC. They had been in post for approximately three weeks. We noted that they were normally employed as an operations manager for the provider and this was a temporary post until a permanent, suitably qualified and skilled general manager could be appointed. However, despite the provider conducting recruitment activity for a manager, the service had been without a registered manager for approximately ten months. The Health and Social Care Act 2008 requires that as a condition of the provider's registration, that they have a registered manager. We have identified this as an area of practice that needs improvement.

People and staff spoke highly of the service and felt that the delivery of care had improved since the last inspection. People and relatives told us that their experience of the care was better, and staff commented they now felt supported and could approach the management team with any concerns or questions. One person told us, "The home is first class. I wouldn't change anything". Another person said, "The owner came recently and the new manager is nice". A relative added, "I think they've improved a lot. My relative seems happy here". A member of staff said, "I now feel supported and hope it will be maintained".

At the last inspection, feedback from staff indicated a negative culture with staff felling demotivated and unsupported, which in turn impacted on the quality of care provided. We discussed the culture and ethos of the service with the manager and staff. One member of staff told us, "Some staff have left and the staff now realise that we have to provide good care. We are where we are at the moment and have improved. We're on the ball now. We know how serious it is. I feel good now when I leave my shift knowing I've done good things". Another said, "I love it here, I love the home and all about it is positive". A further member of staff added, "Very good, very happy, I do not want to leave this home". The induction programme for new staff included a section on the vision, mission and values of the service. The provider also operated a scheme of care awards for staff and we saw a letter of congratulation for one member of staff who had been nominated as registered nurse of the year in the provider's care awards 2015.

Staff said they now felt well supported within their roles and described an 'open door' management approach. One said, "I feel supported. The new manager is great, always an open door". Another said, "We have opportunities to discuss the service, we are really open and can approach the managers". A further member of staff added, "Very supported". Staff were encouraged to ask questions, make suggestions about how the service is run and address problems or concerns with management. We were given an example

whereby from feedback from staff, forms were redesigned to make them more user friendly. The manager told us, "I've really impressed on staff the need to develop the service. The ideas are coming from the staff. I involve them and ask what would work for them. Staff nominated how the food and fluid forms would be used, they are the ones using them". A member of staff said, "The managers are really supportive now. Always asking for our feedback, listening to us and wanting our ideas". Staff were aware of the whistle blowing policy and when to take concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. We saw that policies, procedures and contact details were available for staff to do this.

Additionally, staff told us that in light of the concerns identified at the last inspection, changes to the way they carried out their roles had been made. They stated that this had improved the way the service delivered care. One member of staff told us, "We have new systems that make things easier". Another said, "There has been lots of support from everyone in the organisation. We've looked at different ways of working". A further member of staff added, "Lots of people came in to improve things. Everything is a lot better and there is a nicer atmosphere. We have new ways of working and new teams, we work well together". The manager told us, "The staff team has settled, they are aware of what needs to be done".

People and staff were actively involved in developing the service. We were told that people gave feedback about staff and the service through questionnaires and surveys, and that resident and relative's meetings also took place. One person told us, "Communication is good, I know what's happening in the home". The training co-ordinator told us how their request to have a dedicated training room had been listened to, and as a result they now had a quiet space for training and a hub for information sharing. They told us this had been "a great boost". People were also complimentary of how the service was run. One person told us, "It's like a five star hotel". Another said, "Sometimes, this is a marvellous home".

Management was visible within the service and took a hands-on approach. Since the last inspection, senior management input from Barchester Healthcare Homes Limited had increased and they had carried out monitoring and analysis of the issues identified at the service. A senior manager explained how there would be ongoing senior management involvement at the service, until they were confident that the required improvements had been made and sustained. The manager told us, "There is senior management involvement and we're giving lots of support to the staff and the nurses. We're getting positive feedback". A member of staff said, "The senior managers have been really hands-on, helping on the floor. I think the home is going to keep improving. All the residents are happy". Another said, "The new manager has a very calming effect, but is on the ball". A further member of staff added, "We have a good manager at the moment who listens, she's lovely".
The service had a strong emphasis on team work and communication sharing, and there were open and transparent methods of communication within the home. Staff attended daily meetings. This kept them informed of any developments or changes to people's needs. A member of staff told us, "We have staff meetings regularly. We are kept in the loop". Staff commented that they all worked together and approached concerns as a team. One member of staff said, "I like working here. We've got a good team of staff now, we get on well, they are brilliant. The new people make a difference".

Since the last inspection, the number of people living at the service had reduced from 61 to 41. However, the staffing levels had remained the same. A senior member of staff told us that a decision to keep staffing levels the same, despite the reduction in people living at the service had been made to assist with improving the safety of the care being delivered. We asked staff if they thought that the service would be able to provide safe, person centred, compassionate care when the home had more people living there. One member of staff told us, "It is so nice working here at the moment, as we can provide really good care to the number of residents who are here. I know that they home will fill up again one day, but I think we could cope". Another

said, "We're giving really good care. We will fill up again, but I think we can manage". A further member of staff said, "I wonder what it will be like if we are full with not a lot more staff. I hope they are careful of that". The manager told us, "There will be no pressure on the manager to fill the home. There will be a sustainable plan, with staged admissions". A senior manager showed us a sustainability plan for the service which detailed what action would be taken to ensure quality and safety with a greater number of people living at the service. The sustainability plan appeared practical and appropriate, however the delivery of the plan would need to be monitored over time to ensure that the improvements identified could be implemented and sustained.

The provider undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included nutrition and hydration, medication, analysis of call bell timings and accident and incident recording. The results of which were analysed in order to determine trends and introduce preventative measures. Weekly quality monitoring visits took place with senior management. These visits focussed on areas such as, home presentation, resident interaction, staff interaction, the mealtime experience and clinical governance. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. For example, changes included re-organisation of the breakfast service, to enhance the time available for people to receive personal care. A senior manager they were currently visiting Kingsland House weekly to support the manager and assist and monitor the changes to the service provision. The service had an ongoing action plan for improvement and the manager was required to feedback progress weekly to senior management. This information was then fed into a central action plan to monitor progress.

Mechanisms were in place for the manager to keep up to date with changes in policy, legislation and best practice. The manager was supported and monitored by a senior management team and was able to regularly meet with managers from the group. The manager told us, "I am being supported by clinical development nurses, the regional director and the divisional director. I love it and it motivates me". Up to date sector specific information was also made available for staff, including guidance around moving and handling techniques, updates from the nursing and midwifery council (NMC) and the care of people with dementia. The service also liaised regularly with the Local Authority and Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery, and learning was cascaded down to staff.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The managers at the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The managers at the service were also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and sets out specific guidelines providers must follow if things go wrong with care and treatment.