Express Care (Guest Services) Limited

Kingston Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 6 & 7 December 2016. We last inspected Kingston Court Care Home on 20 January 2014. At that inspection we found the service was not meeting one of the regulations that were in force at that time. We found that the service had not ensured that care plans contained all the detail needed and were updated when people's needs changed. This related to Regulation 9: Care and Welfare of people who use services of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. These regulations have now been replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Kingston Court Care Home is a care home that provides accommodation, nursing and residential care. The home is registered to provide care for up to 80 people who may be living with dementia, physical disability or require nursing care. The home is a three storey purpose built home situated in Carlisle. It is near to all the city amenities and is served by good public transport. All accommodation is in single en-suite rooms. The home cares for people with dementia in a specialist unit situated on the top floor of the building called the Memory Care Centre. The ground and first floors have people who need personal and nursing care, and some may also have dementia.

At the time of our inspection 70 people were living at Kingston Court Care Home. The provider and owner of the home is Executive Care Group. The registered manager informed us that the running of the home had been recently transferred by Executive Care Group from one operating company to another called Careport.

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

We found the home had met the breach found at the last inspection and now had good systems to ensure that care plans were up to date and reviewed when people's health care needs changed.

People told us contradictory things about the service. While some people were happy, others were not. We also received mixed views from relatives about the care. People told us that at times there were not enough staff available to answer their call bells and provide support when they needed it. We observed that staff were very busy and were at times under pressure. Care and support was mainly based around completing tasks and did not always take account of people's preferences or meet their social and recreational needs. People living in the home and several relatives reported issues with fluctuating staffing levels. One person said, "There aren't many staff sometimes, mostly less at night." Another told us, "If you push your buzzer you have to wait." They also told us that staff were often rushed. We found that this was the case with staffing levels on the middle floor of the home particularly being insufficient. Staff reported being "very over stretched" on this floor.

Overall we found that there were insufficient staff available, and deployed in such a way to in order to meet people's needs. The management team agreed to undertake a full review of the dependency levels of people to check how many staff was required to meet people's needs and to adjust staffing levels accordingly. Considerations of roles and task was also to be undertaken to see that staff were clear on their role and where deployed in the most effective way possible.

The majority of people living in the home told us that staff were caring and treated them well. One person told us, "There's a lot of good staff, they are good at their job, it's clean and there's no odours. The cleaners and laundry staff work hard too."

People told us that their family could visit whenever they liked and were made to feel welcome. One relative said, "I can come in when I like and the care is on the whole good."

Whilst the majority of staff had good relationships with the people they were caring for and on the whole respected their privacy and dignity, we noted some issues that compromised people's dignity and did not always demonstrate a very caring attitude. For example, we found that some of the language used by staff was not always respectful. We found that the home was exceptionally noisy through the use of a tannoy system that sounded to all floors along with the call bell and telephone system. This meant that one person pushing their buzzer sounded to all the other floors. This did not respect that this was people's home and numerous people living in the home commented on how intrusive and disruptive this was. One person said, "The bells drive you mad!" Another said of the alarms, "It's hard to get a snooze in the afternoon."

We found overall that the service was not always responsive to the needs of people living with dementia especially in relation to the physical environment, the staffing levels and the level of dementia specific activities on a one to one basis on the ground and second floor units. Care plans did not contain enough detail on people's wishes and preferences.

We have recommended the service looks at ways to ensure that maximum use is made of the skills and expertise of the staff team so that all people living with dementia have the same positive outcomes as those living in the 'Memory Care Centre' on the top floor. For example in sharing best practice on how to diffuse situations where people become agitated and to identify triggers to prevent these situations from occurring.

The home employed two activity coordinators and we saw a range of activities were available. However due to pressures of providing care the coordinators often did care tasks and care staff could not always spend quality time with people such as chatting with them, taking them out or doing activities that interested them. We were concerned that some people living in the home felt isolated. People's life stories, hobbies and interests were not always recorded and care plans did not identify how these needs would be met. Therefore, the activities in the home had not been designed to meet the needs of the individual.

Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely. However, support to assist people at mealtimes and to take drinks was inconsistent. We again received mixed views from people living in the home on the food and menus. We saw some polite and caring interactions from staff but we also noted a number of negative experiences, such as staff standing to assist people with meals or the food being cold. We saw that some people did not get enough help and support to eat their meal in a timely fashion.

We judged that providing a person centred approach to people's care and support needs had not been consistently implemented across the home. The care records for people on the two lower floors were basic and lacked detail about people's backgrounds, preferences for care and interests. Staff also reported on

these floors of having little time to get to know people properly and did not always have time to read people's care plans. People's care records on the unit for people living with dementia, 'The Memory Care Centre', were more detailed containing personalised information about their life histories, backgrounds, interests and family connections.

Overall we found that medicines were not always managed safely as some medicines needed to be recorded more thoroughly and there were lapses in good practice. For example, we found instructions for care staff to administer topical creams did not accurately reflect the directions of the GP. This meant there was a risk that prescribed creams may not have been applied when required, which could have resulted in unnecessary discomfort for the person.

During this inspection we identified that the provider had complied with their duties and notified us of all authorised DoLS. However, we recommended that the service looks for good practice methodology in this area so that people's capacity, ability to give consent and support needs are assessed and recorded more thoroughly and consistently.

The service had good recruitment processes to ensure only suitable staff were employed. Staff were receiving regular supervision and annual appraisals to enable them to carry out the duties they are employed to perform.

People told us they felt safe living in Kingston Court Care Home and the home provided them with a safe environment. Staff understood how to recognise and report abuse which helped make sure people were protected. We saw any allegations of abuse had been dealt with appropriately and reported to the local authority safeguarding team.

People had access to healthcare services and we saw specialist advice was sought in a timely manner. We saw some good instructions set out in care plans and clear instructions for staff on how to respond to people in particular situations.

The home's statement of purpose included information about how to make complaints, which people were provided a copy of when they moved into the home. There was a system in place for receiving, handling and responding to concerns and complaints.

The system the provider had for monitoring the quality of the service had not identified the issues we found on this inspection. While we saw some good practice and care this was not consistently applied across the home. The registered manager and regional manager, from Careport, had recently drawn up an improvement plan for the home, and part of this was to update all the policies and procedures.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including staffing, dignity, meeting nutritional needs, good governance and safe care and treatment. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

At times there were insufficient staff available, or effectively deployed, to provide support to people with their health and personal care in a timely manner.

Shortfalls were found in the administration and recording of some medicines.

Staff had been trained to recognise and report any harm and abuse. Appropriate checks had been undertaken to ensure suitable staff were employed to work with vulnerable people.

Staff had a good understanding of the risks people were exposed to and how to control them.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

Staff received training to ensure they had the skills and knowledge to support people appropriately. However more specialist training was required in dementia care for some staff.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, people's capacity and consent to care and treatment was not always recorded in enough detail.

People did not always receive the support they needed to eat their meals.

Is the service caring?

Requires Improvement

The service was not always caring.

Feedback from people about the attitude and nature of staff was

mixed. The majority of people spoke positively about staff. However, we found a lot of staff interactions were often task-focused with little time for one to one interactions.

There was a lack of consistency in the approach of staff. People's privacy and dignity was not always upheld.

People reported that their visitors were welcomed into the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's life stories, hobbies and interests were not always recorded and care plans did not identify how these needs would be met. Therefore, the activities in the home had not been designed to meet the needs of the individual.

However activities and entertainments were taking place and more were being planned and developed.

The support provided to allow people to engage in the local community was limited.

There was a system in place for receiving, handling and responding to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At the time of this inspection there was a registered manager.

Audit systems were being used to aid service improvement; however they had failed to identify the issues and concerns we found during our inspection.

While we saw some good practice and care this was not consistently applied across the home.

The registered provider has a duty to notify the Care Quality Commission of certain incidents and this had not always been done.

Kingston Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out over two days on the 6 and 7 December 2016 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist adviser in dementia care and an expert by experience working on behalf of CQC. 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 the previous Care Quality Commission (CQC) inspection report about the service and notifications of incidents that we had received from the service. We looked at the Provider Information Return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

We also contacted the local authority commissioners and the health authority commissioners to seek their views about the home.

During the inspection we spoke with the regional operations manager, the registered manager, the deputy manager, two unit managers, three nurses, ten carers, the cook, ten visitors to the home and 20 people living at Kingston Court Care Home. We looked around the building including a sample of bedrooms on all three units, all of the communal areas, toilets, bathrooms, the kitchen and the garden areas.

We examined the care records for nine people living at Kingston Court Care Home, medicine administration records, the recruitment and training records and records relating to the management of the home such as the quality assurances systems. We also looked at four staff personnel files and four supervision records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in Kingston Court Care Home and the home provided them with a safe environment. They said they would speak to a member of staff if they had any concerns. Visitors we spoke with told us they had never heard or seen anything that concerned them. Comments from people and relatives were positive. A relative told us, "I have no worries when I walk out and leave (relative)" and another said, "I have never seen anything to bother me."

We asked people and their relatives about the staffing levels and how their needs were responded to. We received a number of negative comments and the majority of these were about staffing levels on the middle floor which catered for people with more complex physical needs. Comments included, "There aren't many staff sometimes, mostly less at night. If you push your buzzer you have to wait."

We saw numerous examples of people's call bells not being to hand and buzzers going off with a delayed response time. We also saw that some people had to wait up to lunch time to have a wash and to get dressed. One person said, "I don't mind you just have to wait your turn. They will come when they have time. Some people are quite poorly here you know, so you can't make a fuss." Another said in response to the staffing levels, "It's bad, it's bad. I've seen staff in tears. There's been several times I've not been washed or changed all day."

A relative said (middle floor) "Sometimes they are pushed but they do try." Another relative told us, "The carers are brilliant. They do seem rushed though and short staffed sometimes but you expect that nowadays." A relative of a person living on the top floor said, "I am happy with the staffing levels." A relative of a person living on the ground floor said, "There always seems to be enough staff on duty." Another relative of a person living on the ground floor said, "My husband is looked after so well. The staff help me get through the day. I have peace of mind when I go home that he gets the care he needs."

Staff confirmed this stating that while working on the middle floor they felt unable to properly meet people's needs. Staff were visibly upset by this. They told us, "We are not able to give people care when they need it. We are always saying to people, 'hang on a minute I'll be back as soon as I can' but sometimes that can be quite a while." Another said, "The work load is too heavy on this floor. We have lots of people who need two staff for personal care and then we have charts, paperwork, turning people regularly, pushing fluids. It's a fight to get all this done and to be honest sometimes people have to wait. It's beyond stress!" Staff working on other floors also confirmed this by saying they were often "borrowed" by the middle floor and this then negatively impacted on other floors.

Staff also spoke of working long shifts of 12 hours and that this could sometimes be for a run of seven to eight days consecutively. One said, "I get tired and worry about making mistakes." Other staff told us that they didn't have time to read care plans and had to ask other staff. They said they found the shift meetings were their main way for of keeping up to date with changes to people's needs.

We looked at the staffing rota for the last four weeks. Staffing levels had been set for some time and we

could see very little changes to take into account the changing needs, and increased dependency needs of people. Staff, relatives and people reported that at times there were only three care staff on the middle floor. We had been told by the registered manager that this floor required at least four care staff and five during busy times. The senior carer on this floor also had additional responsibilities for administering medicines to those people who were not in receipt of nursing care.

There were 27 people on the middle floor. Of these 18 required two staff to use a hoist to attend to their personal care needs. The remaining people needed one staff member to help them. Staff told us at times people could not have a bath when they required one, for example if they were doubly incontinent. Instead, people were often given bed baths as this was quicker. We frequently observed no staff member in the lounge downstairs with staff only occasionally pausing to look in as they passed. Care staff also had additional duties including stocking up gloves and aprons, taking out the tea trolley, setting tables and recording daily fluids/food charts as well as other records. Staff all said this took away from time that could be spent giving care or attention to people.

This was in breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management team agreed to undertake a full review of the dependency levels of people to check how many staff they needed to safely meet people's needs and adjust staffing levels accordingly. The registered manager said that they would also consider the roles of staff and whether they were being effectively deployed and managed to best effect.

We looked at systems in place for management of medicines including policies and procedures in place relating to the administration of medicines. We asked a nurse about safe handling of medicines to ensure people received the correct medication at the right time. Answers given along with our observations demonstrated medicines were administered competently but there were some lapses in good practice. For example, we saw one person required their medicine to be administered 30 minutes before breakfast, yet we saw it administered after breakfast. We found that two transdermal patch application records did not have the date the patch was removed. This meant it was not possible to determine if the patch had been removed or not, which is not the standard of practice expected and against drug administration and recording protocols.

Whilst the provider's policy stated all 'as necessary' (PRN) medicines for example paracetamol, should be supported by a protocol and written up in a care plan, we saw they were not always supported by robust written instructions, which described situations and presentations where PRN medicines could be given. For example, we saw a person was prescribed medicines to reduce agitation, yet, no protocol existed for the steps that maybe required if this did not work. This was found in care plans on the ground floor, however good guidance was in place on the top floor 'Memory Care Centre'.

The medicines trolleys were stored appropriately. There was an appropriate medicines fridge in good working order with evidence of daily temperature checks. Medicine administration record (MAR) charts all had an up to date identification sheet with a current resident photograph

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were not always appropriately labelled and dated upon opening. Some creams had labels torn off and others were not for the person prescribed on the label. The responsibility for the application of creams was delegated by nurses to care staff. The original MAR sheet instructions were transcribed onto a topical MAR sheet from which the care staff took their instructions. We saw that the transcribed instructions were not always in place in the designated file held in people's rooms. This meant there was a risk that people may not have received prescribed creams as intended by their doctor, which could result in unnecessary

discomfort for the person.

We checked to determine the prescribing and administration of antipsychotic and anxiolytic medicines to treat the behavioural symptoms of dementia. We found no evidence these medicines were being used inappropriately. This meant excessive sedation; accelerated cognitive decline and increased mortality were not a risk factor for people with dementia at the home.

A tin of thickening powder was seen on the drink trolley. This is used to thicken drinks so that people with swallowing difficulties do not take fluids onto their lungs. This would be prescribed by a GP for the use of one person only. The tin was not labelled and staff stated they had used it for everyone who needed to have their drink thickened. The practice of sharing being adopted by the service was not safe and was open to error, with the potential for the person not receiving their prescription and treatment as directed by their GP.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place covering areas such as nutrition, moving and handling, skin care and bed rails. Staff we spoke with had a good understanding of the risks people were exposed to and how to control them.

We saw detailed plans of care in relation to prevention of pressure ulcers and wound care. In one care file we saw the person had been swiftly and appropriately referred to the tissue viability nurse for advice when required. Each wound had been identified on a body map, had a description, measurements and a photograph. A detailed plan of care included evidence of when the wound was dressed and what dressing had been applied. There was an evaluation chart and a progress report for each wound. This demonstrated good practice because staff were able to track and monitor any deterioration or improvements for each wound.

Personal protective equipment (PPE) such as disposable aprons and gloves were available throughout the home as was hand sanitiser, helping reduce the risk of cross infection. We saw the use of colour coded mops for cleaning and we saw good stocks of cleaning products, which helped staff to maintain standards of hygiene and cleanliness all appropriately stored in a locked cupboard to ensure safety. However some equipment and furniture was dirty and required cleaning or replacing. For example the bed frames and dado rails were dusty; bed bumpers and lounge chairs were dirty and worn with splits or tears. This made them difficult to clean and therefore posed an infection risk. We told the registered manager about these and were informed that all bed frames in the home had now been cleaned. We saw that damaged bed bumpers had been replaced. Damaged chairs were identified for replacement and the registered manager will update CQC on progress in relation to the refurbishments required.

Appropriate safety checks had been carried out to ensure people were cared for in a safe environment. For example we saw evidence of gas and electric safety certificates, hoist and lift servicing, window restrictors, thermostatic mixer valve checks to ensure safe water temperature delivery. Everyone in the home had a Personal Emergency Evacuation Plan (PEEP).

We saw that the home had suitable policies and procedures in place for protecting people from harm and abuse. We spoke with staff on duty who were knowledgeable about their responsibilities in relation to safeguarding. A member of the care staff told us "If someone reported something to me I would listen to the person and report it to the nurse on duty, if they didn't act I would take it higher."

We reviewed safeguarding records and saw incidents had been appropriately investigated and Kingston Court Care Home had appropriately notified the Commission. Where further actions had been recommended by the local authority as a result of safeguarding investigation we found these had been completed. This meant lessons had been learnt as a result of investigations and direct action had been taken to prevent potential recurrence. Staff had access to a 'Whistle Blowing' policy which protects an employee who wants to report unsafe or poor practice.

We looked at six staff files which showed procedures were in place to ensure the staff recruited had the appropriate qualities. Pre-employment checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Requires Improvement

Is the service effective?

Our findings

We asked people who lived in the home about how effective they judged the service to be. People we spoke with made many positive comments about the support they received from the staff in the home. We also received some negative comments and again this seemed to be dependent on what floor people lived on. One person told us, "I'm well looked after here and they do anything I ask." And another said, "Staff are nice lasses and they give me all the care and support I need. If I wished I could have my meals in the dining room but I prefer to eat in my room." Another person told us, "There's a lot of good staff, they are good at their job, it's clean and there's no odours. The cleaners and laundry staff work hard too."

A relative said, "We are very pleased, and we are very fussy, you hear such things about care homes and I used to work in care so I know, so we looked hard before we found this one, the staff have been really good and helpful." A relative (top floor) said "Well I'm happy with it. They look after (relative) well". A relative said "It's been very good, I come in when I like, they are very good to (relative)." While another relative (middle floor) told us, "I'm not very happy with some of the staff. Some are okay but others aren't as good. We come in everyday to make sure (relative name) gets the care." They told us they were waiting for their relative to be dressed so they could take them out and they couldn't find any staff to help dress them at 11.00 am.

We received mixed views about the food. People told us about the food and the meal time experience: "The food is very good and you can pick and choose. I'm quite fussy but they can usually find me something." Another person said, "The food is lousy. It's good food ruined. Jacket potatoes congealed on a plate, cheese omelette where cheese isn't grated or melted. No homemade cakes. And desserts like the ones I had as a kid, angel delight, semolina with dollop of jam, meringue with cream. And both the cups of tea and meals are nearly always luke warm or cold." When we observed lunchtime we heard one person say, "I don't like ice cream, I don't like yoghurt, I don't like Tapioca" but this was ignored and the person got up and left.

We looked at how the service supported people to eat and drink and what arrangements they had in place to meet people's nutritional needs. We observed people during the lunchtimes and saw that support to eat meals and take drinks was inconsistent. We saw some polite and caring interactions from staff but we also noted a number of negative outcomes. Some people did not get enough help and support to eat their meal in a timely fashion. For example, we saw people were still trying to manage to eat half an hour after they had been given their food. We saw some people who received support eating well, however as soon as the staff member moved away they stopped eating. Staff told inspectors they didn't always have the time to sit with people to ensure they ate all their meals.

We found that some of the issues were around how the mealtimes were organised. For example we saw that not all equipment was readily available. Staff ran out of aprons, spoons, yogurts and napkins. Staff either made do or had to leave to find these things. For example we saw one person having a soft diet being assisted by a nurse with a large spoon. The nurse had said they were often short of smaller spoons. We heard one person say when offered a plastic apron, "I prefer a cloth one, I like them", the carer said "we don't seem to have any", another carer went off to find some. One person preferred lemonade but we saw this was poured into their teacup. A member of staff was writing down what everyone in the dining room

had eaten on the back of a serviette to later transfer to their records, this was very hard to read. The photo menu on the wall did not match the items on the table menu.

We observed the tea trolley round at 11 am, tea and biscuits plus cold drinks were on offer but we saw that as the trolley went from room to room the care staff also performed whatever task was due for that resident; consequently the trolley took a long time to go from the first room to the last. A person called out, "Can I have a cup of tea, I'm gasping" staff replied "It's alright (name) we will be there in a bit" as they were still four rooms away it took about another 15 minutes to reach this person. A number of people said that often hot drinks were cold or luke warm and this also applied to the meals. Some trays were taken out without covers. We noted that there were jugs of juice in people's rooms but the majority of these were not in reach of people.

Other issues around mealtimes were around poor practices by some staff. We saw a high number of people who had their meals sat in wheelchairs. This made it difficult for people to get right up to the table. A person in a wheelchair had been left sitting at an angle to the table by the nurse and was struggling to eat properly. A carer came and corrected the position and said, "You can't manage like that." We saw another staff member standing over a person to assist with their food and they were often distracted and went to help other people.

These were breaches of Regulation 14 Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did identify areas of good practice in monitoring people's nutrition and hydration. For example, staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietician when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely. For example where people had difficulty in swallowing, staff followed the health professional's advice to provide food that had been pureed. We observed that people were provided with food that was suitable for their medical needs, for example soft foods or pureed meals. We saw that the meals that had been pureed were set out in separate portions to keep the tastes distinctive and to the original colour. This is recognised good practice.

People's care plans contained detailed instructions about people's individual dietary needs, including managing diabetes and food allergies. When the MUST indicated a person was at risk of weight loss then people were put onto more rigorous monitoring, such as fluid and food balance charts and were weighed more frequently. The registered manager monitored weight loss and gain on a monthly basis for the whole home and took appropriate action when a person continued to lose weight.

People had access to their GP on a weekly basis. Staff were prompt at calling the GP for acute health problems when needed. One person's relative said, "They get the doctor out quickly if [name] is not very well; they're working with the doctor at the moment to monitor [name's] medication". We saw evidence that people had regular support from a range of healthcare professionals such as psychiatric services, diabetic nurse and podiatrist.

The staff training system had recently moved to a comprehensive computer learning based system (e-learning). However, we were informed staff were not always given time during work hours to complete modules and were expected to complete them in their own time. A qualified member of staff questioned whether the system catered for staff with limited computer skills. The registered manager told us not all training was online and some was still delivered face to face. We saw on the day of our inspection that a

local authority safeguarding officer delivered a short session of training for staff. The registered manager told us she would monitor the effectiveness of e-learning training during supervisions and appraisals with staff.

New employees received relevant written information about their role and responsibilities to support and guide them through their induction into the service. Staff told us they had received induction training prior to working with people. As part of the induction process staff spent five days shadowing another worker with the same job role. They said, "We do shadowing until we know the tasks such as delivering personal care, moving and handling people and keeping the home clean and hygienic." New employees received relevant written information about their role and responsibilities to support and guide them through their induction into the service. Staff told us they had received induction training prior to working with people who used the service.

A number of staff had undergone a dementia care course facilitated by NHS mental health staff based at the local hospital and a small number of staff had completed a comprehensive Stirling University Dementia Care course, a nationally recognised course from a centre of excellence. We found that the application of this knowledge and training was inconsistent around the home. While in the 'Memory Care Centre' we observed skilled interactions from staff to manage people who became distressed or agitated. On the ground floor staff lacked knowledge on how to manage these distressed behaviours and used approaches and language that did not defuse, distract or calm people. For example, when one person became agitated, a staff member answered back, "Oh come on that's not fair on us." When we asked about the risk assessment for this person who had behaviours that at times challenged the service, only one member of staff was aware that this person had a risk assessment from the mental health team and why. One said, "Why would (name) need a risk assessment?"

We recommend the service looks at ways to ensure that maximum use is made of the skills and expertise already in the home so that all people living with dementia have the same positive outcomes as those living in the 'Memory Care Centre' on the top floor.

We examined the training records and six staff personnel files. From looking at the training certificates, training records and speaking with staff we saw mandatory training such as moving and handling, hoist training, first aid, food hygiene, fire awareness, safeguarding and whistle blowing had been completed. Additional training in wound care, catheter care, diabetes, skin integrity and medicines management had also been undertaken.

The activity staff we spoke with were enthusiastic but had not had the same level of training as other care staff in relation to the needs of people living with dementia, and had not received any training on delivering a programme designed to meet the specific needs of these people.

We recommend that the service seeks out current best practice in relation to delivering an appropriate programme of stimulating and engaging activities both in groups and one to one for people living with dementia.

People received care and support from staff who understood how to ensure that support provided was in people's best interest. Staff applied knowledge of the Act appropriately. The MCA 2005 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).

The registered manager and staff were aware of their responsibilities under the MCA and DoLS codes of practice. One member of care staff told us "We use MCA assessments to understand whether people are able to make their own choices". The service had followed the legal process when applying for DoLS authorisations to place restrictions on people's freedom. Appropriate plans of care were in place to ensure that people's care and support needs were met in the least restrictive way. We saw recordings of use of bed rails and the appropriate best interest meetings that had been held.

We found that people's capacity was mentioned in a number of different places within the care plans. However this was very brief and there was no separate care plans. We found it difficult to tell what level of capacity people had and the support they needed to make day to day or more complex decisions. We did see statements in people's care plans such as "Family deal with finances." However, we could not find any evidence of whether people had a Last Power of Attorney (LPA) and if so, whether this applied to welfare and treatment or finances or both.

We recommended that the service looks for good practice methodology in this area so that people's capacity, ability to give consent and support needs in this area are assessed and recorded more thoroughly, to include any help people may need to communicate wishes and with reference to LPA and any other legal status for each person, such as a Mental Health Act section if required.

Staff were able to gain support and advice from senior staff when necessary and regular supervision meetings were available to all staff. One member of staff said "On a day to day basis, I feel very supported by the nurses, there is good teamwork and communication". Supervision meetings were used to assess staff performance and identify on-going support and training needs. One member of care staff said "We talk about any areas where we need to improve and how we will do that." The home had regular staff meetings to pass on important information and these were organised so that the maximum amount of staff could attend and where paid to do so.

Records showed all staff had received a number of one to one supervision meetings since starting their employment at the service in line with the providers policy. The registered manager told us that following staff induction and a probationary period, staff members were provided with regular supervision sessions. We saw good practice at a recently introduced staff handover session that used newly developed paperwork to communicate people's changing needs. There was an ongoing annual staff appraisal system in place to discuss and evaluate the quality of staff individual performance and where best practice or practice improvement was demonstrated.

The environment was not dementia friendly in terms of layout, decor, furnishings and bathroom facilities. There was only one bathroom and one shower suitable for the client group. There was little communal space in the home, with only one lounge. The unit was also hard to navigate for people as it had long corridors with poor signage and all the doors looked the same making it difficult for people to find their own individual room.

There were plans for a complete refurbishment in line with Stirling University recommendations for dementia friendly services. This refurbishment was scheduled to take place in January 2017. We asked the registered manager to keep us informed of the progress and we will follow this up at the next inspection.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and their relatives about how caring they felt the staff and the service was to them. The majority of people living in the home told us that the staff were caring and treated them well. People told us that their family could visit whenever they liked and were made to feel welcome. There were no restrictions as to when people could have visitors and we saw relatives and friends coming and going throughout the inspection. The staff appeared to know the visitors and have good relationships with them.

However we did get other less positive feedback as well from both people living in the home and their relatives. This again was dependent on which floor people resided on. All the comments from the top floor, Memory Care Centre, were positive. A relative said (top floor) "It's smashing, the staff are very friendly, I'm called by my first name which is great. I sit and join in with everything, I come in when I want, they tell me everything and keep me informed."

Another relative from the other floors said, "The care you get depends on which staff are on duty, some don't seem to bother. Some are good and can go the extra mile but others do not, if you get my meaning". Relatives told us that the care given was variable depending on the staff member and this was also very dependent on how busy staff were. Some relatives reported a lack of care and attention, such as finding their relative regularly without their hearing aid in. We checked on this person and despite the relative expressing frequently to staff that the hearing aids should be used, and this also being in the persons care plan, we found these were on the bedside table with a water jug placed on top. We pointed this out to a member of care staff who said, "That's terrible." But didn't then put them in. This was at 11.30 in the morning and the person had been moved to the lounge without their hearing aids in. Hearing aids require careful handling and can easily be damage. We found this did not respect this person or the equipment they needed to communicate effectively.

We noted other issues that compromised people's dignity and did not always demonstrate a very caring attitude. For example, all the downstairs bedrooms did not have any blinds or nets or any means of offering privacy apart from closing the curtains. We did see that care staff closed curtains to protect people's privacy during personal care. However the home is in a busy area at the entrance to a large hospital and there were many passers-by and cars pulling right up to the bedroom windows to park. We pointed this out to the registered manager who said they had recently taken down the vertical blinds as they had been considered a ligature risk. She agreed to look for other solutions and ask people what they would like to ensure their privacy.

We found that the home was exceptionally noisy through the use of a tannoy system that sounded to all floors along with the call bell and telephone system. This meant that one person pushing their buzzer sounded to all the other floors and staff had to go and check if they were needed. This did not respect that this was people's home and numerous people living in the home commented on how intrusive and disruptive this was. Especially when people were being nursed at the end of their life, or if they were confused due to living with dementia. One person said, "The bells drive you mad!" Another said of the

alarms, "It's hard to get a snooze in the afternoon." While another said, "That's why I have my door closed." When we spoke to the manager about this she said it had always been like this and she had been told that the systems couldn't be changed easily. We found this an unacceptable intrusion and advised the registered manager that the system must be changed. Especially when people are being nursed at the end of their life, or if they are confused due to living with dementia or just trying to read a book, as one person told us.

We noted that staff did not always adhere to the services confidentiality policy and procedures. For example we noted that one of the staff handover sessions took place in the corridor with the potential for confidential information to be overheard. There were relatives visiting at the time and people's bedroom door were open with the potential for personal matters to be overheard. We saw that one person's file and care plan was left out on a chair in the corridor for a number of hours unattended.

We saw that interactions between people living in the service and staff were not always consistent. We found that staff empathy, care and attention to detail differed between care staff. We observed one person ask for help with their meal on several occasions. They received no response from staff who were busy doing other things. When staff were asked why they did not respond they explained that the person was often "agitated". There was no information in the person's care records that said this was their normal behaviour and how staff should respond. One person told us, "Some staff are a bit sharp, some are better than others."

We also noted that the language some staff used was not always respectful or professional. For example at mealtimes we heard staff shouting out, "Who's softs" "He's normal" and another staff member was heard shouting down the corridor "It's three hourly turns now" and "time for fluids." We saw that in a recent group supervision that this had been raised by the registered manager who had stated, "Be careful of the language used, Don't use 'I'm going to do feeds or give outs'." She also emphasised how residents must be given choice of drinks and alternatives at mealtimes. While we can see that some of these issues have been identified by the registered manager this now needs to be put into practice by the seniors and nurses on duty while working directly with staff.

The majority of care plans we viewed did not have life histories, or were very brief, and there was limited information about people's preferences. In discussion with staff they told us they had worked there for a number of years and knew a lot about the people who lived in the service. However this relied on staff remembering information and passing it on to other staff correctly rather than making sure all staff were aware of the same information about people. There were also a number of people from outside of the local area who were new to the home and they too had very little personal information and life histories for staff to refer to. We saw how this happened on the inspection when a carer overheard a staff member speaking to a person about the job they used to do and they had to correct them.

We found that the registered person had not ensured that people were treated with dignity and respect. This was demonstrated by the use of an intrusive communication system, the use of inappropriate staff language and the disregard to people's privacy in their bedrooms with lack of privacy curtains. Care plans were not in enough detail on people's backgrounds and this made it difficult to know and respect people's wishes and preferences. This was a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, the majority of care staff and nurses engaged in a warm, caring and empathic way with people. They adjusted clothing, sorted people's hair out while having pleasant conversations. These staff made the most of every care task to chat to people and ask them if they were ok, and ask if there was anything they needed. We noted that they used touch to enhance interactions with people in a reassuring and calming way. When staff did make use of the opportunity to chat to people whilst carry out tasks we saw that people

became animated and visibly lit up with these positive interactions. One person told us of how kind the laundry lady was telling us, "She makes a point of coming to see me and brings me books in and we have a great chat about them." Another person said that staff would always make them a cup of tea if she asked. We also saw on the day of inspection that staff had organised to wear Christmas jumpers to raise money so that they could buy people living in the home a Christmas present. We also saw lively conversations and staff engaging with people at the weekly reminiscence café session.

The service had policies, procedures and training in place to support people who required end of life care. The registered manager told us staff had undertaken specific training for this. The service worked alongside other providers to ensure that this care was carried out correctly.

The registered manager had details of advocacy services that people could contact if they needed independent support to express their views or wishes about their lives. Advocates are people who are independent of the service and who can support people to make or express decisions about their lives and care. We found evidence within people's care files to show advocacy involvement.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in January 2015 we found the service had not ensured care plans contained all the detail needed and these were not always updated when people's needs changed. This related to Regulation 9: Care and Welfare of people who use services of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. These regulations have now been replaced with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection we found the service had improved how it carried out monitoring and reviews of care plans. We saw a very detailed system in place and checks were undertaken by the registered manager and deputy. The registered manager explained the system, "We now use a Care Plan Audit tool and every two weeks we take a different sample of care records and check them against daily notes. We look to see if the right tools and forms have been used and referrals made for advice. For example if we see an increase in falls, we will check if these are being recorded and assessed. We will see if the person has been referred to their GP in case there is an underlying cause. We would then expect to see follow ups with an occupational therapist or physiotherapist. If we see any of this has not happened we will use the 'RAG' system. If it's rated red then we advise the nurses to take immediate action, if its amber then we will revisit in two weeks time." When we checked people's records and observed the care they received we found that the home was now much more responsive to changing need and care plans reflected this. Relatives spoken with said, "I always receive a phone call from the staff if my wife has seen the doctor for any reason. They keep me informed".

We found the home had met the breach found at the last inspection and now had good systems to monitor care plans. We saw some good descriptions in care plans of how people should be supported with healthcare needs and there were clear instructions for staff regarding how they should respond to people in particular situations. For example where people were at risk of pressure ulcers, their care plans recorded the equipment and support they required to help prevent them. We saw people's pressure relieving mattresses were set to the correct pressure for each person's weight and people were helped to change their position to relieve their pressure areas regularly as detailed in their care plans.

We judged that providing a person centred approach to people's care and support needs had not been properly implemented in the home. Although we did find evidence in the care records examined that there were efforts being made to personalise care plans, we found that these were not in enough detail to meet people's social needs. The care plans did not set out people's backgrounds, personal histories, hobbies and interests. This meant that there was little in the way of offering activities and interests that were person centred. We saw that the recording of one to one and group activities was sporadic, with the last recorded one to one session for one person as 11/11/16. We were informed that there was a weekly reminiscence group for people but this was currently held on the middle floor rather than the top floor which would be more preferable to improve attendance. The activity staff did not have the same level of specialist knowledge and training to meet the needs of people living with dementia. We also noted that the activities office was an out of use bathroom with the bath still in place which was wholly inappropriate and made the room not fit for purpose.

We also found that there was little in the way of equipment or an adapted environment for people living with dementia. We did not see that people's life history had been used to develop things like scrapbooks, picture books or flash cards to help stimulate and engage people.

We judged that for many people their quality of life was affected due to a lack of support to engage in meaningful activities and to have contact with other people. This meant that some people were at risk of being socially isolated and lacked stimulation. We observed a number of people spending long periods either alone in their bedrooms or sitting in the same chair for two to three hours with no activities apart from the television. We did see that there were group activities provided in the home however the one to one activities were limited. One person told us, "There isn't much to do". Another person said, "There are some things to do; I like to watch the movies." A relative said "I join in if there is a singer or something or a quiz". An activity session was taking place in the morning on the middle floor sitting room and residents from the ground floor who wanted to go up; people were making Christmas stockings. There was a list of activities posted in the corridor included, quiz, reminiscence, gentleman's club, newspapers. The Hairdresser was also included as an activity rather than as personal care.

We found that the registered provider had not made suitable arrangements to ensure people's personal preferences, lifestyle and care choices were being met. This was a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who used the service and their relatives, they told us they knew who to speak with if they had a comment or complaint about the service. One relative said, "I would speak to the nurses or the manager."

The service had a formal complaints policy and procedure. The procedure outlined what a person should expect if they made a complaint. There were clear guidelines as to how long it should take the service to respond to and resolve a complaint. The policy mentioned the use of advocates to help support people who found the process of making a complaint difficult. There was also a procedure to follow if the complainant was not satisfied with the outcome. There were no outstanding complaints at the time of our inspection. The registered manager explained that wherever possible they would attempt to resolve complaints informally.

People and visiting relatives told us they knew how and who to raise a concern or complaint with. A copy of the complaints procedure was included in the home's statement of purpose which was given to people on admission and indicated who to contact should they need to raise a complaint and the timescales for action in response to the complaint.

Requires Improvement

Is the service well-led?

Our findings

Overall we gained mixed views about people's experience of the quality of the service they received. In some areas, such as meals and the design of menus people reported positively about being involved in these decisions. With other areas we could see that people's choices and preferences around their life style and care choices had not been gathered either at all or in enough detail, and where they had, these had not always been implemented. We were told that the residents meetings were poorly attended.

Part of a registered managers or registered providers responsibility under their registration with the Care Quality Commission is to have regard to the regulated activities they provide. One of these relates to the registered managers/registered provider's responsibility to notify us of certain events or information. We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the home manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe. However, during the inspection we found that during 2016 the registered provider had failed to notify us about serious falls that resulted in people either requiring hospital treatment or medical treatment. The CQC require this information, so that where needed, we can take follow-up action. We were sent these notifications retrospectively following the inspection. We found there had been twelve occasions when we should have been notified. We have written to the provider about this outside of the report.

Staff reported that the rotas set up by the registered manager were disorganised and not set up in a way that was fair to staff and that they were changed frequently. Staff reported not having time to update records during their shifts. Overall staff reported that morale was low and stress levels were high. However the majority of staff said that the registered manager was approachable, fair and had supported them when they had family commitments.

When we checked the accuracy of records in the home we found these were not always well maintained. We saw that the home held daily records in each person's bedroom and these were used by care staff to record their care interactions with people. For example, recording daily amounts of fluids and food and how often a person had been helped to reposition. When we checked these we found they were not always completed or did not contain the same information as the care plans. We could see that these could be a really useful tool for staff to see at a quick glance what care was needed but some had the brief overview care plan missing or had areas of care not mentioned. For example one did not indicate the size of incontinency pad to be used, and another contained a sheet to record the application of creams but had not been completed since August 2016, with no corresponding detail in the persons main care plan.

Accidents and incidents were recorded and had been regularly monitored by the home manager to ensure any trends were identified, monitored, investigated and results were evaluated. In addition, any safeguarding concerns were recorded and checked for trends.

Systems were in place to monitor the quality of the service and to ensure people received safe and effective care. The home was audited on a quarterly basis by a member of the provider's clinical and care governance

team and visited monthly by the regional manager. We examined records, which showed regular audits and checks were undertaken on all aspects of the running of the service. We saw evidence in the form of reporting systems and audits for wound care, nutritional reviews, medicines audits, care plan audits, risk assessment audits and infection control audits that had been completed regularly and were up to date. We saw in more detail how the registered manager used the monthly weight audit and falls audit to check that people were receiving the right support from healthcare professionals and that care plans were updated accordingly.

Checks were made on the buildings physical environment including safety checks of floor surfaces, areas requiring decorating, stairways, lighting, ventilation and windows. These identified where improvements were needed and the information was then fed into a service improvement plan. Records were in place to show the action taken to address improvements identified and timescales. Additional audits, checklists and reports had been undertaken for kitchen cleaning, all areas of the home cleaned by domestic staff and food served.

However these audits had failed to identify the issues and concerns we found during our inspection. While we saw some good practice and care this was not consistently applied across the home. It was of particular concern that their systems had failed to identify that care records lacked any detail on people's histories or life stories. This is crucial to supporting people with dementia.

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

The provider and owner of the home is Executive Care Group. The registered manager informed us that the running of the home had been recently transferred by Executive Care Group from one operating company to another called Careport. We spoke with a regional Quality manager from Careport who explained how this move was designed to improve the running of the service by using a more robust quality assurance system. This would entail replacing policies and procedures, training programmes, auditing and quality systems. The regional manager explained how they were working with the home's registered manager to draw up an action plan of the planned changes and how many of the shortfalls we found on inspection would be addressed by the new systems going forward.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's personal preferences, lifestyle and care choices were not recorded in enough detail to ensure staff could meet their individual needs. The use of an intrusive communication system, inappropriate language used by staff and lack of privacy in people's bedrooms demonstrated that the provider was failing to treat people with respect and dignity at all times. 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe administration and management of medicines. 12 (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider was not ensuring that people were provided with food that was both appetising and served at the appropriate temperature. People were not always given timely support and encouragement with their food and drink. 14(4)(a)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to make sure they assess and monitor the service. 17 (2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, skilled and experienced staff to make sure they can meet people's care and treatment needs. 18(1)