Bethesda Healthcare Ltd

Kinross

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Kinross is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The inspection took place on the 4 and 5 December 2018 and was unannounced.

The home is registered to accommodate up to 29 people, including people living with dementia care needs. There were 24 people living at the home when we visited. The accommodation is based on two floors connected by stairs and a passenger lift. There is a range of communal areas on the ground floor including a dining room and two lounges.

A registered manager was not in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was being run by a home manager who had applied to register with CQC.

We identified significant concerns about the safety of the service which put people at risk of harm. Although there was a comprehensive quality assurance system in place, this had failed to identify any of the concerns that were raised during the inspection. The duty of candour requirements were not fully followed when people came to harm.

There were not enough staff deployed, which meant people sometimes had to wait for support and staff were not always available in communal areas to support people. This also impacted on the ability of staff to meet people's personal care needs and to effectively manage the laundry.

The laundry room was not fit for purpose and was not operated in a way that minimised the risk of infection and cross contamination.

Risks to the health and safety of people were not always managed safely. These included the risk of people developing pressure injuries, the risks posed by the use of equipment, infection risks and fire safety risks. Following the inspection, we alerted Hampshire Fire and Rescue Service to our concerns.

People's medicines were not always managed safely. Some people did not receive their medicines as prescribed and risks relating to some medicines had not been assessed.

There were clear recruitment procedures in place, but these were not always followed to help ensure only suitable staff were employed.

Staff acted in people's best interests but did not always record decisions they had made on behalf of people

who lacked capacity.

Staff had completed a range of training relevant to their role, but training records did not confirm that all staff had completed all the training deemed essential by the provider and some training had not been effective.

We received mixed views from health and social care professionals about the support people received to access healthcare services. We found advice given by professionals was not always followed and staff were unable to confirm whether some referrals had been made.

Some adaptations had been made to the environment to make it supportive of the people who lived there, but there was a lack of signage to help people navigate around the building. Some carpets and furnishings were badly worn and there was not a plan in place for refurbishing the home.

People were offered a choice of food and drinks. Most people's nutritional needs were met, although action was not always taken when people had lost weight.

People told us they were treated in a caring and compassionate way by staff, although a lack of staff compromised people's dignity at times. Staff usually interacted with people in a supportive way; however, we observed two occasions where staff demonstrated a lack of consideration for people.

People were protected from the risk of abuse and staff understood their safeguarding responsibilities.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. People were involved in planning the care and support they received.

Most people's care plans contained sufficient information to enable staff to deliver support in a personalised way. Staff demonstrated a good understanding of people's care needs.

Family members told us staff were responsive to people's changing needs. Staff were committed to supporting people at the end of their lives to have a comfortable, dignified and pain-free death.

People had access to a wide variety of activities based on their individual interests. People knew how to raise concerns and felt they would be listened to.

There was a clear management structure in place and care staff worked together well as a team. Staff felt supported in their role by managers.

People's views were sought and acted on.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about the commission's regulatory response to the breaches will be added to the report after any representations have been concluded.

Following the inspection, the provider acted quickly to identify and implement immediate changes in response to our findings. They developed a comprehensive action plan and appointed an experienced manager to implement it; they reviewed their quality assurance procedures and they consulted with architects to identify options for improving the laundry.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff deployed to meet people's needs.

Individual risks to people, including fire safety risks were not always managed appropriately.

The laundry was not fit for purpose and staff did follow safe operating procedures to prevent and control the risk and spread of infection.

Medicines were not always managed safely. Some people did not receive their medicines as prescribed.

Safe recruitment procedures were not always followed to ensure staff were suitable.

People were protected from the risk of abuse as allegations of abuse were reported to the relevant authorities.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights.

Staff training was not up to date and some staff lacked essential knowledge to enable them to work effectively.

Staff did not always make referrals to healthcare professionals when needed and did not always follow advice when given.

The environment was not supportive of the needs of people living with dementia.

People were supported appropriately to eat and drink enough; however, action was not always taken when people lost weight.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff told us they were often too busy to spend time with people and a lack of staff compromised people's dignity at times.

Whilst most interactions between staff and people were positive, we observed that staff did not always treat people with consideration.

People's privacy was protected while personal care was being delivered.

People were encouraged to remain as independent as possible and were involved in decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff understood people's individual needs, but a lack of staff meant people's personal care needs were not always met.

A wide range of activities was provided to meet people's interests.

People knew how to raise concerns and felt listened to. There was a complaints procedure in place, but this was not available in an accessible format.

Is the service well-led?

Inadequate

The service was not well-led.

An effective quality assurance system was not in place. This had led to breaches of regulations.

Staff did not always act in an open and transparent way when people came to harm. Duty of Candour requirements were not followed fully.

There was a clear management structure in place and care staff worked together well as a team.

People, family members and staff felt there had been improvements to the service under the current provider.

People's views were sought and acted on.

Kinross

Detailed findings

Background to this inspection

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

The inspection was unannounced and was conducted on 4 and 5 December 2018 by two inspectors. This was the first inspection of the home under the current provider since it was added to their registration with CQC in February 2018.

Before the inspection, we reviewed information that we held about the service including notifications. A notification is information about important events which the service is required to send us by law. We also reviewed information of concern we received from the local authority. This related to pressure injuries sustained by people in two separate incidents. The people concerned were no longer living at the home, but we explored the effectiveness of pressure area care for people who were living at the home.

We spoke with six people and six relatives of people living at the home. We also spoke with the provider's nominated individual, the provider's general manager, the home manager, the deputy manager, five care staff members, an administrator, a cook and a cleaner. We received feedback from two healthcare professionals, two social care professionals and an external activities provider.

We looked at care plans and associated records for seven people, staff duty records and other records related to the running of the service, including staff recruitment and training records, accidents and incidents, policies and procedures and quality assurance records.

We observed care, support and activities being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

We identified significant concerns about the safety of the service which put people at risk of harm.

There were not enough staff deployed to keep people safe. The home manager was not operating a systematic approach to determine the number of staff required and told us the staffing levels had been "inherited" from when they started work at the home. They could not demonstrate that the number of staff deployed was enough to meet people's care needs.

People told us a shortage of staff meant they sometimes had to wait for support. Comments from people included: "People need to wait sometimes", "In some cases, you could do with another one or two staff", "There's never a [staff member] when I need one", "There's not enough staff, we have to wait", and "There's only two or three staff on and you have to wait to get up in the morning". Most staff echoed these comments; for example, one said, "It's hard [to cope] sometimes. I don't know why it goes down to [three care staff] in the afternoon. Sometimes it feels like we're just whizzing by people. We don't get time to sit down with our residents".

Although the provider's nominated individual required a staff member to be present in the main lounge at all times, staff told us this was not always possible and we observed multiple occasions during the inspection when a staff member was not present in the main lounge. The lounge was being used by up to 10 people, most of whom were frail, with limited mobility. This put people at risk of falls and this was confirmed by the home's accident records. These showed a person had fallen in the main lounge three weeks previously when staff had not been present. A staff member told us, "There was [a staff member] in the lounge, but they got called away to answer the buzzer."

On the second day of the inspection, a person in the main lounge became upset as they needed to use the bathroom. There were no staff members present to support them. A second person left the lounge to find a staff member, but when a staff member attended, the second person then needed support when they became "faint" and nearly fell. The first person was finally supported to use the bathroom 21 minutes later. Later that evening, the only two care staff members working were busy supporting a person to bed on the first floor of the home. This left approximately 12 people on the ground floor without any staff support, including two people who were mobilising without their walking frames, placing themselves at high risk of falling.

The provider's nominated individual told us they believed an additional "twilight" care staff member was deployed to support people in the evenings. However, we found this was not organised consistently and an extra staff member had only been scheduled to work on 11 of the previous 31 evenings.

The shortage of staff impacted on infection control procedures. You can see more information about this elsewhere in this section of this report. It also impacted on the frequency with which people were supported to bathe. You can see more information about this in the Responsive section of this report.

The failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to the health and safety of people were not always assessed or mitigated effectively. One person had been given a walking frame on arriving at the home recently, but staff had not completed an assessment of the person's need to use a frame or of the suitability of the frame they had given the person. The home manager told us it should be accessible to the person at all times, but a senior staff member said it was only to support the person with "transfers". This inconsistent approach, together with the failure to assess the person's needs properly, put the person at high risk of falls. Another person had been given bed rails. Bed rails are considered 'medical devices' and require an appropriate assessment of risk to be undertaken before they are used. However, we found a risk assessment had not been completed. Therefore, the provider was unable to confirm that they were safe for the person to use. Staff supported the same person to move and transfer using a hoist. We saw a decision had been made six weeks before the inspection to change the size and type of sling used; however, an assessment had not been completed to show why this was necessary or to ensure it would be safe.

Staff knew what action to take in the event of a fire, but had not been trained to use evacuation equipment, including an evacuation sled and an evacuation chair which were in place on the first floor of the home. This meant they would not have been competent to use the equipment in an emergency. The need for staff to be trained in the use of this equipment was first highlighted during a visit by Hampshire Fire and Rescue Service (HFRS) in April 2018, but had not been actioned. The home manager told us they would address this concern immediately. Their visit had also highlighted the need for the provider to ensure that all fire doors were self-closing. However, records of fire drills showed that two fire doors were repeatedly not self-closing between 9 October 2018 and 15 November 2018, seven months later.

People were not fully protected from the risk of pressure injuries. Prior to the inspection, we were notified of two investigations by the local authority into cases where people had not received safe pressure area care. In
response, arrangements had been made for staff to complete additional checks of people's pressure areas, which we saw were completed consistently. Arrangements were also made for staff to be supported with additional training, provided by a healthcare professional. The home manager had a list of staff who had been invited to the training, but could not tell us which staff had actually attended. Therefore, we could not be assured that all relevant staff had received this important training.

One person, who had been identified as at risk of pressure injuries, had been given a special, pressure-relieving mattress. Pressure relieving mattresses should be adjusted to the person's weight to ensure they work effectively. The person's last recorded weight was 63.9kgs, but the mattress was set at 95kgs. This meant it was not at the optimum setting to reduce the risk of the person developing a pressure injury. Another person had been identified as at risk of pressure injuries due to losing a significant amount of weight; however, neither their skin integrity care plan, nor their nutritional care plan specified any action to enhance the person's nutritional intake and thereby help reduce their risk of skin breakdown.

Our concerns about the management of risk were echoed by a healthcare professional who told us, "I feel that [staff] have no insight regarding risk. They are unable to assess risk or identify risk."

The failure to assess and mitigate the risks to the health and safety of people using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to ensure pressure injuries risks were managed effectively also demonstrated that the service did not maximise learning opportunities from mistakes. However, other learning points from these incidents had been followed through; these included improving the communication systems for staff to share information about people's current needs and increasing the frequency of checks of people's skin.

Other risks to people were managed appropriately. Maintenance staff checked the temperature of water outlets every month, including those in people's rooms. Lifting equipment was checked and maintained according to a strict schedule. In addition, gas and electrical appliances were checked and serviced regularly. The fire alarm system had recently been upgraded and staff conducted regular checks of it. Each person also had a personal emergency evacuation plan (PEEP) in place that detailed the support they would need if they had to be evacuated. Most staff had been trained to deliver first aid and there was a business continuity plan in place.

Infection control procedures were not adequate to prevent the risk and spread of infection. Although the provider had invested in upgrading the laundry facility, we found it was not operated in a way that minimised the risk of cross infection. It was a small room and on both days of the inspection was very cluttered, meaning staff could not access the hand washing sink. Staff told us they used sinks in neighbouring bathrooms to wash their hands after handling soiled linen, but this posed a risk of infection spread if they touched surfaces, such as door handles, en-route. There was not a procedure in place to prevent cross-contamination between dirty washing entering the laundry and clean washing leaving it. On both days of the inspection, we saw soiled washing was laid on the floor of the laundry, mixed in with red bags containing soiled, potentially infectious linen. On the second day of the inspection, there were so many bags on the floor, it was not possible to access the washing machines without moving some of the bags first. Staff told us this was because night staff had been busy supporting people, including a person who had been restless most of the night, so had not had time to do the washing. Cleaning staff told us they had not been able to clean the laundry floor or the hand washing sink because of the build-up of washing in the laundry; this added to the risk of cross contamination.

Staff did not process soiled linen in a consistent way. We asked three staff members which programme they used on the washing machines to process soiled linen and they each gave a different answer. There was a guidance sheet about the washing machines, but the programmes specified on it did not correlate with the programmes available on the washing machines. The lack of consistency in the processing of soiled linen posed an additional infection risk.

One person had a catheter. This is a tube inserted into the bladder and connected to an external bag. The person's care plan specified the need to change the catheter bag every seven days to reduce the risk of infection, but this had not been done consistently. On one occasion, the bag was not changed for a period of 23 days and on a second occasion it was not changed for a period of 12 days. Staff told us they had had difficulty sourcing replacement bags, but the failure to change the bags regularly put the person at risk of developing a urinary tract infection.

The failure to operate effective systems to prevent and control the risk and spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At other times, staff followed appropriate infection control procedures. For example, they used disposable aprons and gloves when completing care tasks. With the exception of the laundry, the home was clean. Domestic staff had clear cleaning schedules to follow; they recorded all the cleaning they had completed, including regular deep cleans of people's rooms. A family member told us, "You only have to look around, you can see it's clean."

People's medicines were not always managed in a safe way. Medication administration records (MARs) showed that two people had not received their prescribed medicines for the two days prior to the inspection. For one person, this was due to an administrative error with the MAR and for the second person, a staff member told us they had made an error. They said they had signed the MAR to show a medicine had been given but had forgotten to give it to the person. They immediately sought advice about these omissions from the GP.

A further person had been prescribed a medicine that should be taken "at least 30 minutes before food or caffeine based products". However, staff told us they usually gave it to the person "at or around breakfast". This was contrary to the guidance and meant the medicine might not have been fully effective.

Risk assessments had not been completed for all people who were prescribed blood thinning medicines. These are required due to an increased risk of bleeding. The absence of risk assessments meant staff might not have taken additional precautions or alerted medical staff if the person had experienced an injury. Another person was prescribed a liquid paraffin gel as a topical skin treatment. Paraffin gels carry a known fire risk, but a risk assessment had not been completed for this and staff told us they were not aware of the risk. By the end of the inspection all relevant risk assessments had been completed. Information about when and in what dose to administer PRN ("as required") medicines was not always in place. This included for people who were prescribed anti-angina sprays and analgesics. This meant people might not have received their PRN medicines in a safe and consistent way.

Guidance issued by the National Institute for Health and Clinical Excellence (NICE) recommends that staff who administer medicines have an "annual review of their knowledge, skills and competencies relating to managing and administering medicines". Although most staff had had their competence assessed, one staff member who regularly administered medicines had not. This put people at risk of harm.

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

Other aspects of medicines management were operated safely. There were clear procedures in place for obtaining and storing medicines and these were followed consistently. Medicines subject to additional controls by law were managed in accordance with best practice guidance and there was a process in place to help ensure topical creams were not used beyond their 'use by' date.

There were clear recruitment procedures in place to help ensure only suitable staff were employed; however, these were not always followed. For example, a full employment history had not been obtained for two staff members; this meant the provider was not able to consider whether their backgrounds impacted on their suitability to work with vulnerable adults. Although references were requested from appropriate sources, we found one staff member had started work before their references had been received. A risk assessment had not been completed to identify any control measures that might be needed to safeguard people in the interim. For another staff member, there was not a health screening form to identify any physical or mental health conditions that might be relevant to their capability. We discussed these issues with the home manager who assured us they would follow the provider's recruitment procedures consistently in the future. Following the inspection, the information not available in relation to individual staff recruitment pathways was actioned by the provider and obtained.

Staff protected people from the risk of abuse and understood their safeguarding responsibilities. People told us they felt safe living at Kinross; for example, one person said, "You're as safe as you can be anywhere." A family member said their relative was "definitely safe" and "happy" living at Kinross. A social care

professional told us, "People are safe." Staff understood their safeguarding responsibilities and knew how to report concerns. For example, one staff member told us, "If I had any safeguarding concerns, I'd tell the manager, but I've not had need to." Records showed the home manager had notified CQC and the local safeguarding authority of all relevant safeguarding incidents and had cooperated with investigations where required.

Requires Improvement

Is the service effective?

Our findings

People felt they received effective care from staff. One person told us, "They look after me well." A family member said, "[My relative] has good carers. I'm quite happy leaving her when we go on holiday. She is looked after." Another family member told us, "It's a difficult job and they [care staff] do it very well."

Staff acted in people's best interests, but we found they did not always follow the Mental Capacity Act, 2005 (MCA) fully to help ensure people's rights were protected. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Most of the people living at the home lacked capacity to make some or all decisions relating to their care needs. Where this was the case, senior staff had assessed people's capacity to make specific decisions, such as to receive medicines or to receive support with personal care. Where the assessment concluded that the person lacked capacity to make certain decisions, staff acted in people's best interests by making decisions on their behalf and providing support. However, they had not documented the best interests decisions they had made to show why the decisions were in the person's best interests and to confirm that relevant people, such as family members and healthcare professionals, had been consulted. For one person, staff had not identified that their 'consent to care' forms had been signed by a relative who did not have the power in law to act on their behalf. In addition, staff had not conducted an MCA assessment for a person who had recently arrived at the home whose records indicated they lacked capacity to make decisions. Therefore, we could not be assured that this person was being cared for with their consent or the consent of a relevant person.

The failure to follow the MCA and ensure that care and support were only provided with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the home manager sent us a template they said they would implement to record best interest decisions made on behalf of people and to capture the views of those consulted during the process.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found some DoLS authorisations had been made and other applications were awaiting assessment by the local authority. Where conditions had been attached to the DoLS authorisation, we found these had been followed. Clear processes were in place to monitor the expiry dates of the DoLS and to submit renewal applications in good time.

Staff had completed a range of training relevant to their role, much of which was delivered by the provider's training manager. However, training records were not kept in an organised way to help ensure staff remained up to date with their training needs. The home manager and the training manager were not always able to find records of the training completed by individual staff members. For example, they could not confirm which staff had completed additional pressure care training. In addition, we found three staff members were not listed on the spreadsheet used to monitor staff training and the home manager could not confirm what training courses those staff members had completed. The home manager initially told us that recent fire safety training for staff had included training in the use of evacuation equipment, but staff told us this element of the training had not been covered. There was a poor completion rate for equality and diversity training and records showed that only seven of the 26 staff members employed had completed it. The provider's training manager told us this training was planned, but we could not be assured that staff knew how to identify and meet the needs of people with protected characteristics or specific cultural needs.

Training that staff had received was not always effective. For example, staff had completed "Laundry" training, yet were not clear about safe operating practices. You can see more information about this in the Safe section of this report. The home manager had attended MCA training but had not understood the need to record best interests decisions made on behalf of people. They had also attended Duty of Candour training, but had not understood the requirements of this legislation. You can see more information about this in the Well-led section of this report.

The failure to ensure staff received appropriate support, training and personal development was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff completed an induction into their role; this included time spent shadowing, (working alongside experienced staff), until they felt confident they could meet people's needs. Following the induction period, staff who were new to care were supported to gain a vocational qualification relevant to their role. This qualification met the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.

Staff were supported through one-to-one sessions of supervision. These provided an opportunity for one of the managers to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff told us the supervision sessions were helpful and spoke positively about the support they received from the home manager on a day to day basis. For example, one staff member said, "I feel supported. If I've got a problem, I can always go to the managers." Another staff member told us, "I feel supported. I can always turn to [the home manager]." Supervisions were not held as frequently as the provider's policy required. The policy specified every six to eight weeks, but we found some staff had not received a supervision for up to 12 weeks. The home manager told us they would take steps to ensure staff received more regular supervisions in future.

We received mixed views from health and social care professionals about the support people received to access healthcare services. A healthcare professional told us the people they visited "seem to be looked after well". A social care professional confirmed this and said staff were "responsive" to any concerns raised. However, another healthcare professional told us this was not always the case. They said, "The home takes on inappropriate patients who they simply are not skilled or equipped to care for safely and do not make referrals for guidance or help when they are not coping. They make decisions themselves with no training or guidance which have had devastating impacts to residents. They make referrals once something drastic has already occurred. The staff do not listen to instructions, i.e. they have repeatedly changed dressings on complex wounds when they have been told not to."

We confirmed that advice given by specialists was not always followed. For example, in November 2018, a physiotherapist had asked staff to support one person with daily exercises, following hip replacement surgery. Staff told us they had not done this and this was confirmed by the person's care records. Another person had been identified as needing a referral to two specialists; one to assess their mobility and one to assess their risk of choking. However, there were no records to show that either referral had been made and the home manager was unable to confirm whether they had been made. The provider's nominated individual acknowledged this was an area for improvement and took action to enhance working relationships with healthcare professionals.

People were supported effectively when they are admitted to or discharged from hospital. We saw essential information was transferred with them, including information about the person's medicines and their care needs, which helped ensure continuity of care for people.

Some adaptations had been made to the environment to make it supportive of the people who lived there, all of whom were older people living with dementia. For example, a passenger lift gave access to the first floor of the home and handrails along the corridors were painted in contrasting colours to make them easy for people to see and use. However, there was lack of signage to help people navigate their way around the home. We heard people repeatedly asking staff to direct them to the bathroom or to their rooms, the doors to which were all painted plain white, making them indistinguishable from one another. The home manager told us they had not conducted an audit to consider the suitability of the environment for people living with dementia, but would do so in the near future. A delivery of memory boxes arrived during the inspection, which the provider's nominated individual said would be installed outside each person's bedroom, for them to fill with objects that were meaningful to them. Memory boxes are known to support people with dementia to help them find their own rooms and to act as prompts for conversation. The provider had also purchased some new, brightly coloured chairs for people to use.

Some carpets and furnishings were badly worn, especially in corridors. Metal cover plates had been put over carpets where they had become badly frayed, although we found two areas of carpet on the first-floor landing that had not been covered and these created a potential trip hazard to people and staff. We discussed the need for improvements to the building with the provider's nominated individual, but they were not able to provide a cohesive plan for refurbishing the home.

People were happy with the meals provided, which they described as "homely". Comments included: "The food is good" and "I couldn't complain about the food". Comments from family members included: "[My relative] eats well. She says the food is good", "Staff would always make something different when [my relative] didn't want what was on the menu" and "[My relative] loves the food. [Staff] say to her 'If there's something you'd like that's not on the menu then let us know'."

People were offered a choice of meals and drinks, although the menus used were not supportive of the people using them. They were printed in small font without any pictures to support them. Most people would not have been able to read or understand the menus due to sight impairment or cognitive impairment. The home manager told us they were planning to introduce picture-based menus, but had not done so yet. These would have helped one person in particular, whose first language was not English and whose care plan specified the need for picture-based prompts to aid communication.

Where people required help to eat, we saw staff offered this in a dignified way. Where people needed their meals preparing in a certain way, we saw this was done consistently. Staff were attentive to people at mealtimes, providing an appropriate level of support in a calm, patient way. One person did not like the sandwiches at teatime, so was offered soup instead, which they accepted. Other people were offered more

helpings of pudding and extra drinks.

We saw information about people's preferences and dietary needs was available to the cook and staff used a white board in the kitchen to share information. Staff monitored the intake for people at risk of malnutrition or dehydration using food and fluid charts. Action was usually taken when people lost weight; for example, their meals were fortified with extra calories or they were referred to specialists for advice. However, this had not been done for one person. The person's weight had reduced significantly over a five-month period. However, the person's nutritional assessment did not identify any action that staff should take to promote weight gain or prevent further weight loss. Staff, including kitchen staff, confirmed the person was receiving a "normal diet" not fortified with extra calories. The lack of positive action to support the person's weight put them at risk of further weight loss. We drew this to the attention of the home manager who agreed to review the person's nutritional needs.

Staff made appropriate use of technology to support people. For example, movement alert equipment was used to alert staff of the need to support people when they moved to unsafe positions. An electronic call bell system allowed people to call for assistance when needed.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated in a caring and compassionate way by staff. One person said, "I'm quite happy here." Other people described staff as "very kind" and "nice". Family members echoed these views and described the atmosphere staff created at Kinross as "bright" and "vibrant". Their comments included: "Staff often have a joke with [my relative] and make her laugh", "The [staff] are lovely. [My relative] laughs a lot" and "Staff are polite and kind, that's the biggest thing". A thank-you card sent by a family member thanked staff for their "warmth, are and cheeriness" towards their relative. A visiting healthcare professional told us, "[Staff] seem to know the residents well. Residents look happy and comfortable."

Although staff expressed a strong commitment to treating people well, they told us they were generally too busy to spend time with people and we found that a shortage of staff meant people's dignity was not always protected. For example, we observed a person sat in the main lounge had pulled their trousers down to their ankles, which compromised their dignity. There was not a care staff member available on the ground floor at that time to support the person. Another person had to wait 21 minutes to use the bathroom as staff were busy supporting other people. While waiting, the person's nose started dripping and we had to intervene to give them a tissue. The person told us, "This is so embarrassing, I am frightened to move." You can find more information about the impact of staff shortages in the Safe section of this report. A shortage of storage space at the home meant staff had stored a hoist in a bedroom shared by two people, neither of whom used the hoist. This showed a lack of consideration for people's private space.

Our observations showed staff usually interacted with people in a supportive and respectful manner. Staff addressed people using their preferred name, knelt to their eye level and used touch appropriately to provide reassurance. For example, during a quiz, the staff member promoted gentle banter between people and family members who had been invited to take part. This created a positive atmosphere with much laughter. When a person's nose started running during a meal, a staff member fetched a tissue and gently wiped it for them. When a person needed to go to the bathroom during lunch, a staff member discreetly supported them to leave the table and made sure the person's meal was kept warm. When another person became unwell, a staff member sat with them and held their hand until they felt better. In all cases when they were supporting people to mobilise, staff were patient and gave people clear, supportive prompts.

However, on one occasion, a staff member was brusque when responding to a person who was becoming restless in the early evening. The person was repeatedly asking when they could go home. The staff member said, "Not yet [person's name]" several times without further explanation. This did not reassure the person and they continued to become more and more restless. A senior staff member then intervened in a positive and supportive way; they engaged with the person, reassured them and asked if they'd like to fold some napkins. They agreed and this distraction helped the person to visibly relax; they became engrossed in the task and stopped asking when they could go home. One another occasion, a member of the management team showed a lack of consideration for people's privacy. We had asked for some information about the person's diet. As they did not know the answer, they entered the dining room and asked other staff about the person's diet in front of five other people. An open discussion then ensued between staff and the member of the management team about the person's dietary needs. The information was confidential, yet

would have been heard by all of the people present.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. People's care plans included information as to what support they needed and which aspects of personal care, such as brushing their teeth, they could do independently. A staff member told us, "We encourage [one person] to use their frame to walk to the dining room. It's important because the more [the person] uses a wheelchair, the more they lose the use of their legs."

People's privacy was protected while personal care was being delivered. Staff described the practical steps they took help ensure people's dignity was upheld, for example by using privacy screens when supporting people in shared rooms. In addition, a staff member told us, "We close the curtains and the door and use towels to keep [the person] covered as much as possible."

People's cultural and diversity needs were explored during pre-admission assessments and were further developed in conversations with staff during care plan reviews. These conversations gave people an opportunity to discuss their background, important relationships faith, lifestyle choices and interests. However, given the poor completion rate staff training in equality and diversity, we could not be assured that staff would use this information effectively to help them identify and meet the needs of people with protected characteristics or specific cultural needs. You can see more information about this in the Effective section of this report.

Staff involved people and their families, where appropriate, in most decisions about their care and treatment. Family members told us they were always involved in care plan reviews and were kept up to date when their relative's needs changed. A family member said of the staff, "They always rang us and kept us up to date."

Requires Improvement

Is the service responsive?

Our findings

People told us staff knew them well and met their needs. A person said, "They [staff] know you pretty good." A family member said of the staff, "I admire them. They do a marvellous job. It's not a job I could do." Other comments from family members included: "[Staff] do look after [my relative]. Generally, she has nice clothes on and they dress her appropriately. Her needs are being met" and "[My relative] is looked after well. Staff understand her and her needs".

Assessments of people's care needs were completed by one of the managers before people moved to the home. This information was then used to develop their care plans, in conjunction with the person and, where appropriate, their families. The care plans were reviewed monthly by nominated 'key workers'. Most people's care plans contained sufficient information to enable staff to deliver support in a personalised way. Two people's care plans lacked information about their current mobility needs, but these care plans were updated during the inspection.

Staff demonstrated a good understanding of the individual support needs of people living at the home. They knew how each person preferred to receive care and support. They knew the support each person needed with their continence and the level of encouragement they needed to maintain their personal care. They knew which people needed support to eat and which people needed encouragement or prompting to eat.

However, we found staff shortages meant staff were not always able to meet people's personal care needs. Most people had chosen to be supported to bathe once a week. Staff told us a shortage of staff meant this did not always happen. On average, across the home, staff needed to support people with 100 baths each month, but the bathing records for the month prior to the inspection showed only 25 baths had been supported. Some people had only been supported to have one bath in the previous month and some people had not had any baths at all. A staff member told us, "We don't do enough [baths], we don't have the time." You can find more information about the impact of staff shortages in the Safe section of this report.

One person was living with a condition that caused them to sometimes act in a way that put themselves or others at risk. Staff monitored such instances using "behaviour logs"; however, these did not capture any information needed to help staff identify the triggers that caused the person's behaviour. We discussed this with the home manager who acknowledged this information would be helpful and undertook to amend the template used for the behaviour logs.

Family members told us staff were responsive to people's changing needs. One family member said, "When [my relative's] needs became more [complex] they responded really well, with respect and patience." Another family member said of the staff, "They do call an ambulance when needed, like when [my relative] has a nose bleed or complains of chest pains." A further family member said, "[My relative] gets UTIs (urinary tract infections) every few weeks. At the first sign, [staff] call the GP straight away." We saw two people were experiencing UTIs at the time of the inspection; they had been referred to their GP promptly and antibiotics had been started quickly.

Staff expressed a commitment to supporting people at the end of their lives to have a comfortable, dignified and pain-free death. The family member of a person who had recently passed away at the home told us, "Staff were sensitive and marvellous with [my relative]; caring and kind, not just to [my relative] but also to us." A letter of thanks from the family of a person who recently passed away at Kinross stated: "Thank you all so very much for the care and love you gave to [my relative]. You all treated her like one of your own family. You all went above and beyond whatever I expected and I couldn't have wished for a better place for [my relative] to have spent her last days." The letter added, "Your love and support meant so much to me in those last few days and we even managed a few laughs along the way that kept me sane and strong."

Staff were in the process of completing an extended end of life training programme run by a local hospice. Most staff had experience of providing end of life care and described the key elements of end of life care as "keeping people comfortable and clean", "talking to them to make sure they [and their relatives] are not scared" and "good mouth care". Other staff explained how they worked with doctors and community nurses to support people and their families in a compassionate way. The care plan of a person who recently passed away at the home confirmed this and showed that a 'proactive medical care' plan had been put in place to help ensure the person's symptoms were controlled and they did not receive unnecessary medicines.

People had access to a wide variety of regular planned activities each day. A family member told us, "I think the activities are good." Another family member said, "[My relative] interacts with the quizzes. She joins in the sing songs and enjoys doing the reminiscing on a Thursday." The home had a designated activities co-ordinator who was responsible for planning and implementing most activities. These included exercise sessions five days a week, games, music, quizzes, bingo, arts and crafts, as well as pampering/sensory sessions and reminiscence. In addition, staff sometimes took people on trips to local attractions, such as museums and coffee shops.

People knew how to raise concerns and felt they would be listened to. One person told us, "If I was unhappy, I would talk to [staff] and they would listen." A family member said, "If I ever have a concern, I go straight to the office. For example, we lost [an item of property] and the manager immediately got up and started looking for it." There was a complaints procedure in place; however, this was not available in an accessible format to suit the needs of people living with a cognitive impairment. We raised this with the home manager who told us they would explore ways of re-writing the complaints procedure in an accessible format. We reviewed the complaint records and saw each complaint had been dealt with promptly and in accordance with the provider's policy. For example, a complaint about an alarm mat being unplugged led to an investigation and the complainant was updated with the outcome.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in post at the time of the inspection. The service was being run by a home manager who had applied to register with CQC.

Providers are required to act in an open and transparent way when accidents occur and to give information about incidents to relevant persons, verbally and in writing, together with a written apology. Family members felt staff were open and honest with them and said they had been notified verbally following incidents where their relatives had come to harm. However, we found one occasion where the information and the apology were not followed up in writing and another occasion where the information provided in writing was not adequate. We discussed this with the home manager, who undertook to ensure sufficient written information was provided to relevant persons consistently in the future. In other ways, the service had an open and transparent culture. Visitors were made welcome and could stay as long as they wished. Links had been developed with the community, including with a parent and baby group who visited to interact with people every two weeks and a school group who sang carols to people at Christmas.

The provider operated a comprehensive quality assurance system. This included monthly care plan reviews by nominated key workers and a wide range of audits conducted by the deputy manager, the home manager and the provider's quality assurance manager. As part of the process, a selection of people and staff were interviewed to gain an understanding of the service from their perspective. Improvements identified by the audits, for example care plans that were identified as in need of further review, were used to inform an action plan. The provider's general manager and the provider's nominated individual had regular contact with the home's management and visited the home every month to monitor. Through discussions with the home manager and they deputy manager, they monitored the progress of the action plan and the findings from recent audits. They described how they held managers to account by challenging delays to the completion of the action plan.

However, we found the quality assurance system was not fully effective. It had not picked up the significant and widespread concerns we identified during this inspection. These included a failure to ensure enough staff were deployed; a failure to monitor staff training effectively; a failure to ensure risks, including fire safety risks to people were managed effectively; a failure to ensure the proper and safe management of medicines; a failure to control the risk and spread of infection; a failure to ensure MCA legislation was followed fully; a failure to ensure safe recruitment practices were followed; and a failure to ensure duty of candour requirements were met. An audit conducted by the home manager five days before the inspection had not identified a trip hazard caused by badly worn carpets, which we were told had been present for "some time". Where issues had been identified by the auditing process, effective action had not always been taken. For example, an audit at the beginning of August 2018 identified the need for a staff member to complete an assessment of their competence to administer medicines, but this had still not been completed four months later. Some audit tools were not appropriate; for example, the medicines audit tool did not examine whether risks assessments were in place for certain medicines. Furthermore, the infection control audit showed the manager completing it had not understood the need to segregate clean and dirty washing in the laundry. These failures had led to breaches of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The systems used to seek and act on feedback from relevant persons on the services provided were not always effective. Records of staff meetings showed staff had raised concerns about staff shortages, but no action had been taken in response. Feedback from the local authority, following two safeguarding investigations, identified the need for improvements in relation to the management of people's skin integrity; however, the home manager was unable to confirm that all the recommended actions had been completed. Feedback from Hampshire Fire and Rescue Service (HFRS) identified the need for improvements to fire safety procedures, but records showed not all of these had been completed in a timely way.

The failure to operate effective systems and processes to assess, monitor and improve the quality and safety of the service and the failure to act on feedback from relevant persons were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Areas where the quality assurance process had been effective included the introduction of residents' meetings, which had not occurred previously, significant improvements to the activity provision and the purchase of some new chairs for the dining room. The provider's quality assurance manager told us, "We are moving in the right direction, but it takes a while [for the quality assurance systems] to become established."

There was a clear management structure in place, consisting of the provider's nominated individual, the provider's general manager, the home manager, the deputy manager, the quality assurance manager, the training manager and senior carer staff. Each had clear responsibilities. Care staff told us they worked together well as team. For example, one said, "Staff speak to each other more. There's a good rapport between staff. [Staff] pitch in and work together as a team."

Staff shared information effectively between themselves, including through the use of 'handover sheets' which provided a summary of people's current needs and any concerns. These complimented a handover meeting held at the beginning of each shift, at which staff received an update on each person and their needs. A series of other meetings was also used to help staff and managers share information. These included a daily "stand-up" meeting where the home manager met with key staff to discuss any pressing matters and regular staff meetings. Staff told us some suggestions they made at staff meetings were listened to. For example, one staff member said, "Today, we suggested making a tweak to the weight charts and we discussed and agreed it."

People and family members told us they had seen improvements to the service under the current provider. One person told us, "The manager's quite good." A family member told us, "We have seen improvements with the new owners; new chairs and tables, cloth napkins and [more] activities." Another family member said, "There's generally an improvement since [the current provider] took over. It seems well organised." Other family members said they would recommend the home to others. One family member added, "When I'm older, I hope my family find me a Kinross."

Staff also felt there had been improvement. A staff member told us, "The residents have benefited from the change of ownership. The atmosphere is a lot better. It's no longer regimental, it's more lively and we're encouraged to involve everybody." Another staff member said, "Things have improved massively [under the current provider], for example the activities and how we interact with residents. There is generally more of a family feel to the home. The menus have got better too. We asked the residents what they wanted; some wanted curry, so we added that." A further staff member said, "Previously, everyone had to be down for breakfast by 8:00am. That's no longer the case [under the current provider]. People can choose when to get up and where to have their meals."

People's views were sought through a variety of surveys conducted every six months and occasional residents' and relatives' meetings. The home manager analysed the results of any feedback and developed an action plan to address any concerns raised. For example, at the most recent survey, family members had asked for more information about the activities their relatives took part in. In response, the activities were posted on an activities board each week and a newsletter was introduced and sent to family members each month. A subsequent email from a family member showed these were being received and enjoyed. In addition, 'You said, we did' posters had been introduced to inform people of the action taken in response to their feedback. For example, one poster said: "You said could we have broad beans on the menu and the chef included them on the menu."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to staff acted in accordance with the Mental Capacity Act 2004 at all times. Regulation 11 (1)&(3).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess and mitigate the risks to the health and safety of people, they had failed to ensure the proper and safe management of medicines, they had failed to prevent, detect and control the spread of infections, including those that are health care associated. Regulation 12(1) and 12(2)(a)(b)(g)&(h).

The enforcement action we took:

We issued a warning notice requiring the provider to become compliant with the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the quality and safety of the service provided; and to seek and act on feedback from relevant persons. Regulation 17(1) and 17(2)(a)&(e).

The enforcement action we took:

We issued a warning notice requiring the provider to become compliant with the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed, and had failed to ensure staff received appropriate support, training and personal development. Regulation 18(1) and 18(2)(a).

The enforcement action we took:

We issued a warning notice requiring the provider to become compliant with the regulation.