Kingsmead Care Home Limited

Kingsmead House Care Home

Inspection report

156 Mytchett Road
Mytchett
Camberley
Surrey
GU16 6AE

Tel: 01252549339

Date of inspection visit:
26 January 2017

Date of publication:
21 March 2017

Ratings

Overall rating for this service	Inadequate
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on the 26 January 2017. Kingsmead House Care Home is a nursing home for up to 40 people, with a range of support needs including personal care, nursing needs and for people who require end of life care. At the time of the inspection there were 18 people living at the service. The provider placed a voluntary suspension of new admissions into the home until they had made the required improvements.

We carried out an unannounced comprehensive inspection of this service on 7 September 2016. At this inspection breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches of good governance and provider management oversight by 28 November 2016.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

While improvements had been made in some areas, we found that sufficient action had not been taken to meet the breaches in the regulations.

The registered manager had not ensured that action was taken once an area of improvement was identified. There were not always sufficient staff to meet people's needs. The registered manager had identified a need for twilight staff (7-11pm) to support people with tasks such as going to bed or eating supper. Although they had identified this need, they had not implemented any staff changes. The registered manager had also deployed care staff to be taken off shift to provide drinks to people which could take up to one hour at a time, meaning other people had to wait for their care needs to be met.

The registered manager did not have a system in place to ensure that record keeping was accurate and up to date. There were some improvements made in managing risks to people. Some people had risk assessments in place that identified and managed risks. Further improvement was required around the record keeping and the accuracy of the information to meet people's needs. This lack of appropriate record keeping could lead to people's health deteriorating and staff not being aware of it.

People had care plans in place that contained information on specific nursing treatments such as wound care. They contained information on people's likes and dislikes. However not all people had up to date and personalised care plans. Care plans lacked information on people's health conditions and how they impacted on their well being. This meant that staff may not always know how to care for a person effectively.

There were some new systems in place to monitor, review and improve the quality of care. However they did

not always identify areas of concern, they were not robust and did not cover all aspects of care. The progress of improvement was slow.

The service was not always well led. Staff felt that they were not always able to approach the registered manager. Staff told us they felt they were not listened to and action was not always taken by the registered manger about their concerns.

The registered manager had introduced a system to ensure that staff received supervision. There was more training for staff, however improvements could be made. Staff lacked training in specific health conditions that people had, which meant that people's needs may not always be understood. Staff had a great understanding of their roles and responsibilities could be made. Staff had a great understanding of their roles and responsibilities.

The registered manager had now made improvements to ensure staff were recruited safely.

We found a continued breach of Regulation 17 in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what we told the provider to do at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Inadequate

We found that sufficient action had not been taken to ensure the service was well led.

The service was not always well led.

There were now some systems in place to monitor the quality of care provided. However, they were not robust, embedded into practise or always able to identify areas for improvement. The timescales for improvements set out in the provider's action plan had not been met.

Record keeping was inconsistent. There was some information missing and inaccuracies in some records. There was a risk to people's health that information was not recorded accurately or kept up to date.

Staff did not always feel listened too or their concerns acted upon. Staff told us that there had been some improvements, but it was slow.

Kingsmead House Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of the service on the 26 January 2017. This inspection was done to check that improvements to meet legal requirements had been made since our comprehensive inspection on the 7 September 2016. We inspected the service against one of the five questions we ask about services, which is 'is the service well led'. This is because the service was not meeting some legal requirements.

The inspection team consisted of two inspectors and an expert by experience (Ex by Ex). An Ex by Ex is a person who has experience for caring for older people.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance teams. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as this was a focused inspection.

During and after the visit, we spoke with four people, one relative, the registered manager, the deputy manager, the consultant (a person with specific knowledge the provider brought in to support the service) and four members of staff. We spent time observing care and support provided throughout the day of inspection, at lunch time and in the communal areas.

We looked at three people's care records, staff rotas and recruitment files, supervision and training records. We looked at records that related to the management of the service. This included minutes of staff meetings, complaints and audits of the service. We asked the registered manager to send us some

additional information following our visit; they sent some of the information but not all.

Inadequate

Is the service well-led?

Our findings

On the first comprehensive inspection in January 2016, we identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider and registered manager did not have sufficient oversight of the service and there were no systems in place to monitor, review and improve the quality of care provided. At this inspection, some people had received unsafe care as risks were not always being managed and identified.

At our second comprehensive inspection in September 2016 we identified a continued breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result, CQC issued a formal warning to Kingsmead House Care Home Limited. The areas for improvement that we identified in the enforcement action were systems and processes in place to monitor, review and improve the quality of care; staff deployment; training and supervision of staff; care plans; unsafe recruitment of staff; lack of effective management of the care staff, and the management of risks to people. The registered manager sent us an action plan to tell us that the actions would be completed within the time scale we made, which was the 28 November 2016.

At this focused inspection, the provider and the registered manager did not have effective systems in place to monitor the quality of care or drive improvement. The provider told us on the last inspection that there had been reliance upon the previous registered managers that the quality assurance was being undertaken and improvements were being made. An improvement plan was in place that was linked to the breaches of regulations identified as a result of the September 2016 inspection. Aspects of the improvement plan had been acted upon in line with its contents but others had not. The provider had not always taken responsibility to ensure that the appropriate work was being carried out.

We asked the registered manager what actions they had taken to improve the service since the last inspection and to meet the Warning Notice we had served. They told us that people had new care plans, there were more permanent staff and they were recruited safely. The registered manager told us that training and supervision for staff had also improved since the last inspection.

There were not robust systems in place to ensure that avoidable risks of harm to people were managed safely. There were some improvements in ensuring that risk assessments were being completed for people who had identified risks such as pressure areas. However it had been identified in an incident report that one person had become distressed and lashed out at staff. There were no guidelines in place to tell staff how to support the person to reduce their distress. We asked the registered manager about this and she confirmed that the risk assessment had not been done and they were unaware that one needed to be completed.

The registered manager had not ensured that records relating to the care and treatment of people were accurate and up to date. For example a skin integrity risk assessment was completed for one person. It omitted important information about their health condition that would have increased the risk of developing pressure wounds to that person. There were risk assessments in place for people who needed

assistance with moving and handling, pressure care, falls and malnutrition and no direct harm had come to people. However, some of the assessments for people had not been completed regularly or updated to contain accurate information. For example, a wound observation chart was in place for a person who had a pressure sore. This had not been updated for five weeks. We asked the nurse in charge about this and they told us that there was an inconsistency in staff keeping records up to date, particularly due to use of agency staff. This lack of appropriate record keeping could lead to people's health deteriorating and staff not being aware of it.

At the previous inspection of September 2016, we identified that staff did not always know people's needs. The registered manager did not have a robust system in place to ensure that staff had the right information about people's health conditions to care for people effectively. One person told us that some staff still did not understand their health condition and how it impacted on their wellbeing. For people with specific health conditions there were still no care plans in place to tell staff how to care and support the person. This meant that some people may not always be getting the care that they needed.

We identified in September 2016 that the registered manager did not have systems in place to monitor, review and improve the quality of care. There was also not a robust system in place to encourage feedback from people and staff about the service to improve the care. At this inspection, some improvements had been made as there were some quality assurance processes in place. However, some were not in place until January 2017. There were systems in place to review infection control, people's nutrition, complaints and safe guarding. Actions had been taken to improve the service when there had been an identified concern. For example, it was noted that meal times were lengthy, to cut the time down for people, it was decided that the kitchen staff would serve the food instead of carers. This freed up time for carers to support people.

Systems had not been entirely rolled out and were not robust enough to ensure that there were processes in place to review all aspects of care as they had not identified areas of concern that we had. For example, a system that was put in place to ensure that people's rights were protected was a system for recording who had legal responsibility for making decision on people's behalf about their care. This record was incomplete. We were told by the registered manager that it was a work in progress.

The progress of improvement in the home had been slow and not all improvements that were required had been met. We asked the registered manager why care plans and quality assurance systems were only introduced in December 2016 and January 2017 respectively. She told us that it was because she was waiting for a stable staff team to be able to introduce the changes.

During the inspection in September 2016 we identified that staff deployment was a concern and the provider did not have an effective system in place to identify that. Although there had been some improvements in this area, people were still telling us that sometimes they had to wait too long for the call bell to be answered. One person said "Sometimes the staff here take a little while to answer the bell, but they are so busy." Another person said "The call bells sometimes could be answered more quickly". The registered manager had a system in place that had identified from the call bell audits in December 2016 and January 2017 that there were extra pressures on staff in the twilight hours, between (7-11pm). She told us that they would recruit some extra staff to cover those hours to ensure that people received the care they needed. We asked her when this would occur, she told us that a review of the staffing would occur first and then recruit if necessary; she was unable to put a time frame on this. We also observed that care staff were taking the drinks trolley around for morning and afternoon tea. Staff told us that this could take up to one hour to do this each time. Staff told us that they had raised it with the registered manager before, but nothing had changed. We asked the registered manager why care staff rather than the domestic or kitchen staff were doing this; she told us that she would change it that day. However, we saw care staff were still with

the drinks trolley later that that afternoon.

The home was not always well led. The provider had not ensured that there was a system in place to act on feedback from staff to ensure that improvements in the service occurred. There were improvements in the atmosphere in the home. Staff seemed less rushed and it felt calmer in the home since the last inspection. Staff told us that there were improvements in place, but they told us that changes were slow. A staff member said "We have seen a difference in the last three months. We now have new care plans and communication has improved." However, staff told us that they felt unable to speak up to the registered manager as "Nothing gets done." And "I'm scared to complain as nothing gets followed up."

New care plans were in the process of being introduced for people, however they had not been rolled out to everyone. One staff member told us that "The paperwork was a mess, we have worked so hard. We have been going through everybody's care plans. We only started working on them in December." People's care plans had improved, they contained information relating to people's nursing needs, such as pressure care and wound care. There was an improvement in the care plans containing more personalised and detailed information. A document called 'all about me' had been introduced which included information on people's past histories, their likes and dislikes. Staff knew people well and could tell us about people. For example, a staff member told us about how a person communicated with their facial expressions as they were unable to talk.

The registered manager had not ensured that there was a system in place to ensure that staff were competent and skilled sufficiently to support people effectively. There had been some improvements in training for staff, although further improvements were needed as staff did not receive training in health conditions that affected people. Nurses had received clinical skills training in catheter care, and use of some medical equipment. The registered manager confirmed that new staff were not undertaking the Care Certificate for those who had little or no experience in care. This is a certificate that sets out standards and competencies for care workers. There was a new induction programme in place which briefly covered whistleblowing, fire safety, moving and handling and health and safety. Staff had received training in safeguarding, infection control and fire safety. Some staff had received training in hydration and nutrition. There were significant gaps in the training record for the service. Lack of training such as end of life care, medication, care planning and pressure care meant that staff may not have had the right knowledge and skills to support people.

The registered manager ensured that there was a process in place to ensure that staff received regular supervision. Staff told us that they had supervision and records confirmed this. Staff were now more aware of their roles and responsibilities. A daily planner was used to allocate staff to certain people to care for throughout the day. Although, some staff told us that this could change throughout the day. The registered manager told us that they had recruited senior carers to support and direct the carers on shift. More permanent staff had been recruited and therefore there was less reliance of agency staff. This meant that more consistent care was provided to people. There was clear direction and supervision from the nurses leading the shift. We saw nurses providing advice and direction to staff about completing people's food and fluid charts.

A keyworker system was being rolled out into the home, although this had occurred on the ground floor only. A relative told us that they were told about this back in October and could not understand why it had taken so long to roll out. A keyworker system benefits people and staff as they have a named staff member who gets to know the person well and is the main point of contact between the person and relatives. The registered manager was unable to tell us when it would be rolled out onto the first floor.

The provider had ensured that there was now a process in place to ensure that staff were recruited safely. Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. Staff recruitment records contained information to show us the provider had taken the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Although the registered manager and provider had put some systems in place to monitor and review the quality of care, they were not effective as they did not always identify areas that needed further improvement. The process of improvement was also slow. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Robust and effective systems were not in place to monitor, review and improve the quality of care. The progress of improvements were slow.