Review of compliance

Barchester Healthcare Homes Ltd Kingsland House	
Region:	South East
Location address:	Kingsland Close (off Middle Road) Shoreham by Sea, West Sussex BN43 6LT
Type of service:	Care Home with nursing
Date the review was completed:	January 2011
Overview of the service:	Kingsland House is registered as a care home with nursing to accommodate people requiring nursing care and people requiring care for dementia and related mental health conditions of older people. The accommodation is divided into two units. The Bluebell Unit accommodates thirty people who require nursing care and the Memory Lane Unit accommodates forty-one people who have mental health conditions of the older person.

	The property has been purpose built and is situated in a residential area of Shoreham by Sea and is reasonably close to local amenities.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Kingsland House was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were raised with CQC regarding the following:

- Care and welfare of people who use services
- Management of medicines
- Staffing
- Supporting workers

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 18th January 2011, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services.

What people told us

People told us that there were insufficient staff on duty and that they had to wait a long time for care to be given. They commented that staff were kind and patient but were always rushed and that medications were sometimes late.

What we found about the standards we reviewed and how well Kingsland House was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

People are not receiving the level of care they require and their needs are not being met. Staff do not have time to update nursing and care records or to give care in a manner which reflects the individual choices of the people who use the service.

- Overall, we found that improvements are needed for this essential standard.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

Failure to implement security measures in the service put people at risk and could result in medication misuse.

The service did not have systems in place to ensure that sufficient staff were on duty to ensure that medication was administered in a safe manner at the times for which it was prescribed. They had failed to ensure that sufficient supplies of medication were available for people's use.

- Overall, we found that improvements are needed for this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The service had failed to maintain staff levels at a level which ensured that people who lived in the service had the care that they required. This had impacted across all elements of care including medication and record updating. Management had failed to address this when brought to their notice.

- Overall, we found that improvements are needed for this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The service has failed to ensure that staff are sufficiently supported to meet the needs of the people living in the home.

- Overall, we found that improvements are needed for this essential standard.

Action we have asked the service to take

During the visit we reviewed four of the essential standards related to the areas of concern raised with CQC. We found clear evidence of non compliance with Outcome 4, Outcome 9, Outcome 13 and Outcome 14.

We found that there are major concerns in all four Outcomes that we reviewed. Therefore the provider has failed to ensure people using the service receive a suitable level of care that delivers good outcomes for them. We have set compliance actions upon the service to address these issues.

We use a judgement framework, a document called '*setting the bar',* to bring together and score the overall risk that an organisation is not compliant with the essential standards of quality and safety.

Using this framework, we judge that the overall level of concern that Kingsland House is not fully compliant with the essential standards as ***Major.***

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

We will monitor their plans to address these concerns and take additional action if necessary.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are major concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We did not, on this occasion speak to people, so cannot report on what the people using the service said.

Other evidence

We had received concerns about the care of the people living in the service, particularly the general care unit. These included concerns people who were ill were receiving sufficient fluids as fluid charts were not showing that fluids were being given on a regular basis.

A further concern had been received that staff were putting two incontinence aids on people at night as there were insufficient staff to give care at regular intervals, and a concern raised that one person in this unit was very depressed and not receiving sufficient staff input or stimulation.

During our visit to the specific unit affected -'Bluebell Unit' we asked staff which people needed the most care and we were told that fluid charts were not necessary for any of these people at the current time. Therefore we were unable to evidence whether people who were ill were receiving sufficient fluids. Staff confirmed that there was insufficient staff on duty to enable them to give all the care that people

required.

We had asked the provider to respond to us regarding the doubling of incontinence aids at night due to lack of staff. At the time of our visit we had not received a response. The operations manager later confirmed that subsequent to our visit she made a night visit to the home. There was no evidence of this during her visit, although staff told her that due to shortage of supplies last year there had been a period when they had to use double the amount of lightweight incontinence aids to ensure people's comfort.

Staff told us that they were not able to give people care in a timely manner, and we saw that people were not getting up until later in the morning. One person was still in bed at lunchtime, which was not their choice. Other people were also not getting up until later in the morning. Staff told us that it is people that 'do not shout the loudest who get left'.

A member of staff told us that there was insufficient time to write up the care plans, do dressings, and check fluid charts and other essential nursing tasks. They told us that lack of staffing levels was impacting on all levels of people's care. Another told us that they had not had time to write up care plans that day. We saw staff trying to write up records but being called away, either by the telephone or by people who required care.

We received information that there were insufficient leisure activities and mental stimulation in the general care unit.

We saw that whilst there was sufficient leisure activities provided in the dementia care unit 'Memory Lane', we did not see any evidence of leisure activities at this time in the 'Bluebell Unit'. Judging by the lack of staff in this unit, staff would not have time to spend with individual people. Therefore people who required social interaction or mental stimulation would not receive this.

Our judgement

People are not receiving the level of care they require and their needs are not being met. Staff do not have time to update nursing and care records or to give care in a manner which reflects the individual choices of the people who use the service.

Overall we found that Kingsland House was not meeting this essential standard.

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:

- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with outcome 9: Management of medicines.

Our findings

What people who use the service experienced and told us

We did not, on this occasion speak to people, so cannot report on what the people using the service said.

Other evidence

We visited the service at 08.12 and were able to walk directly into the service through an unlocked door. There were no staff members around and on entering 'Bluebell Unit' we found the locked medicines trolley outside the door with all the morning medications lying on the top of it. Some members of staff passed the entrance to the unit but did not challenge us. We waited by the medications trolley to ensure security until the registered nurse came out of a room 7 minutes later. She told us that she had been intercepted by the need to assist with care.

We had received concerns that the service was not ordering or receiving medications promptly. Some people who were prescribed antibiotics were not being able to commence these until 48-72 hours following them being prescribed. We saw evidence of this when looking at records on both units.

Staff told us of difficulties in obtaining medications after 3pm and at weekends, but we also found that in some cases staff had not faxed prescriptions through to the dispensing chemist.

We found that staff was not recording when medications had not been received from the dispensing chemist which resulted in some people running out of medication.

A member of staff told us that on one occasion recently there had only been one registered nurse for both units. Therefore the early evening medication round had not taken place on one unit, resulting in some people going without essential or time specific medications until the night medication round.

We were told that on some night duties there has only been one registered nurse on duty for both units, this resulted in them having to do the medications for all people living in the home. The member of staff described this as 'unsafe practice'. Whilst there were 54 people living in the home on our visit the home can take up to 70 people.

We noted that the 8am medication round was not completed until 11.45 which meant that people had not received their medication at the time prescribed and in some cases would mean that another dose of the medication would be given with the midday drugs round.

Our judgement

Failure to implement security measures in the service put people at risk and could result in medication misuse.

The service did not have systems in place to ensure that sufficient staff were on duty to ensure that medication was administered in a safe manner at the times for which it was prescribed. They had failed to ensure that sufficient supplies of medication were available for people's use.

Overall we found that Kingsland House was not meeting this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are major concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

People told us that there was often insufficient staff on duty to give them the care or get them up at the times they wished.

Other evidence

When we visited the service we asked for copies of the staff duty rotas for the past month. It was difficult to assess staffing levels from these rotas therefore we asked several members of staff to go through these rotas with us.

Staff showed us where there had been very low levels of staff on duty. They told us that one unit, 'Bluebell Unit', there were people with complex physical needs, over 50% of whom required assistance from two care workers, and we saw records that showed this.

We saw from the rota that on one occasion the previous week only one registered nurse was on duty for both units. That on one night there was only one registered nurse between two units and one care staff on 'Bluebell Unit'. The rota showed us that staffing levels were erratic both on day and night shifts and particularly at weekends. The 'Memory Lane' unit had also had some times when there were insufficient staff.

Staff told us that the duty rota did not always accurately reflect who was on duty,

showing some staff as working when they were off sick. They said they now switch their phones off to avoid being asked to come on duty when they had a day off, and that duty rotas were constantly rearranged so they were never sure how many staff will be on.

During our visit there were two care workers and one registered nurse on duty on duty in 'Bluebell Unit' which we saw was insufficient. Later in the morning a third care worker was sent over from the other unit.

We were told that the registered nurse had to interrupt the medication round to assist with general care, had no time to write up care notes and had complex dressings and other nursing duties to do.

Unit managers are permitted to contact bank staff but this was often unsuccessful and the shift would be over before cover was found.

The manager of the home had been in post for 18 months and was not registered with The Care Quality Commission.

Staff said that concerns about staffing had been put to management but had not been addressed.

Our judgement

The service had failed to maintain staff levels at a level which ensured that people who lived in the service had the care that they required. This had impacted across all elements of care including medication and record updating. Management had failed to address this when brought to their notice.

Overall we found that Kingsland House was not meeting this essential standard.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are major concerns with outcome 14: Supporting workers

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Our findings

What people who use the service experienced and told us

We did not, on this occasion speak to people, so cannot report on what the people using the service said.

Other evidence

We had received concerns relating to the support given by management and management's knowledge of the people that use the service.

We found that whilst staff felt supported by the individual unit managers they did not feel supported or listened to by the general management.

In discussion we found that the appointed general manager who had overall management responsibility of the home, was unable to demonstrate understanding of the care requirements of people living there. There was a failure to maintain adequate staffing levels and to enable staff to have sufficient time to meet these needs.

Our judgement

The service has failed to ensure that staff are sufficiently supported to meet the needs of the people living in the home.

Overall we found that Kingsland House was not meeting this essential standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for people who require nursing and personal care. Treatment of disease disorder or injury. Diagnostic and screening procedures	9	4
	How the regulation is not being met: People are not receiving the level of care they require and their needs are not being met. Staff do not have time to update nursing and care records or to give care in a manner which reflects the individual choices of the people who use the service.	
Accommodation for people who require nursing and personal care. Treatment of disease disorder or injury. Diagnostic and screening procedures	13	9
	How the regulation is not being met: Failure to implement security measures in the service put people at risk and could result in medication misuse. The service did not have systems in place to ensure that sufficient staff were on duty to ensure that medication was administered in a safe manner at the times for which it was prescribed. They had failed to ensure that sufficient supplies of medication were available for people's use.	
Accommodation for people who require nursing and personal care. Treatment of disease disorder or injury. Diagnostic and screening procedures	22	13
	How the regulation is not being met: The service had failed to maintain staff levels at a level which ensured that people who lived in the service had the care that they required. This had impacted across all elements of care including medication and record updating. Management had failed to address this when brought to their notice.	

Accommodation for people who require nursing and personal care. Treatment of disease disorder or injury. Diagnostic and screening procedures	23	14
	How the regulation is not being met: The service has failed to ensure that staff are sufficiently supported to meet the needs of the people living in the home.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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