Barchester Healthcare Homes Limited

Kingfisher Lodge

Inspection report

Chestnut Walk
Saltford
Bristol
Avon
BS31 3BG

Tel: 01225871030

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Kingfisher Lodge is a residential care home providing regulated activities personal and nursing care to up to 60 people. The service provides support to people with dementia, older and younger adults, and people with a learning and/or physical disability. At the time of our inspection there were 52 people using the service.

Kingfisher Lodge is laid out over two floors, with en-suite bedrooms, communal dining and lounging areas, to each floor. Both floors are accessible by lift and stairs. People have level access to a large, well-stocked garden from the ground-floor. The manager's office is located adjacent to the reception area on the ground-floor.

People's experience of using this service and what we found
The manager raised potential safeguarding concerns with the local authority safeguarding team. Staff spoke confidently about how they would identify abuse and what they would do if abuse was witnessed or suspected. Risk assessments were in place where required, for example for people at risk of falls. The manager had identified medicines related recording was not always robust and was working to improve this at the time of our inspection. The provider used a staffing dependency tool based on peoples' needs, we received mixed comments about staffing levels.

The provider submitted notifications as required and used checks and audits to identify shortfalls, errors and omissions. Staff knew people well and had recently worked with a dementia specialist to provide people with more person-centred care. At the time of our inspection, the service did not have a registered manager in place, a recent application for registration had been withdrawn and a general manager was in post for the interim. The manager and regional director had identified areas for development, plans were in place to support this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well-led, the service was able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support: People were supported to have maximum control of their lives and make their own choices. The service shared relevant information with external professionals to support these choices.
Right care: Staff had not received learning disabilities training, however this had not impacted people and the manager planned to rectify this. Staff knew people well.
Right Culture; The service worked with peoples' families to ensure people experienced good outcomes.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection the last rating for this service good (published 20 November 2020)

Why we inspected
We received concerns in relation to the management of medicines and safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

Follow-up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Kingfisher Lodge

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team was made up of one inspector, one bank inspector and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Kingfisher Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Kingfisher Lodge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

The service had recently undergone a change in management, with the previous applicant withdrawing their application to register with the Care Quality Commission (CQC). At the time of our inspection, a general

manager was in day to day charge of the service, and a job advert for the post of registered manager had been published.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 12 people, five relatives, two visiting professionals and eight members of staff including the general manager, cook, senior care staff and care staff. We reviewed various records in relation to the running of the service, including three recruitment files, maintenance checks and various audits. 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. After the inspection we continued to clarify information with the general manager and spoke with one relative.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of experiencing abuse, and there were processes in place to ensure potential safeguarding concerns were shared with the local authority safeguarding team.
- Staff spoke confidently about how they would identify indicators of abuse and what they would do if abuse was witnessed or suspected. Comments from staff included, "I've never seen abuse here. If I had seen anything like that, I would be the first one getting in touch with you" and, "I would look for bruising, if people are not themselves, quiet….I would report [suspected abuse] to the manager, if I wasn't happy then I would go to safeguarding and report it to them."
- Relatives we spoke with said they felt people were safe. Comments included, "[Relative] is safe, I'm friendly with all the carers" and, "Mum's safe." One person said, "I feel safe, they [staff] are attentive."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
- Where required, capacity assessments were in place and were decision specific. For example, we reviewed capacity assessments in relation to the use of bed rails.
- Overall, the staff we spoke with were confident about how they applied the principles of the MCA in their work. Comments from staff included, "Always assume capacity; I always support people with their choices, people are allowed to make bad decisions, support people in the least restrictive way. I think we do that on a day to day basis." For staff less confident about the principles of the MCA, the manager had planned refresher training.

Staffing and recruitment

- Recruitment processes were in place to reduce the risk of unsuitable applicants being employed to work in the service. For example, checks were made with applicants' previous employers in care and the Disclosure and Barring Service (DBS). DBS checks are important as they alert potential employers about

criminal convictions, and about applicants who are on the barred list.
● The manager used a staffing dependency tool to determine staffing levels. The tool looked at people's individual care requirements, such as the levels of support required for personal care, mobilisation and communication.
● We received mixed comments from staff and people, about staffing levels. People said, "There appear to be enough" and, "There are staff shortages." Comments from staff included, "I feel the staffing level is low. People get the care, but you are always on your feet" and, "Most of the time there are enough staff; we do get sickness, if everyone turns up it feels like enough staff."
● We spoke with the manager about the mixed comments we received, and they confirmed recent changes had been made to improve and monitor staffing efficacy. For example, some people now had 1:1 staff support, and the manager pressed call bells to monitor staff response times. The call-bell report we reviewed confirmed call bells were answered within the required timeframe.
● The manager had identified that staff training was not always up to date and had planned training sessions to address this.
● We identified the provider had not supported staff to access training for people living with learning disabilities, although people with learning disabilities were living at the service. We found no impact on people. In response to our feedback, the manager arranged for all staff to attend relevant in-person training.

Assessing risk, safety monitoring and management
● People's needs had been assessed prior to moving to the service. Pre-admission assessments had been completed.
● Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition and included guidance for staff about how to reduce these risks. For example, people assessed as being at risk of skin damage, had plans that detailed the use of any pressure relieving aids, such as air mattresses. Air mattresses we looked at were all set correctly and in good working order.
● When staff needed to support people with moving and handling equipment, corresponding plans detailed which equipment to use and how to use it. This information was clear and informative. People told us they were moved in line with their assessments, one person said, "They [staff] always hoist with two. I have my own sling, they [staff] don't leave it in my wheelchair."
● Risks to people's nutrition and hydration were assessed. When people had been assessed as being at risk of malnutrition, guidance and support was sought from the GP, dietician and speech and language therapy team (SALT).

Using medicines safely
● Medicines related records were not always accurate. Medicines were stored and administered in line with guidance and prescribers' instructions.
● Whilst people had their medicines as required there were some shortfalls in medicines recording. We found some gaps in records and not all 'as required' medicines had detailed protocols in place.'
● Prior to our inspection, the manager had identified change was needed in relation to medicines related records, and confirmed the deputy manager would be assuming responsibility for medicines audits. Additionally, nurses were encouraged to review, and check work undertaken by colleagues. We found people had not been impacted by the recording errors.

We recommend the provider continues to review medicines governance systems to ensure recording gaps, errors and omissions are identified and rectified promptly.

● Some people were having their medicines administered covertly. This is when medicines are "disguised" in food or drink. We saw the service had sought the advice of the GP prior to administering medicines this

way.
● At the front of MARs there were photographs of people. These were dated to show they were a true likeness of people. People's allergies were listed, including their preferences for how they liked to take their medicines.
● Medicines were stored safely. Medicine fridge temperatures were recorded as were clinical room temperatures.
● Controlled medicines were managed safely. A random stock check was carried out with one of the nurses and this was accurate. Medicines that were no longer required, were disposed of safely.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● Peoples' relatives were supported to visit the service, we observed visitors with people during our inspection.

Learning lessons when things go wrong
● The manager reviewed and monitored accidents and incidents to prevent a recurrence. The manager also reviewed any 'near misses' and said this was important because, "They can tell us things too."
● The manager was working with the regional director to drive improvement in the service, action plans were in place to support this. For example, staff told us about how they were implementing a 'key-worker' system. One staff member said, "I will be key worker for three people. [The key worker system] is being revamped and reintroduced."

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Prior to our inspection, the service had been through a period of change and a recently submitted application for registered manager had been withdrawn. A newly appointed general manager was overseeing the service at the time of our inspection and the registered manager's post was advertised.
- Overall, checks and audits had been used to identify shortfalls, errors and omissions. For example, recent manager checks had identified recording errors in relation to medicines management.
- Staff, relatives and people we spoke with said they could speak with the manager. Comments from people included, "[Manager's name] is very good, she listens and if you have an issue, she will look into it and sort it out" and, "If I had an issue, I would go to [manager's name]." Comments from staff included, "[Manager's name] listens and tries to do things" and, "[Manager's name] is very open to conversations with anyone and is easy to access."
- The manager had recently implemented a concerns log and reviewed concerns to identify themes, trends and areas for improvement.
- Statutory notifications were submitted in line with requirements. Notifications are important because they support us to monitor the services we regulate.
- The provider had identified through their quality checks and audits that there were further improvements to be made. As a result of this, we requested the provider submit an action plan within one month of this inspection, in order for us to monitor and assess their progress.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff we spoke with knew people well, including their likes and dislikes. Comments from relatives included, "There are staff around that know [person], [person] can be aggressive…they [staff] have the knack in dealing with [person]" and, "They [staff] all know [person's name]."
- People told us they were involved with their care planning. Comments from people included, "I was involved with the care plan."
- The provider had supported people with learning disabilities to maintain relationships important to them and to support relatives' involvement in care. For example, the provider worked with another service to ensure one person and their relative remained in contact. One relative of a person with learning disabilities said, "They support with health appointments; always let me know because I always come to see them with [person's name], like last week they let me know the GP was coming." One person said, "The care is pretty good."

● The manager had recently invited a 'Dementia Care Specialist' to provide person-centred support for people who were, for example, experiencing distress.

Continuous learning and improving care

● The newly appointed manager had identified some previous admissions into the service were inappropriate. At the time of our inspection, the manager was working with external organisations and making changes internally to address this. Staff told us they had already seen improvements, one staff member said, "The changes to date have made a massive difference to the residents and us…which means our work is easier and we can do more with people."

● People and staff told us activities provision could be improved. Comments from people included, "Improvement would be more activities" and, "Activities are not very good." We spoke with the manager, and regional director, who had identified the activities provision was lacking. The provider was in the process of recruiting an additional activities coordinator and developing existing staff.

● To improve community links and with the aim of organising community-based events, the provider had implemented a 'community engagement plan'. The regional director was monitoring the plan.

Working in partnership with others

● Staff worked with other agencies effectively. For example, people living with learning disabilities were supported by the local learning disability team and psychiatrists. One person with a learning disability had recently disclosed their wishes for their future, the manager shared this information with the person's social worker.

● During our inspection, we saw staff working with the local GP, Podiatrist and a member of the Speech and Language Therapy Team. One professional said, "The nurses seem very on the ball. They inform us quickly if they need advice and I know they're also very good at contacting the TVN team when needed." Comments from people included, "I feel safe; they (staff) are attentive, they arranged today for the doctor to come and examine me."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had a 'suggestions box' where visitors, relatives and people could post ideas, feedback and suggestions to help the service develop and improve. The service had recently completed a survey with people and their relatives and communicated their response with a 'you said, we did' feedback sheet. Most recently, work had been carried out to improve the garden and plans were in place for a monthly 'big bash' to celebrate peoples' birthdays.

● Staff had recently attended staff meetings where they had discussed changes to peoples' needs, risk levels and call-bell management.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager was aware of their responsibility to act openly and honestly when things went wrong. The manager said, "Being open, honest and transparent is important."