Mr & Mrs R S Rai

Kingsley Cottage

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

Kingsley Cottage is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Kingsley Cottage accommodates up to 17 people with bedrooms on the ground floor and first floor, which is accessible by a lift and stairway. At this inspection 17 people were living there.

Kingsley Cottage had a registered manager in post who was present during day one of this inspection's site visit but was not available on day two due to pre-planned annual leave. The registered provider was available and present during day two. 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.

Following our last inspection we published our report in November 2017. At that inspection we identified areas of improvement that needed to be made. These were in relation to the key questions, Effective, it was not evident how decisions were made with people, Responsive, people had differing experiences regarding social activities, and Well Led, the provider needed to embed their quality monitoring processes to ensure people received a "Good" service.

At this inspection we identified that improvements had been made regarding people's activities and social interactions. However, we found serious concerns regarding people's safety, care planning and medicines and improvements relating to decision making and quality monitoring were still needed.

In total, during this inspection, we identified four breaches of regulations. These were in relation to, unsafe care and treatment of people, people not having personalised care, ineffective quality assurance systems to identify improvements and the requirement to display the rating of the latest inspection.

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 provider and management team did not fully understand their requirements of registration with the Care Quality Commission in meeting the associated regulations. The provider and management team had been unable to achieve an overall "good" since March 2016 when we first inspected them using our current methodology. This is their fourth consecutive inspection where improvements have been required. They have repeatedly failed to act on areas of concern previously identified to them.

People were not safe as the provider failed to act on known areas of risk associated with the environment within which they lived. The provider had not embedded effective infection prevention and control practices. People did not always receive their medicines as prescribed.

It was not evident how decisions affecting people's care and support were made. The provider had not embedded the principles of the Mental Capacity Act 2005 into the assessment of people's needs putting their human rights at risk of abuse. People received assistance with food and fluids to maintain their well-being. When needed people had the assistance of community based healthcare professionals.

The provider could not assure us that people were involved in the decision-making process in relation to their care and support. People's protected characteristics, such as disability and sexuality, were not explored or promoted by the management team as part of their assessment process.

People were not involved in the development of their care and support plans. Care and support plans did not accurately and robustly reflect people's current care needs. There were no end of life care plans for people.

People took part in activities they found enjoyable and stimulating. People and relatives found the provider and management team approachable and interactive. People and relatives felt able to raise any concerns with the registered manager or the provider and were confident that they would be listened too. There were enough staff to meet people's needs and the provider followed safe recruitment practices. People received care and support from a compassionate and caring staff team. Families and friends felt welcome and could visit whenever they wanted.

You can see what action we told the provider to take at the back of the full version 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 safe?

Inadequate

The service was not safe.

Risks to the environment, where people lived, had not been assessed or action taken to reduce the possibility of harm. People did not have individual assessments of risk associated with their care. People did not always receive medicines as prescribed. The provider had not embedded effective infection prevention and control procedures.

People were protected from the risks of harm or abuse as the staff team knew how to recognise the signs and how to report concerns. The provider followed safe staff recruitment checks.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not protected and the provider failed to accurately apply the principles of the Mental Capacity Act 2005. The provider could not evidence that people were involved in decisions affecting their care and support. The environment required improvement to ensure people were safe and able to access all areas of the service.

People received assistance from staff members who felt well supported in their role. People received enough food and fluids to maintain good health. When needed people were referred onto community based health professionals promptly.

Is the service caring?

Requires Improvement

The service was not always caring.

People's protected characteristics, such as disability and sexuality, were not understood or promoted as part of the assessment of care and support.

People had their privacy and dignity respected by staff members. People felt valued by a kind and caring staff team. People were supported at times of upset. People were encouraged to maintain relationships that mattered to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not have access to relevant information to support their understanding about people's specific assessed needs. Care and support plans were not reviewed when changes to people's needs occurred. There was no end of life care plans for people when they were required. People did not have access to information in a format they could understand.

People and relatives knew how to raise concerns and the management team had systems in place to respond to any concerns or compliments raised with them.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's governance was ineffective to assess, monitor or drive improvements to ensure people received a safe and effective service. The provider did not fully understand the requirements of their registration. The provider failed to display their last inspection rating.

People and relatives found the provider and management team approachable. People were asked their views on the care and support but could not identify any changes made as a result of being asked their opinion.

Kingsley Cottage

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 checked 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 partly prompted by an incident which had a serious impact on a person using the service and that indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, which is subject to investigation, we did look at the associated risks.

The inspection site visit took place on 27 June and 05 July 2018 and was an unannounced comprehensive inspection. This inspection was completed by one Inspector.

Before our inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

We asked the local authority and Healthwatch for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

We spoke with three people, six relatives, the registered manager, the deputy manager, three staff members, the provider and two visiting healthcare professionals. We looked at the care and support plans for five people including assessments of risk and guidance for the use of medicines. We looked at any records of

quality checks and incident and accident reports. We further confirmed the recruitment details of two staff members.

Inadequate

Is the service safe?

Our findings

At the time of our last inspection in September 2017 the 'Safe' key question was rated as 'Good.' At this inspection we had serious concerns about the safety of the service and we have rated this key question as 'Inadequate.'

People were not safe from the risks of harm associated with receiving care and support at Kingsley Cottage. The provider and management team had ineffective systems in place to identify or respond to potential risks to people. We had been made aware of a serious accident within the service resulting in an injury to one person. The injury had occurred due to poor maintenance of the building. At this inspection we found that minimal action had been taken to improve the environment and people were still at risk of harm.

We checked throughout the building and identified a number of exposed hot pipes in people's bedrooms and communal areas putting them at risk from burns. We saw trip hazards had not been identified or corrected putting people at risk of falling and injury. Risk assessments had not been completed to mitigate the risks to people when external trade professionals were working within the building. We saw that the door into the boiler room had been propped open. This allowed people and visitors access to this potentially dangerous part of the building as it contained hot water pipes and systems.

The provider failed to identify the risk from "hot work". This is the process of using a naked flame at work, such as plumbing. At this inspection the fire alarms were activated as a result of such work taking place within the building resulting in staff members having to reassure people that they were alright and there was nothing to worry about.

We saw that people had individual assessments of risk associated with their care and support needs. These included mobility, skin integrity, diet and hydration. However, these were inconsistently applied and in some instances only partly completed. For example, we identified from one completed Waterlow assessment (The Waterlow score gives an estimated risk for the development of a pressure sore) that a person was identified as high risk. However, there was no corresponding preventive support plan in place to minimise the risk of harm for this person. This meant people were at risk of developing skin damage as a result of poor risk assessment and intervention.

We saw bed rail assessments had only been partly completed and the question regarding the need for in-fill wedges was missing. Infill wedges sit on the mattress against the side rails, reducing the gap between the mattress and side rails, helping to avoid entrapment. This put people at the risk of avoidable injury as a result of incomplete assessments of risk associated with their care and support. Despite our findings people we spoke with told us they felt safe living at Kingsley Cottage. One person said, "I have no concerns. Everything appears to be ok here." One relative said, "I don't worry about things here. Everything seems to be working fine and they (staff) look after [relative's name] well."

The provider had a fire risk assessment which was completed in February 2017. The provider told us there was no requirement for them to complete this yearly but acknowledged it should be reviewed regularly.

However, at this inspection they told us this review was out of date and there was no current plan to identify when this was to be completed. We identified two, out of the three exits from the conservatory, were blocked either by chairs or an air conditioner unit. This put people at risk of confinement with no effective means of escape during an emergency in this area. The provider told us this had never been identified as an issue in any of their assessments. However, they could not identify a safe escape route for people which did not involve returning to the main building.

We saw that some people had individual personal emergency evacuation plans in their personal file but not everyone. However, we did see information regarding the assistance people would need in the case of an evacuation was contained in an emergency "grab bag". We saw that the fire alarm systems and emergency lighting had been regularly serviced and no faults had been identified at the last check.

The provider had commissioned a contractor to complete a Legionella risk assessment aimed at the control of legionella bacteria. The purpose of carrying out a risk assessment is to identify and assess any risks in the water system and to protect people living at Kingsley Cottage. This assessment identified that the risk was medium and that this would reduce to low on the completion of the recommendations made. However, we asked the provider about what action they had taken since to reduce the risks to people in accordance with this assessment. The provider told us they completed water temperature checks but this was in order to identify if the thermostats were working and to minimise the risk of scalding. However, they had not completed any actions in relation to this specific piece of work or identified any timescales for reducing the risks to people. This put people at risk of contracting water borne diseases.

Incidents, accidents and dangerous occurrences were recorded. These were then looked at by the management team to identify any patterns which required additional support, or environmental adaptation, to minimise the risk of harm to people. However, we saw one person had fallen 17 times in the last 12 months. The majority of these falls had taken place in their bedroom. No assessment had been completed regarding this person's room to minimise the risks of falling or adapting their room to minimise the risk of injury. Following a fall in their bedroom this person was admitted to hospital as a result of the injuries sustained from a piece of equipment. It was following this injury that changes were made to their room. For example, a new radiator was provided. However, prior to the injury no preventative action was taken to identify or mitigate the risks from furniture or equipment in this person's room.

Despite the risk presented by the equipment the provider had not taken any action for a period of time, in excess of three months, to mitigate any risks to others in similar circumstances. The provider had failed to demonstrate learning from previous incidents and failed to take corrective action in other areas throughout the building. This put people at risk of harm as the provider had failed to act on risks which they knew about.

The provider told us that they were now in the process of replacing radiators and covering hot water pipes to minimise the risks to people. However, they were not able to tell us when this would be happening. At day two of this inspection we saw some radiators were being replaced but not all those that presented a risk to people. We asked the provider why and they were not able to identify where their priorities were in terms of replacements or why some were being replaced whilst others were not. One staff member told us, "We keep reporting repairs and concerns but they never seem to be done. It is frustrating that there is no plan to repair things here."

The provider had not embedded effective infection prevention and control practices at Kingsley Cottage. For example, we saw the radiator in the staff toilet was extensively rusted preventing effective cleaning. Pull cords in the toilet and bathroom were stained and were not suitable for effective cleaning. Access to the

hand washing facilities in the staff toilet was prevented by the storage of wheelchairs and a commode. This hampered staff member's attempts to wash their hands and follow effective preventative practices. In the communal areas we saw side tables had evidence of water ingress leading to bobbling of the surface preventing effective cleaning. We asked the registered manager if they had an infection prevention and control lead. They said they didn't. We sought clarity from the provider regarding the lead role and they believed the registered manager was this lead. The lack of clarity regarding roles and ineffective infection prevention and control practice put people at risk of contracting preventable illnesses.

Despite people telling us they were happy with how they received their medicines they did not always safely receive them as prescribed. We saw that there was not a detailed care and support plan for people who received time specific medicines. We looked at one person's medicine administration records (MARS). This identified that they should receive a specific medicine for a period of five days. However, the records we looked at indicated that they had received this for a total of 13 days. Neither the provider nor the deputy manager could account for this deviation from the instructions of the prescriber. We asked the deputy manager to contact the GP to confirm that this person was safe and that there were no concerns following this potential overdose pending an internal investigation by Kingsley Cottage. Despite there being internal quality checks for the safe administration of medicines they had failed to identify this potential error or safeguard people from such mistakes.

We saw staff members supporting people with their medicines by asking them if they wanted them and assisting them in a way they preferred. For example, some people preferred to take their medicines from a spoon rather than from a pot. Staff members we spoke with told us they had received training in the safe administration of medicines and that they had been assessed as competent before they were able to support people. However, despite this training, and clear instructions on the medicines record, multiple staff members provided medicine for one person against the instructions provided. This meant people were at risk of receiving unsafe support with their medicines.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of abuse. One person said, "They (staff) are fine. I have no concerns about any of them." The staff members we spoke with told us they had received training on how to recognise and respond to the signs of abuse. One staff member said, "I would report anything to the manager straight away." Staff members we spoke with were aware of how to report abuse and to whom. This included reporting concerns outside of Kingsley Cottage if needed. For example, to the local authority or the police. We saw the registered manager had made appropriate notifications to the local authority to keep people safe.

The provider followed safe recruitment processes when employing new staff members. As part of their recruitment process the provider completed a check with the Disclosure and Barring Service (DBS). The (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with others. In addition, the provider gained references regarding the suitability of prospective employees. The provider used this information to assist them in making safe recruitment decisions.

We saw, and people told us, that there were enough staff to safely support them in a way they wanted. One relative told us, "They (staff) are always there for [relative's name]. They never have to wait and are happy and interactive. I know they can get busy at times but doesn't everyone. However, this never shows and I know [relatives name] gets the care they need when they need it." The staff members we spoke with told us they believed there were enough staff to safely support people.

Requires Improvement

Is the service effective?

Our findings

At the time of our last inspection in September 2017 the 'Effective' key question was rated as 'Requires Improvement.' At that inspection we found concerns with the application of the Mental Capacity Act 2015. At this inspection improvements were still required.

We looked at how people's individual rights were protected. 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 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.

We looked at the bed rail assessment for one person. The decision had been made for them but there was no assessment of capacity which was specific to this issue. We asked the staff member and they told us the person could decide for themselves. In such instances the person's wishes should be recorded and no one else would have the authority to make such a decision for them.

The registered manager told us one person had a lasting power of attorney (LPA) in place authorising another person to make decision in their best interest. However, when we looked at this document there was no indication if this had been registered or if it related to the person living at Kingsley Cottage as it had no name on it. It was incomplete and without the appropriate security features. The registered manager could not assure us that they understood the LPA process and did not recognise significant details were missing, not least the person's name, from the document. The provider's, and the management teams, lack of accurate application of the MCA principles put people at risk of not having their rights maintained.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had not properly trained and prepared all their staff in understanding the requirements of the MCA. The provider's policies and procedures were not followed meaning that people did not have maximum control over their lives. At this inspection the provider could not assure us that people's human rights were being maintained. For example, we asked one staff member who was currently subject to an authorised DoLS. We were told the names of two people and their individual files had a visual indication on them informing staff they were subject to an authorised DoLS.

When we looked through the files it was apparent that these people had the mental capacity to make decisions for themselves. The staff member we spoke with confirmed they had decision making ability. We spoke with one person and it was clear they could retain information and communicate their decisions to us and that they did not have any impairment which would affect their cognitive abilities. This person went on to say that they were not restricted in any way and could go out if they wanted. This was confirmed by the staff we spoke with. The assessment, referral for a DoLS authorisation and the indicators on these people's

files were inaccurate and did not reflect their current situation.

As we could not be assured that these people were correctly being deprived of their liberty we requested that checks were made with the authorising authority. They confirmed that these two people were not subject to DoLS. We checked the assessments of those who were identified by the authorising authority and their files were correctly marked. However, we looked at one which did not contain the relevant authorised documentation. The initial application was made in 2016 and would have been for a period of 12 months. The provider could not demonstrate that there was a process in place for re-applying for DoLS authorisation or for complying with any recommendations made. This meant that people were at risk of not having their rights protected.

Despite the direct care staff members having a good understanding of the Mental Capacity Act 2005 those completing the assessments of capacity and subsequent DoLS applications did not accurately apply the principles of the Act to protect people's rights. The inaccurate recording and flawed assessments of people's capacity put them at risk of their rights being abused. one staff member said, "If someone wanted to go out and do something we would support them and not just say no."

We saw there was contradiction in what was recorded in people's care and support plans and what they experienced at Kingsley Cottage. For example, despite the inconsistent and wrongly applied principles of the MCA people were supported to have choice and to retain control over their day to day lives by those supporting them. We saw people made decisions about what they wanted to do, where they wanted to go, what they wanted to eat and what care and support they wanted at any given time. For example, we saw one staff member asking what someone would like for lunch. The person appeared to be distracted. The staff member adapted their approach. They crouched down beside them, gently touched their arm to focus their attention and, once the person was engaged, asked them again. The person was not in a position to answer at that time so the staff member returned later and the person was able to make a definite decision. This showed staff members had a good understanding of the decision-making abilities of those they supported albeit this was not supported by people's care and support plans. This put people at risk of receiving inconsistent care and support from staff members.

Family members we spoke with described the physical environment at Kingsley Cottage as "homely." Kingsley Cottage was not a purpose-built establishment but had been adapted to accommodate people with care and support needs. However, not all areas were easily accessible for people. For example, we saw one person being assisted with a wheelchair through a corridor into a toilet. The staff member had to lift the rear wheels of the chair to manoeuvre around a tight corner putting the person at risk of falling. We saw the slope from the lounge into the dining area was poorly defined as was the slope from one corridor into the lounge. Neither sloping area had been highlighted to those with visual impairments which meant people were at risk of trips or falls.

Staff members told us they were supported in their role by the management team which included taking part in regular supervision sessions. A supervision is a one-on-one discussion with a senior staff member. It is during these discussions that issues relating to their employment and those they support can be had. Areas of concerns can be raised and actions identified to increase staff members skills and confidence. One staff member said, "They (management team) are approachable and I can go to them at any time and discuss anything." Although people were supported by staff members who felt suitably supported in their role the management team demonstrated gaps in their knowledge to us during this inspection. For example, incomplete risk assessments and the poorly applied MCA principles. This means that the management team were not in an informed position to effectively instruct staff members in their best practice.

Despite the gaps in the providers and management team's knowledge, people told us they received care and support from a trained and competent direct care staff team. One person told us, "All the staff seem to be knowledgeable." One relative told us they believed the staff members to be competent and skilled at what they do. They went on to say, "It is clear they (staff) have received training." Staff members told us they had received training suitable to the work they completed. One staff member said, "I completed my adult safeguarding training recently as well as my moving and handling." Another staff member said, "I completed training on how to safely support people whilst using the hoist. I was assessed as competent before I could support anyone." Staff members new to working at Kingsley Cottage undertook a structured induction to their work. This included working alongside other staff members in order to be introduced to people and to understand how to support them. The provider told us that staff members who had not previously worked in care were supported to complete the care certificate. The care certificate is a nationally recognised qualification in social care.

People told us they liked the food they were given and that they had a choice. One person described the food as, "Homely." Another person told us, "It's good old-fashioned cooking, just like mother's." We saw people had a choice of food and could make decisions about what they wanted. Should someone not want what was on offer they had the choice of alternatives which would be made by the kitchen staff. People had adapted cutlery if needed to assist with eating and any additional support was highlighted in people's care and support plans. For example, we saw one person was living with a weakness to one side of their body. The recommendation was for food to be cut and moved to a specific part of their plate. We saw this person's food was provided as instructed and they remained independent whilst eating.

Specific diets were catered for including soft or diabetic diets. Staff members, including the catering staff, knew people's individual dietary requirements and personal likes and dislikes. During this inspection the region was experiencing very high temperatures. We saw people had regular access to drinks to prevent dehydration. When it was required people were regularly weighed to identify any unexplained or unplanned weight loss and referrals were made to the district nurse team or to the doctors for advice and guidance. People received support with their food and fluids to maintain a healthy lifestyle.

People had access to healthcare services when they needed it. These included GP and district nurses and specialists regarding eating and drinking. One visiting professional told us, "We, as a team, have no concerns about (Kingsley Cottage). All the staff here follow our instructions and give us up to date information if we need it." Another visiting professional said, "The staff are knowledgeable about those they support and can give me clear information I need to make an accurate assessment."

Requires Improvement

Is the service caring?

Our findings

At the time of our last inspection in September 2017 the 'Caring' key question was rated as 'Good.' At this inspection we rated this key question as 'Requires Improvement'.

Staff members were not provided with the information they required, by the management team, to be able to support people with compassion and in a personal way. For example, at the end of life. This was because the management team did not complete comprehensive care plans for those they supported. We explored this further with staff members we spoke with. They could not describe people's individual preferences at such a time. Because people's individual preferences were not recorded they were at risk of not receiving the care and support they needed at the end of their life and risked having their wishes and preferences not being fulfilled.

We asked the registered manager how they assess and support people and staff regarding their protected characteristics. This included people's ethnicity, religion, sexuality, disability etc. We saw a record had been made regarding people's religious preferences but the one person who had a recorded religion had made the decision not to practice any specific faith. It was recorded that they did take part in specific religious celebrations at certain times of the year. People did not have assessment of care and support in relation to other areas of their life, for example, ethnicity or sexuality. This meant they were at risk of not having these specific needs met.

The provider and management team did not seek accessible ways to communicate with people with communication and sensory difficulties. For example, someone with a visual impairment had not been provided with information regarding their care and support, in an accessible format. This means that people were at risk of not being supported in a way that met their individual protected characteristics as their needs had not been fully assessed and plans introduced to remove any barriers.

The care and support plans we looked at contained confusing and contradicting information regarding people's individual decision making. This means that the information to staff members was inconsistent and that people may not be fully involved in making choices and decisions.

People described the staff members supporting them as, "Lovely," "Kind," and "Wonderful." One relative told us, "The staff here are all lovely. They not only support [relative's name] but they support us all as a family. We are made to feel welcome and we are never made to feel like we are in the way. It is nice and homely and this is just what [relative's name] wants at this time of life."

Staff members we spoke with could tell us about those they supported. This included people's life histories, where they used to live, what they used to do and what they still liked doing. For example, one person liked a specific type of music. We saw a staff member supported this person with their choice of music and spent time with them dancing. Staff member's we spoke with talked about those they supported with respect and fondness.

People were supported to maintain relationships with those that matter to them. We saw friends and families coming in and visiting people throughout this inspection. Private areas were available for people to spend time together when needed or requested. All those that we spoke with told us that their friends and families could visit at any time they wanted and without any restrictions. One relative said, "I can come and spend time whenever I can. It is lovely and we are made to feel welcome here. Everyone seems that they are pleased to see us which is so nice." We saw information was available for people and families to seek the assistance of an advocate if it was required.

People were supported by staff members in a way that reduced their anxiety and worry. We saw one person become upset. A staff member quickly responded to this person and spoke with them about what was concerning them. The person could describe to the staff member their concerns. The staff member did not automatically attempt to rectify the situation for the person but asked them what they would like them to do. The person thought about it before responding, "Nothing, I am alright." This enabled the person to talk about their concerns and to decide about the possible course of action. Although this resulted in the staff member doing nothing about it the person was in a position to make that decision. The person visually appeared to relax after talking with this staff member.

People told us they were encouraged to do what they could with the assistance of staff members which promoted their independence. One person said, "I can still do almost everything for myself. I just need a bit of a nudge sometimes and they (staff) are always there as my safety net." One visiting professional told us, "Something that impressed me was that the staff did not go for the easy option when supporting someone. They instead encouraged this person to walk to a different part of the building and supported them along the way. This helped the person's independence and recovery."

People told us their privacy and dignity was respected by the staff members supporting them. One person said, "I like to do what I can for myself and if needed they (staff) come to my room and help me out." Those we spoke with believed they were treated in a way that supported their privacy and respected their dignity. One relative said, "I have never seen anything which I would think is a concern. They treat [relative's name] with the utmost respect and dignity. I wouldn't have it any other way."

We saw information which was confidential to the individual was kept securely in the office and only accessed by those with authority to do so. When people had the authority to access people's information this was provided in a private and confidential area.

Requires Improvement

Is the service responsive?

Our findings

At the time of our last inspection in September 2017 the 'Responsive' key question was rated as 'Requires improvement.' At this inspection we rated this key question as still 'Requires Improvement'.

At the time of this inspection's site visits we were told by the registered manager that there were two people receiving end of life care. We asked the registered manager and the deputy manager to see the end of life care and support plans for these people. What we saw were entries in the care and support plan's which just read "end of life." There was no specific plan for supporting these people in their final months of life. The registered manager told us they could contact the local Hospice or a national palliative care charity for advice. However, there was no indication that they had done so in these instances. The management team could not assure us that they were meeting the needs of those at the end of their lives. One relative told us, "I think [relative's name] is looked after here and is comfortable which is the main thing." Another relative told us they had initially spoken with the registered manager when their family member first moved into Kingsley Cottage. However, they went on to say that they don't recall reading a care and support plan. The staff members we spoke with could not tell us about people's individual preferences for their end of life care.

Generally, people's care was delivered to meet their individual needs. Staff were able to tell us about those they supported and demonstrated a good understanding of people's needs and preferences. However, this was not clearly reflected in the care and support plans that we looked at. Care plans lacked basic information and there was a lack of any evidence of the involvement of people and, if required, their families. It was difficult to determine the current and most up to date needs of people, due to the way care plans had been completed. Staff members we spoke with had difficulty identifying the location of key pieces of information which should be in the care plans. For example, we asked to see one person's assessment for falls prevention. This could not be found. In addition, we could not locate a care plan to mitigate the risk of skin deterioration for one person who was identified as being at high risk. We asked the registered manager about these concerns. They could not explain why there were no specific care and support plans when a need had been identified.

When information was provided this was sometimes contradictory and confusing. For example, we saw one person's care and support plan directed staff members to contact a named family member regarding important decisions. However, we later saw a direction to staff members not to contact this family member. The care and support plans we saw did not present a clear and up to date instruction to staff members in order for them to consistently support people with their needs.

We found guidance provided by healthcare professionals regarding people's care. This information was recorded in the record of professional's visits. For example, guidance on the recording of people's blood sugar levels. However, this information was not recorded in a clear and accessible format for staff members to follow. The registered manager told us they needed to spend time and review everyone's care plan to get them up to date and organised. People were at risk of not receiving care and support which met their current needs owing to poor care planning and reviews.

At this inspection Kingsley Cottage was providing support for those experiencing hearing loss, sight loss and those living with dementia. We saw information was available to staff members on their communication needs. However, this was non-specific and did not give clear guidance as outlined in the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. For example, there was no indication that information regarding people's care was available in large print for those with impaired sight. People we spoke with told us they had not seen their care and support plans and did not know what had been written about them. This meant people, supported by Kingsley Cottage, with a disability or sensory impairment were not given information in a way they could access or understand.

These concerns were a Breach of Regulation 9: Person-centred care, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw information had been provided informing staff members about people's life histories. These included where they grew up, where they went to school and what they did for a living. One person said, "We (they and staff member's) are always having a chat. We talk about all sorts." We saw staff members chatting with people about things they knew they would be interested in. This included families and differing taste in music. The staff we spoke with knew those they supported well. Relatives told us, and we saw, the staff members were interactive with them and their family members.

People were involved in activities they found enjoyable and stimulating. Throughout this inspection we saw people engaged in music and movement, singing and crafts. People told us they regularly went out to places of interest and attended in house entertainment which included exotic animals and singers.

All the relatives we spoke with told us they received information from Kingsley Cottage regarding any changes in the health and well-being of their family members. One relative said, "I will get a call every time there is a change. I have confidence in them (staff) to let me know if there is something up. I would hate to think I have missed something and I wasn't there for [relative's name]." We saw records of communication with families and any involved healthcare professionals. This meant relevant information concerning people was passed appropriately to those who required it.

People, and visitors, we spoke with told us they had the information they needed should they need to express a concern or make a complaint. One person said, "I don't have any worries at all. If I did I would just speak up and it would be OK." One relative said, "I have never needed to raise any concerns. I can talk to anyone from [provider's name] to [registered manager's name] or just about anyone. Everyone is receptive and we all work together." We saw information was available in communal areas for people to refer to if they needed to make a complaint. However, this information was not in an accessible format for people with sensory impairments. The registered manager and provider had systems in place to receive and respond to complaints.

Inadequate

Is the service well-led?

Our findings

At the time of our last inspection in September 2017 the 'Well-led' key question was rated as 'Requires improvement.' At this inspection we had concerns about the overall management of the service and we rated this key question as 'Inadequate'. The provider and management team had failed to meet the required standards and achieve a rating of 'good' over the previous three inspections and sustain improvements that they had previously made.

Management and governance systems were not effective. There was no clear policy or strategy in relation to the effective monitoring of the quality and safety of services by both the provider and the registered manager. There was no clear strategy for ensuring the environment was safe or that people received care and support that reflected their current needs.

People were at risk of injury as a result of a poorly maintained environment and the lack of pro-active and preventative action by the provider regarding known risks. For example, at this inspection's site visit we saw the boiler room's door was unlocked and propped open by a bin. This exposed people and staff members to the risk of entering a room with exposed heating pipes. As the door was propped open there was the risk of the spread of fire from this area. We asked the provider about this. They told us they knew about it and the room keeps overheating and setting off the alarms. They went on to say they were waiting for vents to be fitted to the door. We reported concerns regarding this room to the provider following a previous inspection in February 2017. However, they have yet to take any action to reduce the risk of harm to people. This meant people were not protected from harm because effective systems were not in place to mitigate risks.

The provider and management team failed to identify learning from previous serious incidents and failed to act to reduce the potential for reoccurrence. For example, following a serious injury incident the provider had failed to take corrective action in other areas of Kingsley Cottage for a significant period. They did not complete an environment risk assessment regarding known risks and they did not have a plan of action to make the necessary changes to reduce the potential for harm.

We saw some quality monitoring checks were completed by the management team including mattress checks and medicine audits. However, these checks failed to highlight the potentially serious medicines error that we found at this inspection.

There was no assessment of the care and support plans to ensure they met people's current needs. For example, there were no end of life care plans and staff were unaware of people's needs in relation to their mental capacity and the decisions they could make. The checks to the environment failed to identify the risks to people and the provider did not have a plan of action to address issues when they were highlighted to them. For example, they did not have an action plan in place to mitigate the risks to people regarding Legionnaires disease despite being informed what to do to reduce or remove the risks to people.

Staff members we spoke with told us they felt supported and that they could approach any of the management team at any time for advice and guidance. One staff member said, "We have regular staff

meetings and can say what we want especially if it concerns those living here. However, when we talk about the environment and repairs it is like banging your head against a wall as no one seems to be doing anything." This meant that when concerns were raised action, was not taken in to keep people safe.

These issues constitute a breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and registered manager did not fully understand the requirement of their registration with the Care Quality Commission. At this inspection the provider was displaying an inaccurate rating of their previous inspection. The rating on display was from a report published in March 2017. However, our latest inspection report was published in November 2017. They are required by law to display the most up to date rating.

This was a breach of Regulation 20A: Requirement as to display of performance assessments, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us they knew who the management team were and that they saw them regularly. Throughout this inspection we saw the provider, registered manager and deputy manager supporting people, chatting with them and generally spending time with them. All those we spoke with told us they felt valued by the management team and the provider. We asked people and relatives if they are asked about the service that is provided by Kingsley Cottage. None of those living there could recall being asked but a couple of relatives told us they had completed satisfaction surveys given out by the provider. Neither of those we spoke with had any concerns or recommendations. However, both told us they had not seen a response from these surveys and didn't know what had happened to the answers they gave.

We asked staff members about the values and ethos of Kingsley Cottage. Those we spoke with told us it was about creating a homely environment for people where they could relax. People, and relatives, we spoke with believed the staff and management team reflected these values when supporting them and their family members.

Staff members we spoke with told us they felt happy to question practice and to raise concerns if they needed. They felt they would be supported, by policies such as the whistleblowing policy, if they needed it. However, they had raised concerns regarding the environment which had not been acted on.

At this inspection there was a registered manager in post. The registered manager had appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale.

The provider had established working links with the local community, other healthcare professionals, and community services providing support for people. These included, GP, district nurses and specialist health professionals. People living at Kingsley Cottage benefited from these established links as they had good access to these services.