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Kingsgate Residential Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We inspected Kingsgate Residential Home on the 18 November 2014. This was an unannounced inspection.

Kingsgate Residential Home provides care for up to 33 older people who require nursing or personal care. The home was fully occupied when we inspected.

At the time of the inspection the home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The DoLS are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice.

Summary of findings

We looked at whether the service was applying the DoLS appropriately. These safeguards protect the rights of adults using the services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The registered manager told us there was no-one in the home who was subject to a DoLS restriction.

People we spoke with were able to tell us how and why they felt safe living in the home. Staff were able to identify the different types of abuse, what they would do if they felt abuse was happening. Staff had recently received training in equality and diversity which helped them identify anyone who might be at risk of having their personal preferences abused or ignored, and what they should do about it.

There were enough staff on duty day and night to make sure people's needs were met in a safe and timely way.

Medication was administered in a safe and appropriate way. We found no issues with either the administration or recording of medicines taken.

People living in the home were confident in the way that staff cared for them. Staff knew the people they cared for and were able to meet their needs. People were treated with respect and that their dignity was upheld at all times.

The provider had a thorough and tested induction period before staff were allowed to work alone. Relevant training and refresher and optional training took place across a broad range of training needs. Staff were encouraged to work towards National Vocational Qualifications (NVQ's).

People were supported to have enough to eat and drink. We found that mealtimes were pleasant and that people were appropriately supported and had choices available with regard to what they chose to eat and where to eat.

People's health and social needs were met in a timely way. Direct links with the GP practice and district nurses resulted in any medical needs being met in a timely and professional way. Regular visits by chiropody and physiotherapy services took place and people's personal preferences for dental treatment were respected where possible.

The choices, likes and dislikes of people living in the home were documented, listened to, discussed with all concerned and acted on by all staff if appropriate. People were supported to carry out their wishes and desires and if this was not possible alternatives were discussed and agreed.

Whilst regular activities took place in the home, management were committed to improving this experience so that everyone could benefit in their own individual way.

At the time of the inspection there were no complaints logged or outstanding. Both staff and people living in the home knew how to make complaints.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Systems and checks were in place to ensure that risks were assessed.

Staff had received training about how to prevent abuse and knew how to make the appropriate referrals if they had concerns.

Medicines were administered appropriately.

Good

Is the service effective?
The service was effective.

Staff were well trained and knowledgeable about how to meet people's individual needs.

The manager was aware of their responsibilities regarding Deprivation of Liberties Safeguards (DoLS) and all staff had received training in the Mental Capacity Act 2005 (MCA).

Good

Is the service caring?
The service was caring.

All interactions we observed were carried out in a caring and compassionate way. Staff were polite, gentle and took time to listen or explain things.

People living in the home could be confident that their needs would be met and that they would be treated with respect and dignity.

Good

Is the service responsive?
The service was responsive.

People were involved in planning care that was centred around their individual needs.

People who lived in the service were aware of the complaints policy and how to raise any concerns about their care.

Good

Is the service well-led?
The service was well led.

Core standards of care were enriched by the home's commitment to continuous improvement.

There were structured and robust training and assessments of staff in place and this was combined with supportive management processes.

The provider had a system in place to audit and quality assure all aspects of the service provision.

Good

Kingsgate Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 November 2014 and was unannounced. One adult social care inspector carried out this inspection.

Prior to the inspection we reviewed all information we held about the provider, including safeguarding notifications, and any complaints received. A provider information return (PIR) had been received from the provider at the time of the inspection. 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.

During this inspection we spoke with the owners, the registered manager, six people living in the home, two family members and three members of staff. We looked at four care records and three medication records. We also reviewed management records for the home. We made enquiries of the local authority about the home and were assured that they had no concerns.

Good

Is the service safe?

Our findings

People living at Kingsgate Residential Home were kept safe from the risk of avoidable harm. One person told us, "Staff make sure I know about risks such as making sure I use my walking frame to get around. And they remind me about putting my slippers on properly, so I don't trip myself up." This person went on to say, "I have lived here a very long time. If I didn't feel safe and looked after then I wouldn't have stayed. It's as simple as that really."

People living in the home also told us what they would do if they felt they were being abused, physically or emotionally, or if they felt their human rights were being breached.

We discussed with staff how they identified and reported any safeguarding concerns they may have. They explained to us the circumstances under which they would report incidents relating to safeguarding concerns, abuse or potential breaches of human rights. Staff knew who to report any concerns to, how to respond to any allegations of abuse or other serious incidents and what to expect as a result of reporting any such concerns. Staff also undertook regular training relevant to keeping people safe and free from harm. This knowledge helped reduce the potential risk of abuse for people living in the home. Staff also told us what they would do and who they would go to if they did not wish to discuss things which concerned them with the provider or registered manager.

The provider and registered manager ensured the premises were well maintained and kept clean and tidy. Maintenance of the building and equipment used was checked regularly and any works carried out or equipment repaired or replaced. Where necessary the provider took immediate action to call in external experts if required. They also had appropriate risk management policies and procedures in place to support keeping people safe and free from harm.

There were emergency plans in place which covered things such as what to do in case of emergencies such as fire or dangerous hazards. Staff were trained in what to do and who to contact in case of emergencies and training was regularly refreshed and updated. Business contingency plans were in place which would help ensure people were kept safe in an emergency situation.

When people were first admitted to the home their needs were assessed. One of the assessments used is known as a risk assessment and forms part of the person's care plan. Risk assessments included, for example, assessing whether a person was at risk of falling, how they should be moved and whether they were at risk of developing pressure sores. These risk assessments formed part of the person's agreed care plan. They also included any community nursing or other therapeutic services required. All were reviewed regularly or as and when needed and included discussions and decisions made with all parties concerned.

The registered manager told us that staffing levels were always above the number needed to meet people's needs. We checked and confirmed this by looking at previous and planned staff duty rosters. We observed that staff were not pressured or rushed to make sure people's care was delivered in a safe and timely way.

We observed the medication round over the lunchtime period. We particularly noted how the medications were dispensed, offered and taken. People's identity was checked prior to dispensing and they were asked if they knew what the medication was for. Where people did not know, or could not remember, they were reminded. One person living in the home was able to describe their medicines to us. They could also tell us exactly what their medicines were for, how they should be taken and what likely side effects might be. They also told us that they would tell staff immediately if they felt unwell after taking medicines. Medicines were stored in a locked trolley which itself was locked away when not in use.

Medication training for staff was up to date at July 2014. Staff handled and dispensed medications safely and confidently. Regular medication audits took place and staff received additional training in supplier dosage systems.

One person receiving their medication after lunch was able to self-administer with a small amount of prompting. This demonstrated that the provider took steps to ensure people's independence, including the management of their conditions, was encouraged and supported where possible.

We reviewed three people's medicines administration records (MAR) charts. Medication was dispensed on time. Where a person had refused their medication this was noted with the reason why. People were later asked if they would like to take their medication. If medication refusal continued there was a policy of contacting the dispensing agent or doctor for advice.

Good

Is the service effective?

Our findings

People living in the home told us that they believed staff knew them well. One person we spoke with, who had lived at the home for a long time, told us, "I feel as if they know me very well. That's very comforting. This place really is my home."

Staff demonstrated a good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were also able to tell us about recent MCA and DoLS refresher training they had undertaken. At the time of the inspection no-one living in the home was subject to a DoLS application. This is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests.

Lunch could be eaten either in the dining room or in individual rooms. We noted a varied menu was available with plenty of choice including vegetarian options. Hot and cold drinks were available. Where people were assisted to eat their meals this was done sympathetically and carefully. For example, people were asked first if they needed assistance with eating or with cutting their food. Staff encouraged conversation across the table and between people eating and staff. We noted that where required people had access to dietary and nutritional specialists. Where a GP or Speech and Language Therapist had recommended thickened fluids or pureed foods these were given as required.

Hot and cold drinks were available at all times during the inspection and a drinks trolley was taken around three times during the day with biscuits or cake available. Hot drinks were offered at supper time. We noted that visitors were offered a hot or cold drink on arrival.

We asked people living in the home how frequently they saw a doctor, chiropodist or a nurse. They all informed us that access to health care professionals was provided in a timely manner. They added that they rarely waited more than two days to see a doctor if they needed one.

A rigorous induction and training programme was in place and this was reflected in the knowledge base of staff working in the home. The ongoing training and learning philosophy within the home was enhanced by regular quizzes which staff took part in and which followed time to read and understand the home's, 'seven standards of care'. These standards related to job roles, personal development, communication, equality and inclusion, duty of care, principles of safeguarding and person centred care. Staff were actively encouraged to work towards National Vocational Qualifications (NVQ) in care levels 1 to 4.

One member of staff we spoke with told us how they had benefited from receiving training in first aid. They added that they were now confident that they could identify a potential fractured hip by looking at the position of the leg and would know what to do, or not what to do, depending upon the circumstances. This meant that this member of staff could act in an appropriate and effective way should this circumstance happen.

Good

Is the service caring?

Our findings

Family members of people living in the home provided us with an insight into how they valued their family member's care at Kingsgate Residential Home. One family member told us, "They made both [my relative] and us, the family, feel immediately welcomed."

Another person said, "[My Relative] likes routine, that's important to them. Their health has improved so much since being here that they have put on a good amount of weight and look really well as a consequence. I have absolutely no concerns here. None at all."

We observed that care staff addressed people living in the home in the way they preferred to be addressed. We also observed that staff explained what would happen next and asked for consent before carrying out any interactions with people living in the home. For example, one member of staff explained that lunch was finished. They asked the person they were talking to whether they wished to go to the lounge or their room. This was rather than assume that this was what wanted to do. We observed this sort of polite interaction throughout the inspection.

When speaking with staff about people in their care, we were provided with in-depth knowledge, genuine understanding of, and fondness for, people living in the home. For example, one member of staff told us, "[The person] has good and bad days. On a bad day they like to have a day in bed. We check on them regularly but not so as to be a nuisance. We always make time for a chat too. That's so important, and we can do it here because staff numbers allow it."

People living in the home were supported to make decisions for themselves. We also saw that some people living in the home were encouraged to be independent. This included encouraging people to continue to carry out small tasks. These tasks could be laying tables, clearing up after lunch and helping people less able than themselves. We spoke with one person who told us, "It's important to me that I can carry on doing things for myself for as long as I can. I know they keep an eye on me but it's good of them to let me carry on." Another person living in the home told us, "Some staff are very good indeed. They always explain things to you."

During the inspection we saw the registered manager assist one person struggling with memory issues. The person concerned was becoming distressed at not being able to remember something important to them. The registered manager spoke in a quiet, calm manner and encouraged them to breathe slowly and take their time. Throughout this interaction the registered manager dealt compassionately and professionally with the person concerned. We saw similar instances of such care throughout the day. No-one was rushed. We saw staff deal with a potential disagreement between two people living in the home in a respectful and caring way and which left all parties happy with the outcome.

All the people living in the home that we spoke with told us that they were treated with respect and that their dignity was upheld at all times. This was confirmed by family members visiting during the inspection. Family members confirmed the 'open door' policy of the home and that they were free to visit their family as and when they wished.

Staff were able to explain to us what privacy, dignity and respect meant to them and how they interpreted it and applied it in working practice. For example one staff member we spoke with told us how one person living in the home preferred to have their door open at all times except when they were receiving personal care when the door was closed. We spoke with the person concerned who told us, "Yes, I do like the door to be open if possible. I like to see people coming and going. Also if I need something I can easily attract staff's attention if the door is open." We asked this person what they would do if the door was closed accidently. They told us they would use the call bell system adding that they were confident it would be responded to promptly.

Good

Is the service responsive?

Our findings

Throughout the inspection we saw how choice, preferences, cultural and social needs were offered and managed. This included such things as what to wear, when and where to eat, where to sit and whether a person preferred to spend time alone or to socialise with others. We found that care plans supported the practices we saw carried out throughout the inspection. For example, one person's daily routine was recorded as liking to go straight to a particular lounge after lunch, to a particular seat. The care plan also detailed what to do if this seat was taken by another person. Staff were aware of what to do if such circumstances arose and the required approach to be used.

We saw that people had been involved in planning their care wherever possible. Where this was not possible every effort had been made to involve family or friends and other relevant health and social care professionals. These reviews of care plans and risk assessments took place every six months or sooner if required.

Each care plan we looked at had a document in it called "Remember List". This was stored at the front of the care plan and detailed things that were important to people and which staff should remember to do, or not do, each time they carried out personal care. For example, whether a person liked to go to bed at a certain time, what they preferred to have as their last drink of the evening and whether they wanted particular assistance with personal care.

Recent training in equality and diversity had taken place in the home. Staff explained to us how this helped them to understand how people's choices and rights could be upheld. They also told us how the training had assisted them in identifying potential social isolation and what they could do about it.

We found a regular programme of activities in place. These included art, religious services, and music for health. However, the registered manager was in the process of discussing and developing a more tailored one-to-one programme of stimulation, engagement and interaction. These discussions were to take place with people living in the home and where possible family members, friends and staff.

Some people living in the home enjoyed regular outings, either alone or with family or friends. One person we spoke with said, "I get out most days. Sometimes I go alone and sometimes with a family member. I enjoy the walk. Of course they know when I go out and who with and they always check I'm okay when I get back." Other people we spoke with told us they were satisfied that their needs and interests were met and suited their individual requirements.

Meetings of people living in the home and their family members took place regularly. Feedback and learning from these meetings was also shared with staff. The provider and registered manager welcomed views and opinions about how to improve services. One item being taken forward was the review of hobbies and interests and how these could be woven into every day care and practice.

People living in the home, family members and others involved in the provision of health and social care were invited to comment, raise a concern or make a complaint. The 'open door' policy of "discussion first" meant that no complaints had been made at the time of the inspection. There were no outstanding or unresolved complaints. People living in the home were aware of how to make a complaint should they need to. They told us if they were unhappy about anything they would speak to the registered manager first. They told us they were aware of the complaints process and that there were posters about complaints around the building. Visitors also told us that they would speak to the registered manager first but that they too had seen the posters. They added that making complaints was also covered in the brochure they were given when their family member was admitted to the home.

Staff were aware of how to make or respond to complaints appropriately. Staff also told us where the complaints policy and procedures were kept and where notices about how to make complaints were placed in the home. One family member told us, "I know how I would make a complaint, if I needed to. But to be honest, there is nothing to complain about. [My relative] is content and well looked after and I would know if something wasn't right and if that was so, then I would discuss with [the registered manager]".

Good

Is the service well-led?

Our findings

One person living in the home, when asked if they would recommend the home said, “Too late, I’ve already done that. Twice.” This was confirmed by a family member visiting at the time.

Kingsgate Residential Home had a registered manager and provider who were approachable and knowledgeable about the people in their care. People living in the home and staff told us that the culture in the home was excellent. One person told us, “We are always asked our opinion about things. Of course sometimes it’s worthwhile but other times, well, I’m just not interested. I know they will do what’s best for me and I am satisfied with that.” The ‘open door’ policy of the home meant that anyone living in the home, family members and staff could discuss openly their views or requirements with the registered manager.

Regular meetings between staff, management, people living in the home and family members took place. Feedback from minutes was shared and people were free to make suggestions to improve the service both informally and formally. The management team took learning not just informally through everyday living in the home but also formally via meetings, training and supervision feedback.

A ‘Mission Statement’ underpinned the homes management style of being “homely, safe, meeting personal needs, emotional needs, spiritual needs and maintaining independence”. We asked one member of staff where we could find the mission statement. They told us straight away, “It’s in the information pack given out, but it’s also in our induction training pack.”

We asked staff what they would do if they saw or heard something that they felt was not right. They all told us what they would do, why and how. All were clear about the reporting structure, what they needed to do and what would happen as a result. They were clear about their roles and responsibilities and told us how well supported they felt not just by management but their colleagues also. One member of staff told us, “I’ve worked here a very long time. There is no-one nicer to work for. I connected with them immediately, not like some of the other homes I’ve worked in in the past.”

The provider and registered manager made sure all equipment was safe and serviced, or replaced, regularly. Any incidents or accidents were investigated, recorded and dealt with appropriately. Where any learning was taken from accidents or incidents this was shared through regular supervision, training and relevant meetings.

There were comprehensive quality assurance policies and procedures in place. These were backed up by training which underpinned what a quality service could and should provide. Regular reviews of care plans, risk assessments, needs assessments and regular one-to-one discussions meant that quality checks were built into every day practice.

The registered manager undertook regular audits and results were shared with staff. These acted as learning points for discussion and improvement. Where follow up actions resulted from the audits, which again were shared with staff, and if relevant with people living in the home.

Staff meetings also took place on a regular basis and the minutes of these meetings were put forward for discussion and learning. All staff we spoke with said they felt confident that any areas of strengths or weakness would be discussed at staff meetings and that management would act on them in a positive way.

The provider undertook yearly quality surveys and was in the process of drawing up the 2014 quality survey questionnaire at the time of the inspection. This was one way in which the provider collected people’s ideas and suggestions for ways to improve the service provided.

The provider had a robust system of ensuring that all conditions of registration were met and that statutory notifications were sent to CQC in a timely manner.