Kingsley Care Homes Limited

Lynfield

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected this service on the 24 August 2016 and the inspection was unannounced.

Lynfield provides accommodation and support for adults living with a learning disability. On the day of our inspection there were nine people using the service which is the maximum number the service is registered for. People living at the service could not easily give us their views and opinions about their care. Therefore, to help us gain a better understanding of people's experiences of living in the service we observed interactions between staff and people living in the service and saw care and support being provided in the communal areas. We also spoke to staff and looked at responses from visitors and healthcare professionals.

At the time of the inspection there was a registered manager in post. 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.'

We assessed this service to be providing good outcomes for people with only a number of minor improvements required.

People received their medicines as intended and medicines were administered by staff who had the skills and training to do this safely.

Risks to people's safety were minimised by good staff supervision and staff who had knowledge of people's needs. Risk assessments were reviewed in line with people's needs.

There were enough staff at this service which meant that people were supported around their individual needs and interests. Staff recruitment was mostly robust but records did not always demonstrate this.

Staff training induction, and support was adequate but we were not assured of the frequency of staff supervision and whether all staff had the required knowledge and skills. We have made a recommendation about supervision.

Staff promoted people's choice but we were not clear that staff followed the principles of the Mental Capacity Act. The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People's health care needs and dietary were monitored and met by staff.

Staff provided good support to people and recognised individuals potential and strengths. They provided individualised care and promoted people's independence, validating how people felt and expressed themselves.

Consultation with people using the service was difficult but staff tried to offer choice in everything they did and valued and respected people's choices.

Care plans were comprehensive and person centred. Staff knew people's needs well and tried to enhance people's experiences.

Complaints or feedback about the service was taken into account when planning and developing the service.

The service was mostly well led with a system of audits and ways to measure the effectiveness and quality of the service. The manager led her staff team and was well respected. Improvement in records would demonstrate how the staff were meeting people's changing needs and responding accordingly.

We found breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this 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?

Good

The service was safe

Medicines were administered as prescribed but minor improvements were required in terms of auditing and storage.

Risks to people's safety were well managed.

Staffing levels were good and supported personalised care.

Recruitment of new staff was adequate

Is the service effective?

Requires Improvement

The service was not always effective

Staff were adequately trained and supported but the level of support was not always clearly documented in formal supervisions so we could not always see how staff were being developed.

We could not be assured that staff always acted lawfully in terms of supporting people around mental capacity.

Staff supported people with their health care needs and their nutritional needs and records reflected this.

Is the service caring?

Good

The service was caring

People were respected and their independence and autonomy promoted.

People were consulted about their day to day choices.

Is the service responsive?

Good

The service was responsive

Staff were aware of people's individual needs and support was planned accordingly.

People were encouraged to participate in their local communities.

The service had a complaints/compliments procedure which was used to assess the levels of care.

Is the service well-led?

Good

The manager was motivated and supportive of her staff and people she supported.

There were good systems in place to measure the effectiveness and quality of the care provided.

Improvements in the way the service was managed were identified but the service was already addressing some of these areas.

Lynfield

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.

The inspection took place on the 24 August 2016 and was unannounced. The inspection was undertaken on one day and was carried out by one inspector and an 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. Our expert had a back ground in learning disability with both personal and professional experience.

During our inspection we spoke with seven staff, including care staff, the manager and senior staff. There were no visitors to the home. We were not able to converse with people using the service in the depth we would have liked so relied heavily on other means such as observations of interactions and the relationships people had with staff. We observed people's behaviours and how this was responded to by staff. We also looked at some staffing records and records relating to the management of the service.

Good

Is the service safe?

Our findings

We found that the service was a safe environment for people to live our observations of people using the service indicated that people felt safe and secure.

Staff were aware of the risks associated with people's behaviours and health care conditions. Of the nine people living at the service, seven people had epilepsy of which four were unstable and required both regular medication and medication occasionally to help manage their seizure activity. Only staff trained to administer medication did so and staff knew enough about epilepsy and what actions they should take to keep people safe. There were protocols in people's files which gave guidance to staff as to when they should intervene and give rescue medication and when they should call the emergency services. There were also protocols and risk assessments around how to support people when out with their epilepsy and other potential risks. For example a person with epilepsy regularly went swimming but the risk associated with the activity and the immediate environment had been assessed to ensure the person was as safe as possible.

Some assessments were dated 2010/2011 and we could not be assured of the relevance of the information. There were a large number of risk assessments in people's files, some generic and some person specific. Systems in place to review documents did not always highlight changes in need or result in revisions being made to risk assessments or individual protocols. We have advised the provider to ensure records are up to date and reflect people's current needs.

There were protocols for the management of epilepsy. The provider told us these are drawn up with the involvement of the GP and other health care professionals and kept under annual review as a minimum. Evidence of this was provided.

We found people received their medicines as prescribed. On arrival people had already received their medicines. There was a designated medical room where medicines were kept and staff would dispense people's individual medication and take it to the person directly.

We looked at the storage of medicines and saw they were stored in an orderly fashion but we were concerned about the temperatures of the medicines room which was in excess of 25 degrees. We saw that on several occasions the temperature had been recorded as exceeding the manufacturers' safe guidelines, which meant that medicines and creams may become less effective. The provider told us they had identified this and was addressing it. Audits had highlighted issues around missed signatures on the drug sheet most which were for creams and this was being addressed with individual staff members. We did not note any missed signatures for the records we looked at. We saw a safeguarding concern had been raised by the service due to a drug error being made and found the service had taken robust action to address these concerns and prevent a reoccurrence.

We noted that the log book for the schedule of controlled drugs was in place but the stock balance was only checked occasionally and staff were not able to tell us how often it was checked other than when controlled drugs were administered. We fed this back and were assured that measures to ensure stocks tallied with

records were in place.

Staff spoken with told us they had face to face training, e-learning and yearly medication competency assessments where they would be observed administering medication until they were signed off as being competent. Staff had additional training for the administration of midazolam which was used to help manage severe epilepsy. There was not a clear expectation that all staff should administer medicines. The manager wanted staff to be happy and willing to undertake this extra responsibility and ensured that there was always sufficiently trained staff on duty.

There was guidance in place for administering prescribed when necessary medicines (PRN. Some people had medication to help them maintain a healthy bowel function and bowel motions were being recorded to help guide staff as to when this medicine was necessary. In addition medicines used to help manage people's anxiety were in place but the PRN guidance were not always sufficiently clear as the best time to administer medicines to ensure they were as effective as they could be.. One person's record stated administer, "For extreme challenging behaviour." There was no information recorded to inform staff what the behaviours were or how and when to administer medicines. We saw for one person PRN had been administered 4 times in a week but we were unable to see a clear rationale for this or if the medicines helped in terms of managing the person's anxiety. Medicines were individually prescribed and labelled and it was clear what each person was taking, what it was for and any potential side effects.

Managing behaviours which could challenge was discussed with staff, as a number of people could be unpredictable and could potentially hurt themselves or others. We noted the environment people were being supported in was very calm and staff were good at observing and picking up on tensions as they arose so these could be diffused before they escalated. The emphasis appeared to be on preventative strategies rather than reacting to situations which had already escalated. Staff were trained in understanding behaviour, managing conflict and when necessary intervention. We noted that the skills mix of the team enabled more experienced members of staff to focus on people who might need more support in terms of their behaviour. One staff member told us, "They can be unpredictable and their behaviour can change quite suddenly. " They then also told us what kind of things the person did not like and what might raise their anxiety and frustration. This knowledge enabled them to respond appropriately to the person and keep their day as calm as possible. One staff member told us, "People back you up" and "we can nip it (challenging behaviour) in the bud more now." Clearly the staff levels, activities outside the home and resources within the service such as quiet areas to move to, were contributing factors as well as the service having experienced and caring staff.

The service safeguarded people in their care. Staff knew their responsibilities for reporting and accounting for incidents but were less clear in relation to whistleblowing, preferring to say that they would take any concerns to higher management within Kingsley Care rather than an independent body such as the local authority or CQC. We discussed this with the manager who was surprised as they were able to evidence that staff had received training around safeguarding and whistle blowing. However when she asked staff she agreed they did lack some knowledge. There was information located around the service but this related to raising complaints and not safeguarding or whistle blowing. We asked the manager to ensure the information was at hand and regularly discussed with staff.

We looked at three staff records to assess if the service followed a robust recruitment process. Staff were only appointed after necessary checks were carried out including a checkable work history, references, proof of address and identification. We noted there were interview notes for some but not on all files looked at. This meant we could not be assured that potential barriers to employment had been fully discussed and explored as part of the interview process.

The service had good staffing levels and staff were familiar with people's needs. There were no staffing vacancies and no use of outside agency staff. At night there were always two waking night staff and sometimes a staff member sleeping in who could be woken to respond to an emergency. In addition there was an established on-call system. We viewed the staffing rotas which showed staffing levels were maintained consistently throughout the week. The numbers of staff on each shift were high. This ensured people had one to one support when needed and occasionally two to one support when out in the community. The rotas also showed that new staff were supported adequately until they were confident to work on their own. The manager was not included in the staffing numbers but helped out as required. During our inspection a manager from another service was present and said they supported each other and knew each other's services so could cover if required or provide support and advice.

Requires Improvement

Is the service effective?

Our findings

We were not confident that staff had sufficient knowledge of the Mental Capacity Act and its application. We saw that staff had completed some training on the MCA 2015 and Deprivation of liberty safeguards, (DoLS). We saw DoLS applications had been made for people and people lived in the least restrictive environment as possible but it would not be safe for people to leave independently and that staff took sensible precautions to keep people safe. Staff who were interviewed at length all gave examples of how they facilitated people to make choices or understood from people's behaviour or expression whether they either liked or disliked something. Staff promoted people's choices as far as they were able to demonstrated through their relationships that they knew people well.

None of staff asked could give any examples of when to apply the MCA and DoLS legislation. We spoke with the manager who was clear about how they promoted people's choice. However, when asked about specific health interventions such as the flu jab the manager said that they would consult a family member if the person lacked capacity which they felt some people did. They had not undertaken an assessment of the person's capacity to understand and retain information relating to specific decisions. In the case of one person the next of kin had made a decision on their behalf and this had not been recorded or reviewed to consider if this was in the best interest of the person concerned or shown that this was discussed with anyone else.

This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consent.

During our inspection we felt the service benefitted from a body of experienced, skilled and knowledgeable staff, including the manager, who was confident in supporting people with very complex and difficult behaviours. Staffing and resources were good and enabled people to have purposeful activity both in and out of the service including those who needed 2-1 staffing because of their identified needs.

Staff spoken with and records showed what training they had undertaken. This included training specific to the role and to the needs of people using the service. The manager told us that over 80% of all staff held additional qualifications in care and there was a staff bonus scheme and award ceremony aimed at rewarding good practice and acting as a motivational tool. However, we could not see from staff's records that all their mandatory training was up to date. Some training that we would expect to be completed annually had not been undertaken. As an organisation, there was a heavy reliance on e-learning which we were not confident was sufficient given the complex needs of people that used the service. Staff experiences varied and we found for some staff there were gaps in their knowledge in areas such as whistle blowing and the application and relevance of Mental Capacity.

For one staff member we were unable to see how they were progressing through their induction as we were unable to establish where their work book was. Staffs initial induction covered all essential elements of the care workers role. If staff were new to care they completed the care certificate, a nationally recognised and accredited scheme for care staff. There was also a more general checklist which was covered with staff

when they first arrived on site and covered policies and procedures and the immediate environment such as fire exits. Staff covered all the induction standards within the first six months of employment as well as their e-learning which is computer based study. They also did basic e-learning in mental health, autism and learning disability. However, in order to provide new staff with the knowledge and skills to effectively care for the complex needs of people living in the service this training needed to be more in depth.

It was clear that staff were supported on shift and only undertook as much as they were comfortable to do. The more experienced members of staff helped to support people with more complex needs until such a time that newer staff felt ready and sufficiently skilled to do so. This meant staff were adequately supported but we could not see that this was not always recorded.

Staff received supervision and appraisal of their performance, although the frequency of this varied. However, the manager told us a new competency framework had recently been introduced which involved them carrying out direct observations of staff practice to ensure staff were demonstrating the right skills, competencies and behaviours. They said they would be doing this every three to four months for all staff and showed us the format.

We recommend the frequency of supervision is reviewed to ensure all staffs performance and competencies are assessed at regular intervals.

Staff spoke with had a good awareness of people's health care needs. Each person had a health action plan which was reviewed monthly and gave us some information about the person's needs and any medical history which was relevant. The manager had told us about an issue regarding one person whose health care needs had not been responded to well by outside health care professionals and actions they had taken to improve the situation. They told us that they had a good relationship with the GP who visited regularly and knew people's needs very well.

A number of people had special dietary needs, including dairy and gluten free, the menu reflected this and people were offered a stock alternative at each meal. Staff who were asked were aware of the risks associated with constipation and epilepsy though recording of bowel movements was considered unreliable so the management of this was through observation of behaviour and physical appearance.

All those with epilepsy had reviews with their consultant and protocols for PRN administration were based on these reviews. When people were out in the community portable PRN packs were used which contained the protocol and there were systems both within the service and outside for summoning senior staff to attend to seizures when they occurred.

People's records, risk assessments and care plans provided evidence that they were subject to review. There was good documentation about people's health care needs and engagement with other health care professionals such as the speech and language team, dietician, chiropodist and dentist.

Good

Is the service caring?

Our findings

During the day we observed many interactions with staff and people using the service and they were positive and respectful. We also noted that staff got on well with each other and were supportive of each other's needs. The staff team had complimentary skills and different life experiences which seemed to work well. The manager in particular seemed skilled in keeping up morale and getting the most out of her staff. They told us they were particularly proud of staff and what they had achieved in terms of creating a stable, happy environment for people to live.

Staff were genuinely interested in people they were supporting and knew a lot about them. They listened to people and talked about things which were of interest to the person. Staff were patient and helped to manage people's, sometimes obsessional, behaviours which consumed a lot of time.

Staff that we spoke with described people in a very positive way such as, "He's brilliant," and "He's lovely." Staff were able to describe in detail the things people really liked doing and how they facilitated them to do this in a meaningful way. We saw staff promoting people's independence as far as possible and encouraging people to do things for themselves rather than doing it for them. Where people needed assistance there were different aids to support people's independence likes plate guards, slip mats and bespoke chairs.

Staff worked on a 1 to 1 basis with people throughout their shifts, which reduced the impact of being in a relatively large group and provided people with the opportunity to do activities away from others if they preferred. People were given choice and encouragement to pursue their own interests and this was evident on the day of our inspection. Staff consulted with people about their needs and wishes. People were involved in decision making as far as reasonably possible. People had individual, annual holidays. Several people went with one other with whom they got on well with. Activities were planned in advance to ensure that they went smoothly and staff anticipated anything which might had an effect on the success of the activity. This enabled staff to take necessary steps to reduce people's anxiety and stress. Staff responded to the needs of people, rather than trying to influence them to do things they were guided by what people wanted to do. One staff member said, "I take my lead from him." Staff told us that if they had a relative with additional needs they would be happy for them to use the service as they thought it was the best it could be.

People were engaged throughout the day. Staff supported people to maintain relationships with their extended families and took people to their family members address. Most people through their autism did not particularly enjoy doing things with others but where they did this was facilitated.
People were involved in day to day decisions and family members were kept in the picture but there were no formal meetings held other than annual reviews of care. This incorporated people's views about how the person's needs were being met.

Good

Is the service responsive?

Our findings

The service was responsive to people's individual needs and staff supported them to live their lives in a fulfilling way. On the day of our inspection we observed staff supporting people with their day to day routines. Six out of the nine people went out during the day to undertake different activities, including horse riding and shopping, and one person attended a health care appointment. Staff offered different things to do for people who stayed in the house and we saw a number of examples of staff engaging with people in a person centred way. One staff member spent a long time putting together a scrap book with a person who was enthusiastic about a particular TV character, they were very knowledgeable and staff engaged with them about their interest. We observed a person engaging in obsessional behaviours which the staff member was skilfully able to divert their attention without upsetting them and keeping them on task. We observed people having breakfast and lunch at different times to fit in with their schedules. In the evening people were encouraged to have their meals together and the manager told us that the evening was a time when people relaxed after their day's activities. The home could accommodate people's different needs and had extensive space and outdoor space. There was also a small hydrotherapy pool and a multi-sensory room.

We looked at daily notes which demonstrated that people were supported to access the community and also to keep in touch with family members. Staff were able to describe in detail what individual's liked about being out in the community. Contact with family members was variable. People had opportunities to go on holidays either by themselves with staff support or with a particular person they got on with at the service. Holidays took a lot of planning to ensure they were successful. Staff supported interaction between people in the house whilst recognising their different needs and interests. For a number of people who previously came from different services the home had continued to engage with these services and day care for a number of people was provided by staff working for a different service. The manager told us this was to better support those who had established routines and relationships before moving to the home and it was important to maintain them. The records we viewed showed the range of activities undertaken by people varied from person to person with some people choosing to spend a lot of time at home. Staff told us each person was afforded the same opportunities to go out and access community facilities The manager was clear that they wanted people to be happy and live in a nice environment. Changes were afoot to ensure every one had a clear plan stating what their goals and objectives were and how staff would support people to achieve them.

Care plans started with a document, 'Getting to know me.' This gave an insightful account as to the person's needs, wishes and routines. It described the person's character and great things about the person. This was reflected by what staff told us about people. The profile also contained information about things that people did not like, or were likely to make them anxious which was helpful in terms of supporting people with their needs. Their routines were written in a person centred way. Guidance was provided comprehensively around their specific needs and health issues including childhood history. People's needs were respected and it was clear staff knew people really well and were able to understand what they wanted and how to promote choices for people. Advocates were used as required but in reality most people have family members or other people who could support them. Staff told us people were supported with

their non verbal communication and could use computer equipment or other aids and staff were aware of when a person was unhappy or unwell and could address this with the manager with the involvement and inclusion of others.

The service had a quality assurance system which relied on verbal and written feedback about people's experiences. Most people using the service could not give feedback in this format but were supported by staff and others to feedback how their needs were being met and staff consulted with people and other staff in how best to meet people's needs or introduce changes that needed to be made. Staff meetings were held where staff who knew the person best discussed individual people's needs to find ways forward and to reflect and how the persons needs were being met or any changes necessary.

The service had a complaints procedure which was available throughout the service and also in pictorial form and staff supported people to raise concerns and were able to read/anticipate people's needs through their in-depth knowledge of people they were supporting.

Good

Is the service well-led?

Our findings

The service was mostly well managed and run in the interest of the people using it. We found monitoring of staff practice was in place. Supervisions took place but these were determined by the needs of the individual staff members, with some staff were receiving more support than others. Supervision records seen varied in terms of how often they were carried out. Staff interviewed indicated that they received supervision but this was infrequent, and occurred approximately every six months. This was reflected by the supervision records we saw. However the organisation had just introduced direct observational assessments of staff performance which would help in terms of evidence based assessments for all staff.

All staff did however feel that their opinions were valued and that the manager was approachable. We observed during the day the manager supporting staff and taking an interest in their well-being. Staff felt well supported by the manager, who showed a willingness to work as a team member should the need arise. Some staff worked long hours (one staff member averaged 52 hours per week) and the working day was long, fourteen hours without a formal break. Staff were encouraged by the manager to look after themselves and could eat and drink with people whenever needed. Staffs return to work after a period of ill health was carefully managed and staffs progress was regularly monitored to ensure the persons wellbeing and safety.

Equally we found the manager very caring of people who used the service. They were positive throughout and said they aimed to provide a service where people were happy and well cared for. Their interactions with people demonstrated their warmth and affection for people. We asked the manager about what they had achieved since being in post, they told us that there was good continuity of care and staff were able to anticipate people's needs which they believed had resulted in less challenging incidents. The manager also told us they had good engagement with the local community and people using the service regularly participated in things locally. They referred to one person who did not really like going our now having a much fuller life.

The manager said they felt well supported both by managers from other services and by their area manager and that they attended regular meetings to share ideas and best practice. Staff also held and attended regular meetings.

The service was run around the needs of the individuals using it and this was evidenced through the staff rotas which showed people had one to one support and activity based around their needs. Individualised care was also reflected by people's plan of care. In addition a form had been introduced which was around goal setting for each individual using the service to demonstrate that people were being supported and encouraged to reach their full potential and to achieve what they wanted to.

People did not generally have allocated social workers and annual reviews were not up to date for everyone but staff were proactive in contacting health care professionals as required and identifying gaps in services where these occurred.

We asked about the services overarching quality assurance system and how they engaged with people using

the service and asked for their feedback. People were consulted on a daily basis and care given was based around people's individual need by staff who knew people well. The organisation sent out surveys to families, visitors and health care professionals and from this the team would give feedback to the manager as to actions they should take if required to improve the service. Feedback to people using the service was through a 'you said, we did' poster, which showed how the service had responded to the feedback it received. Following the inspection we were sent a range of visitor's questionnaires which asked a series of questions based on the key areas that we look at as part of our inspection. For example one of the questions asked about how responsive staff were and if people were involved in their plan of care. Feedback was also received from health care professionals but feedback from people using the service was limited and the service relied on feedback from their relatives or staff, without the acknowledgement that the people living in the service were adults. The service relied on verbal and written feedback about people's experiences. However, because many people living in the service could not verbalise their views or opinions this was not the most effective way to engage people. In order to improve feedback from people using the service the organisation was introducing an electronic stakeholder survey which could be completed on line using a tablet. We would anticipate that people using the service would still require help to complete this.

The service had a quality assurance plan which set out its objectives, the process for achieving its objectives and who was responsible for carrying out the actions and by when. This provided us with a clear audit trail in terms of service improvements. What was less clear was how the information had been collated or how feedback from people using the service and staffs views had been taken into account.

Moving forward the manager told us they were going to use an accreditation scheme to evidence how they are meeting best practice. This related to how they were meeting the needs of people with autism and in line with current guidance.

We noted that the service did have records of incidents, accidents, safeguarding concerns and anything else which might affect the service delivery. These were recorded and showed what actions were taken and lesson learnt. The manager told us all information was collated and would be signed off by the regional manager as part of their quality assurance system to oversee the manager's actions.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Fit and proper persons employed. Staff were not familiar with the Mental Capacity Act or its application.