The Cotswold Nursing Home Company Limited

Kingsley House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 10, 12 and 17 January 2018.

Kingsley House 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 House provides residential and nursing care for up to 37 people. At the time of our inspection there were 29 people living there, some people were living with dementia. Kingsley house accommodates people in one home over four floors and has five large bedrooms where people can choose to share.

There was a registered manager. 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 previously inspected the service on 11 and 12 June 2015 and rated the service 'Good' overall. At this inspection we found a number of concerns and the service was rated 'Requires Improvement' overall. Following the inspection, the registered manager informed us about some of the measures they had implemented immediately following our inspection to drive improvement. This included reviewing people's choking risk assessments.

People told us they felt safe. However we found improvements were needed to ensure people would always receive the care they required to remain safe. Medicine management and the use of thickening agents for people with swallowing difficulties required improvement. Some people's care plans required updating to provide correct information for staff to follow with regard to choking risk assessments.

Quality monitoring of the service was not always effective when care plans were not checked for their accuracy and accidents were not always reflected upon to prevent further occurrences and this required improvement. People were treated with compassion and kindness but they did not always understand staff whose first language was not English. This could make people feel not listened to and not always engaged in their care.

People's care and support needs were assessed to monitor the staffing levels required. Sufficient staffing levels were maintained and the recent recruitment of an activity organiser would improve people's choice of activities and add additional individual engagement.

People made most decisions and choices about their care when possible. When people did not have the capacity to make decisions staff followed the Mental Capacity Act guidance to protect them. People had access to healthcare professionals and their health and welfare was monitored by them.

People told us staff were kind when they supported them with their care. People were supported by staff that had access to training and supervision to develop their knowledge.

Some people joined in with activities provided which included musical entertainment, crafts and exercises. People had some access to the community. Improvements were needed to ensure all people had opportunities to remain active and pursue their interests.

The registered manager was approachable with relatives and people. People and their relative's concerns were taken seriously and acted upon by the registered manager. The registered manager wanted to ensure the service continued to improve and were keen to take action to ensure good care was provided to people. The staff felt well supported by the registered manager and staff meetings had increased to monthly.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.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?

Requires Improvement

The service was not safe.

Areas of risk were identified and risk assessments were in place. However risk assessments were not always current or reflective of people's needs. Care staff did not always have clear guidance on how to manage choking risks to people.

People's medicines were not always managed safely to ensure errors would not occur.

There were sufficient staff to keep people safe and meet their needs.

Recruitment procedures operated by the registered manager and provider ensured staff were of good character.

Is the service effective?

Good

The service was effective.

People's dietary needs were met.

People's needs were met by staff who had access to the training they required to meet people's needs.

People made most decisions and choices about their care when possible. When people did not have the capacity to make decisions staff followed the Mental Capacity Act (2005) guidance correctly.

People had access to healthcare professionals and their health and welfare was monitored by them.

Is the service caring?

Requires Improvement

The service was not as caring as it could be.

People were treated with compassion and kindness but they did not always understand staff whose first language was not English. This could make people feel not listened to and not

always engaged in their care.

Some improvements were needed to ensure people's privacy and dignity would always be promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People took part in some activities but there was a lack of individual engagement and access to the community to ensure people had opportunities to remain active and pursue their interests.

Complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance systems were not always effective to identify and sustain improvements.

Improvement was needed to ensure staff could communicate effectively and always understood people.

Regular staff meetings were held and staff were able to discuss required improvements.

The registered manager was approachable with relatives, staff and people and had plans to improve the service.

Kingsley House

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 was prompted in part by notification of an incident following which a person using the service sustained a serious injury. CQC was aware of past injuries sustained at the location and we explored particular aspects of current care and treatment during the inspection. The information shared with CQC about the incident indicated potential concerns about the management of risk of falls from moving and handling equipment. This inspection examined those risks.

This inspection took place on 10, 12 and 17 January 2018 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection, 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 have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

We spoke with the registered manager, the registered provider, the deputy manager, the quality consultancy agent, one nurse, three care staff, a chef and a housekeeper. We spoke with nine people who use the service and three relatives. We looked at information in ten people's care records, three staff recruitment records, people's medicine records, staff training information, the duty rosters and quality assurance and management records. We also contacted three healthcare professionals involved with the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Kingsley House. One person told us, "Yes, there's no abuse. They are [the staff] always good, they are all nice. They are so patient with those with dementia, the staff here are so good to them." Another person told us they felt safe and the staff were "kind."

Although people told us they felt safe we found improvements were needed to ensure people would always receive the care they required to remain safe. Medicines records were complete but administration was not safe when tablets were put in named pots for transportation around the home. People had received their medicines as staff had signed the record and any topical creams were applied correctly and also recorded. When one person was asked if they received their medicines on time they told us, "Yes they [the staff] are very good with those." They told us there were no mistakes with their medicines because the pot had a little ticket in it with their name on. One nurse told us this was because some people's medicines were dispensed from the trolley downstairs and then taken up to them in their rooms. They confirmed there could be more than one person's medicines dispensed at a time, which is why they put names in the pots. This was not best practice and was open to errors when not transporting medicines securely and not dispensing medicines directly to people from the original containers. The registered manager immediately stopped this practice and ordered a carry case from the pharmacy to transport medicines securely.

Some people's topical creams and drink thickening agents had been left in places where other people may use them inappropriately and be at risk. We saw prescribed topical creams in two bedrooms that were not safely stored as they should be, to protect people from inappropriate use. One person had a container of thickening powder in their bedroom which had no pharmacy label to indicate who it was prescribed for. Another person had a jug of thickened liquid already made left in their bedroom. Due to swallowing difficulties one person had been prescribed a thickening agent to be used to thicken their drinks and reduce the risk of choking and aspiration. One nurse was observed providing the person with a thickened drink at lunch time. They stated that they had added one scoop of thickener in 200ml of drink. They had used one of two containers of thickener from a trolley in the kitchen. We noted that both the containers had pharmacy labels that indicated they had been prescribed for another person in the home. Two care staff told us they used one scoop in 200mls of drink to thicken the person's drink. The correct amount to obtain stage one consistency (minimum required) using thick and easy was two scoops in 200ml of liquid.

Individual risk assessments were not always in place to help minimise risks to people. For example, for the use of thickeners when people were at risk from choking. Three people prescribed thickeners did not have a care plan relating to the use of thickeners and there was no risk assessment relating to choking.

The registered manager contacted the Speech and Language Therapy (SALT) team immediately and obtained copies of the drinking assessment and instructions for the three people, then found the scanned copies on the computer system. The following day we saw the registered manager had put notes in people's rooms about their thickeners and fluid consistency to help ensure this would not happen again. They had also arranged training for staff from the thickening powder supplier.

Another person's care plan lacked detail and contained conflicting information in relation to their mobility needs. We had seen the person being hoisted, using a midi hoist and sling from a chair into a wheelchair by staff. The person's moving and handling assessment advocated the use of a midi hoist and medium sling when the person was in pain, which they were not. Another section of their assessment stated 'Due to reduced mobility, standing hoist will be used'. The care plan for safety and wellbeing did not mention hoisting but stated one to two staff to assist when walking. The registered manager told us they were currently not using a 'standing aid hoist' for anyone. Clear information was therefore not available to staff to know how to support this person's mobility needs safely. The registered manager updated the care plan immediately to reflect the correct information.

All of the above demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people were involved in accidents and incidents these were recorded on the computer care management system and daily alerts informed the nurse in charge. When people were involved in accidents and incidents these were recorded on the computer care management system and daily alerts informed the nurse in charge there had been an accident. The information was shared at handover between staff and the severity of accidents was colour coded to inform staff and the registered manager and inform relatives if the person sustained an injury.

We found one reflective practice for a person who had many accidents. However reflective practice was not evident to look at preventative measures on the accidents records. The registered manager told us they would complete an individual meeting with the staff where necessary or share at staff group meetings to discuss any learning that could reduce the likelihood of accidents or incidents recurring. One staff member's individual meeting, regarding an accident, had an observation competency record by the registered manager for moving and handling and from an occupational therapist to ensure their practice was safe. Accident audits were completed monthly and annually which mainly looked at the number of accidents. When one person had a number of accidents the circumstances would be explored to look for any preventative measures. We discussed how the audits could be more detailed to look at all the aspects of every accident. The registered manager told us they would ensure reflective practice was completed consistently for all accidents. When we returned on 17 January the handover sheet for 16 January 2018 had recorded instructions for staff to look at the reflective learning and preventative measures for a person who had just had a fall.

There was some good medicine practice where 'as required' medicine protocols were recorded to ensure all staff used the same criteria when administering and informed the GP if the medicine was needed regularly. People's topical creams were applied correctly and recorded on a topical cream chart with a body map to inform staff where to apply the cream. Generally the records were well completed with only a few gaps in the administration. The medicines were stored securely and the temperature of the room and refrigerator was checked daily. Stock levels were appropriate for medicine not in the monitored dosage system. There was good practice with antibiotic medicines as they were counted daily to ensure safe administration. One error was noted when there was one tablet too many left at the end of one day. Staff had contacted the GP and this was recorded. The medicines were audited monthly and tablet counts were recorded with amounts carried forward each month. People confirmed that nurses always gave them their medicines.

We looked at four moving and handling risk assessments. The consultancy agent told us there were risk assessments for hoisting seven people. One person's falls risk assessment for moving and handling was clear and staff could access the summary on the electronic touch screen tablet computer they used. The person had experienced many falls and there was an assistive technology sensor to alert staff when they

started to move. The person was living with progressing dementia. Their mobility care plan had detailed information about their needs for variable assistance with one or two staff which depended on the person's mental health and wellbeing. Night staff had checked the sensor was working and they had a 'crash mat' beside the bed. Some nights the person got up several times and was assisted back to bed. The mental health team had recently reviewed their medicine and they had a hearing and sight check completed. The handover alert system highlighted when a review was needed and the latest care plan review was on 3 January 2018. Three carers told us that all people had individual moving and handling slings.

There were recruitment procedures where checks had been completed to help ensure suitable staff were employed to care for people. Staff had appropriate identity checks and nurses registration personal identity number (PIN) was checked with the Nursing and Midwifery council (NMC). References had been sought from the last health or social care employer. Staff completed an induction before they started their employment and were on probation from six to nine months. Some staff did not have English as their first language and did not always understand what people or staff said to them and needed an interpreter to complete their induction training. The registered manager told us they tried to ensure these members' of staff worked alongside staff with fluent English.

Staff were trained to keep people safe and had completed adult safeguarding training. There was a safeguarding procedure for staff to follow with contact details of the local authority safeguarding team. The staff we spoke with knew what abuse was and how to report any allegations of abuse to the registered manager. They also knew about 'whistleblowing'. Whistleblowing allows staff to raise concerns about their service without having to identify themselves.

The home was clean and people and relatives told us it was usually clean. There were infection control procedures for staff to follow. There was equipment around the home for staff with regard to infection control and hand cleansing. Staff used aprons and gloves when they provided personal care. The laundry had an infection control procedure on the wall. However we found all staff were not following the procedure and soiled clothes were strewn on the floor. One staff member who did not have English as their first language had begun English lessons but could not read the infection control procedure. The registered manager told us they had translated procedures to make certain staff understood what was expected of them.

People were cared for in a safe and well maintained environment. They were protected from risks associated with Legionella disease, fire, electrical systems and equipment. People had individual emergency evacuation plans in place to ensure their safety in an emergency. The monthly visit by the quality consultancy agent checked all health and safety checks had been completed and we looked at a copy of 2017 quality management system where action were highlighted and completed.

Sufficient staffing levels to support people with their care needs were maintained. The registered manager explained how they used a staffing levels calculator and we looked at an example completed on 9 January 2018 and the staff roster for the two week period following the calculation. The need to ensure there was an activity person to organise more engagement with people remained but the registered manager had recruited to this post shortly after the inspection.

There was always a registered nurse on duty in the care home. The quality consultant told us the dependency tool worked and identified the additional needs of those people living with dementia. One senior care staff member said there were enough staff. People told us they didn't have to wait too long for the call bell to be answered. There were normally two care assistants and one nurse on night duty. The registered manager told us in November 2017 the dependency levels were high and staff levels were

increased to reflect this. The staff roster for November 2017 verified this.

Good

Is the service effective?

Our findings

People's care plans and assessments were held on a computer based care management system. Assessments were based on personal needs for example their mobility and nutrition. Care plans were compiled based on the findings of the assessments. Those seen included communication, daily life and social activities, elimination, mobilisation, medication, oral health, personal care and wellbeing, safety, skin care and sleeping.

People had their weight monitored and a Malnutrition Universal Screening Tool (MUST) was used to identify people who were malnourished, at risk of malnutrition or obese. The tool was used correctly and included people's height measured from their forearm. The computer generated the correct percentage of weight loss. People's keyworkers checked the weight loss at monthly reviews and informed the nurse in charge. Food and fluid charts were used to monitor people's intake and they were weighed every two weeks when required. A pain assessment tool was used to determine if people who could not express their discomfort were in pain so that prompt pain relief could be provided.

People had a variety of meals and special diets were provided. They told us they liked the food provided. One person said, "The food has improved there is more variety". The catering staff knew people's dietary needs and kept a list of the types of pureed food provided for six people. Nurses supervised lunch and supper meals. People's likes and dislikes in food were also recorded. A new meal system had been introduced during the week of the inspection. Prepared meals were delivered to the home. Tasting sessions had been held with people living in the home and their relatives prior to the introduction of the new menus. Meals were provided in various textures for those with swallowing difficulties. Allergen free meals were also available if required and the nutritional values of all meals were supplied. Two relatives told us there were always fresh drinks available and offered. One care staff member told us that people who could not eat solid food had a supplementary liquid food chart and were weighed monthly. They said their weight was recorded for the person's air flow mattress to prevent pressure ulcers and staff could look on the electronic pads to check the settings were correct.

People were assisted with their meal in a calm and relaxed manner. One person told us they were pleased the new meals had been introduced. They said they had enjoyed the meal they were served in their room the previous day saying, "It was lovely and hot." They also told us they had enough to eat and drink stating "I have far more cups of tea then I ever did at home. If you ever want more (food), you only have to ask, even at eleven o'clock at night". People had a copy of the week's menu which included a choice of a cooked breakfast. One person ate finger food for example crisps, cheese and fish fingers to support them to eat independently .

We observed a lunchtime meal where people sitting in the dining room received their meals promptly. There were enough staff available to assist people who required support to eat. People were told the choice of meals available. Two people were assisted by staff to eat their meals. Both care staff were sat at the same level as the person they were assisting, they did not rush them and gave them time to eat.

People's needs were met by care staff that received suitable training, support and had regular individual meetings called supervisions to discuss their progress. Records showed staff had received training in relevant subjects, for example, infection control, moving and handling people, nutrition and fire safety. Induction training was completed over five days. One staff member told us the induction was very good and they had completed most of their training and felt well supported by the nurses. The registered manager was taking action to ensured staff who did not have English as their first language received additional support to help them understand the training content.

The staff we spoke with told us their training was complete and they had regular individual meetings to discuss their progress and training needs. One senior care staff member told us they were up-to-date with all their training and had completed dementia care training. Eight staff had completed dementia care training in 2017. The deputy manager had completed a leadership training course in 2017 and had updated their training with regard to using a syringe driver, catheterisation and wound care. They also provided clinical supervision for all the nurses employed to ensure they were up-to-date with their training. Both the registered manager and the deputy manager had a training qualification to train others in moving and handling. The local authority Care Home Support Team had completed training with care staff in 2017 in, for example, diet and nutrition, helping people to eat and end of life care.

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. People had a pre-admission assessment of their needs and their preferences were respected. Staff had knowledge of the Mental Capacity Act and people's rights were upheld. People consented to their care and support. One person living with dementia had a mental capacity assessment and best interest record for the care at the end of their life which included input from two relatives who had a Lasting Power of Attorney for the person.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Two people had a DoLS application and one was authorised. A copy of the authorisation was kept on file, it was in date and there were no conditions recorded. The person living with advanced dementia had a sensory beam used when they were in their bedroom. We saw them relaxing in the dining room and talking to a relative.

There was liaison with social and healthcare professionals when required to help ensure people had the care and treatment they required. The GP visited weekly and staff made sure they gave them prior information to support the visit. One person confirmed they were able to see their GP when they wished and said, "I had a nasty cough and the doctor was here straight away." They said the home had provided them with transport to attend a hospital appointment. Records in people's care plans indicated they had been seen by their GP and other healthcare professionals for example; chiropodists, opticians and consultant psychiatrists.

People were supported with some technology and equipment to help promote their independence. The register manager told us they had magnified a book on the electronic tablet computer for one person with sight impairment. One person had large print books and another person now had their own electronic tablet. There was a social media page for Kingsley House where relatives became friends and they asked the

staff to show people pictures from them. With consent from people the registered manager had put pictures on the homes social media page of some activities people had enjoyed doing for their friends and relatives to see.

There were some adaptations to support people living with dementia, for example toilet signs. Some people shared a double bedroom and the registered manager told us they liked to share. One relative told us the person liked sharing as they didn't want to be alone. There were eight double bedrooms in the home, two were empty, one was occupied by one person and five were occupied by two people. We discussed the use of double bedrooms with the provider who told us the plan was to reduce the number over time. The registered manager told us if people no longer wanted to share a bedroom they would move them to a single bedroom.

When people move between services, for example admitted to hospital, staff completed a transfer form all about them and sent a copy of the person's medicine record. This ensured information about their care needs was shared effectively.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us the staff were kind and caring and they were called by their preferred name. One person told us they were happy at the home and the staff were "kind". They said they got on with most people but they didn't want to share a bedroom and they had one of their own. One relative told us the staff had a caring attitude even though the communication of staff who did not have English as their first language was not strong. Two people told us they had difficulty understanding staff whose first language was not English. One person told us the staff were "very kind" but they couldn't always understand them but they respected them. They thought the staff more or less understood what they were saying. One relative told us the staff were kind but occasionally it was difficult to understand some staff.

The consultancy agent and registered manager told us it was taking time to improve staff's English language skills. One staff member told us some staff did not speak to people and some of their English phrases were incorrect. People and their relatives might therefore feel that staff did not listen to them and could feel frustrated and isolated.

When staff did not understand people and their relatives this had at times led to ineffective communication and misunderstandings. One relative raised a complaint when a staff member who did not have English as their first language, told them the person was in hospital when they were not, as they did not understand the relative over the telephone. One staff member whose first language was not English, was unable to tell us what a keyworker did for people. They told us there were no keyworkers there. The keyworker system was used in the service to enable people to have individual support for their needs from a named member of staff who were responsible for ensuring they had everything they needed for example, toiletries. The keyworker was also responsible for creating opportunities for people to raise any concerns they might have about their care. Due to communication difficulties with some staff people might not always be supported to be engaged in their care.

Some improvements were needed to ensure people's privacy and dignity would always be promoted. People eating in the dining room had blue plastic aprons on to protect their clothes. We discussed with the registered manager that this did not show that individualised options had been explored for each person to support them to eat with dignity. The registered manager agreed to look into this to meet people's individual needs. On two occasions during a conversation with one person they told us about things staff had told them about other people. This indicated that people's privacy was not always respected by the staff.

One relative said the person was cared for well by the staff and was given a choice of when to get up and go to bed. One family were concerned that the person was undressing themselves so staff completed an hourly check to maintain their dignity.

Staff had information about people to understand how they had lived their life. We looked at an example of a "This is me" record for one person living with advanced dementia. The record described their dementia and how they sometimes could have hallucinations and what staff could do to support them to feel less

anxious. There was a life history of work, family members and what the person liked doing most in their life. How they liked to communicate and what made them more anxious, for example; loud noises. Their mobility, sleep pattern, personal care, any sensory loss and preferred food and drinks were all recorded to encourage staff to get to know them and talk about their life. The registered manager told us 18 people living with dementia had "This is me" records. We saw another person had a similar record in their bedroom which said they liked the staff to read the bible to them and had lived abroad. One person had a dry wipe board in their bedroom with relatives' telephone numbers and notes by people who had visited. There were also holiday type postcards from friends or relatives posted there.

Requires Improvement

Is the service responsive?

Our findings

Although improvements were needed in relation to the risk management information in people's care plans, we found most care plans had detailed information for staff to follow to meet people's individual care preferences and needs. There was a record of the support care staff had provided to people in relation to their daily care.

We looked at one person's wound record and this had been completed to record the wound size, discharge, the condition and some healing was noted. There was detailed information of the type of wound dressing the tissue viability nurse required the nurses to use to promote healing and how often it should be changed. One person living with dementia had been a high risk for moving and handling due to their anxiety and there were clear records of the actions staff should take to achieve the outcome. Detailed records of the person's mood were on a special chart to record what may trigger anxiety and the action taken. The community mental health team had visited to support the person and the risk of harm had been reduced to low. We spoke to the person's relative and they said, "He is calmer I have no doubts about the staff they are fabulous" and "Staff take him for a walk".

Relatives told us the staff kept them informed when people were unwell. One relative told us the staff had been concerned about the person not eating and had provided a smaller plate and weighed them regularly and their weight was increasing now. The relative also told us the staff had identified the person had a urinary tract infection and it was treated early. They praised the staff for recognising the signs of the infection. One staff member told us they were a keyworker for three people and completed their care plan reviews. They said they informed the relatives about the reviews so they could be there if they wished to contribute to the care plan review.

Handover between staff took place at shift change over to help ensure staff knew when people's needs changed and they required additional or different care and support. We observed a handover session between nurses and care staff. Relevant information regarding all the people in the home was discussed and the clinical lead nurse communicated the outcome of a GP's visit to the home that morning. The handover record generated from the computer records had people's medical history, any special instructions, for example how they mobilised and whether they required supervision or a hoist. Certain important information was highlighted, for example, when a person's wound dressing needed to be changed and medicine allergies. Precise handover information for the day included concerns from the night staff, any physical problems for example; any pain, poor appetite, change in medicine and constipation. Planned visits from health or social care professionals were also identified. One care staff member told us, "Handovers can be good and sometimes too long" and "Care plans are good but staff need to read them." They also told us they use computers and can access all the care plan records on three electronic touch screen tablet computers.

Improvements were needed to ensure all people had opportunities to remain active and pursue their interests. We observed there was little social activity for people in the home. People had some organised activities provided five hours each week, fortnightly exercise classes and monthly singing entertainment but

there was not enough individual engagement with the staff. There were records in people's care plans of how many activities people had joined in with and if they had been out with their relatives. There were some individual engagements recorded for example, where staff had talked to one person about the new meals. One person was taken to visit their relative at home every Sunday and people had been taken to a bird sanctuary and to church. Recently some people had been to the local library to see a 'Yarn Bombing' where they could see and touch different items knitted by local people. Similar sensory objects for people living with dementia to feel and look at and reminiscence articles were not readily available in the service. The service also had some local volunteers who visited people.

The provider told us there had been three visits out in the community in 2017 and they had provided transport for people. When asked about activities one person told us, "A lady comes in to do music and exercises. I like knitting and [Name of registered manager] is going to organise a knitting club. We used to go out two or three times a year but we didn't go anywhere last year." Another person, when asked if there was enough to do told, told us, "No, it's a bit boring really." There was no activity coordinator although the registered manager was in the process of recruiting one.

There were periods when there were no staff in the ground floor and first floor lounges and two people told us they were bored. One person said "We need more things to do, my life is fading away". One person said the staff speak in their own language which they couldn't understand. One staff member told us they did activities in the afternoon with people, if they had time, but this was not recorded. One relative said people, "need to do more." They told us during the Christmas period some people went to a Pantomime and made Christmas cards. One staff member said there was not enough staff to take people out in the town locally. Subsequently, after the inspection visit, the registered manager told us they had employed a full time activity person to help engage people in more activities and take them out regularly.

There was an accessible complaints procedure. Complaints had been recorded, investigated and responded to in writing within the complaint procedures timescales. The last complaint in January 2018 was investigated and staff had completed reflective learning to improve their response to relatives when they asked for assistance. A letter of apology was sent to the relative. One relative told us they would raise any concerns to the new manager. There had been ten complimentary letters during the previous year.

The staff supported people to make advanced decisions about their care and plan any wishes at the end of their life. The registered manager stated that there were no people receiving end of life care. One person described the care their relative received from the staff at Kingsley House at the end of their life as, "Absolutely marvellous, I couldn't have asked for more."

Requires Improvement

Is the service well-led?

Our findings

Systems were in place for the provider, manager and staff to assess and monitor quality in the service and to identify shortfalls that might place people at risk of receiving unsafe care. The provider required quality assurance audits in relation to recruitment records, health and safety, fire safety, equipment safety and medicines to be completed routinely. For example, the maintenance staff completed weekly checks of the environment and issues raised were recorded and dated when completed. The ground floor lounge had been identified as requiring decoration which was planned for 2018.

However, the provider's quality assurance audits were not always effective in identifying shortfalls and driving improvements in the service. Issues that required improvement and might as a result place people at increased risk of receiving unsafe care, had not been identified prior to our inspection. For example, care plan audits had been planned to be completed during the consultancy agent's monthly quality visits however this system was not effective in monitoring the quality of peoples' care records. The provider had not identified that information was not always available for staff to know how to support people at risk of choking to drink safely and what to do if people were to choke. People's care records had not been checked effectively to ensure they included all the information staff required to deliver safe care.

There was a service improvement plan updated monthly by the consultancy agent to monitor improvements and was added to throughout 2017. For example, medicine audits had been completed in October 2017 and December 2017and the December 2017 medicine audit identified people had topical creams in their bedroom. Some improvements had been made from the medicine audits which included the staff signing when topical creams were applied. However this audit had not identified that topical creams and people's thickening agents had not been stored safely. The unsafe medicine administration practice of using named pots to transport medicine had also not been identified. We discussed with the registered manger the need to complete a regular complete audit of the medicines monthly to ensure compliance. The registered provider visited the service weekly to monitor quality but there was no record of any actions required or what people or staff told them. This meant there was no record for the registered manager or staff to refer to ensure that action would be taken and completed to address any shortfalls identified through these monitoring visits. We discussed this with the provider and they told us they would record what improvements were needed when they visited.

Quality assurance systems included regularly asking people and their families about the service. Three people and five relatives had completed a survey to check their satisfaction with the service. In September 2017, one person commented, "Some of the staff do not understand English well enough and often ignore me". The registered manager was taking action to support staff to develop their English language skills. However, these support systems were not always effective in making the required improvements and we found staff, relatives and people continued to experience difficulty in communicating effectively with staff.

The above demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not ensured the Care Quality Commission was notified when a Deprivation of Liberty Safeguard (DoLS) had been authorised by a supervisory body. This is required by law so that CQC can monitor the appropriate use of DoLS and where needed can take follow-up action.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications of other incidents.

It was evident through our conversations with the registered manager they were motivated to improve the service and were keen to take action to ensure good care was provided to people. The service improvement plan for 2017 had identified many issues that had been completed, an example was a medicine audit for two people had identified issues that were addressed and completed. The improvement plan was updated monthly by the quality consultancy agent and actions recorded as completed and new action added where necessary. Many actions to include health and safety issues and staff training had been addressed and completed throughout the year. The new registered manager had their own action plan for 2018 to complete areas for improvement for example, to recruit an activity coordinator and schedule staff training for person centred care planning and understanding the computer system.

Staff felt they were well supported by the registered manager and they had monthly staff meetings to discuss improvements required. One staff member told us the registered manager was supportive, helpful and understanding. They said staff meeting used to be every three months but were now monthly. Minutes from a staff meeting in December 2017 reminded some staff to practice speaking English so they would improve. Staff were also congratulated for their hard work during Christmas and for the party held there. Care staff were also reminded about their keyworker duties to ensure people's room were well kept and they had toiletries.

One person told us about the registered manager, they said, "[Name of registered manager] is very, very good. Things are getting back up to like they used to be." One relative did not know who the registered manager was as their office was named 'Admin'. The registered manager had planned to change the sign to indicate where relatives and people could find them. One member of staff said they had a good relationship with the registered manager and attended the staff meetings. The relatives we spoke with thought the home was generally well run and they were able to comment in a survey in September 2017 where improvements could be made. For example they had said activities had decreased and this was being addressed. The registered manager had completed a Duty of Candour record and letter for an incident that happened in 2017 and had met with the relatives.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified CQC of a Deprivation of Liberty Safeguard (DoLS) authorisation by a supervisory body for a person. Registration Regulations 2009 Regulation 18 Notification of Other Incidents 4A and (B) (a), (b), (c) and (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with assessing risks to their health and safety, receiving the correct care and unsafe medicine management. Regulation 12 (1) (2) (a) (b) (e) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems established to ensure compliance were not always operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The service did not maintain accurate and complete records in respect of each service user. Regulation 17 (1)(2)(a)(b)(c).