Kingsley Nursing Homes Limited

Kingsley Nursing Home

Inspection report

4-6 Trafalgar Road
Birkdale
Southport
Merseyside
PR8 2EA

Tel: 01704566386
Website: www.kingsleynursinghome.co.uk

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

Summary of findings

Overall summary

This unannounced inspection of Kingsley Nursing Home Limited took place on 10 & 11 January 2017.

The Kingsley Nursing Home is a care home in the Birkdale area of Southport. The service offers accommodation, support and nursing care for up to 25 older people. The nursing home is accommodated across two Victorian houses that are connected through an internal corridor. Car parking is available at the front of the building and there is a garden to the rear of the building.

A registered manager was 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.

There were processes in place to monitor and review the safety and maintenance of the premises. We however identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulation 12 of the Health and Social Care Act 2014. This was because the provider did not always have suitable systems and processes in place to ensure the environment and equipment was safe and used safely.

Quality assurance processes and systems were in place to monitor standards and to support future improvement in the home. Areas such as care medicines, staff performance and cleanliness of the premises were well monitored. The current auditing system and health and safety checks for the environment and equipment had however not identified the shortfalls we found during the inspection. For example, general maintenance and safety checks of windows and the heating, also radiator covers not secure.

The provider and registered manager took prompt action to address these areas during and following the inspection.

We recommend further development of the current auditing system for the environment and equipment to monitor standards and ensure the safety of people living at the home.

People living at the home told us they felt staff delivered safe care.

The staff in the home knew the people they were supporting and the care they needed. Staff approach was kind and supportive and people's individual needs and preferences were respected by staff.

There were enough staff on duty to help ensure people's care needs were met. The registered manager was however aware of the need to review people's dependencies on a regular basis and changes were being made to the morning routine to provide more time with people.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults.

Staff were being provided with training and received the support they needed to undertake their job role safely and effectively.

Care plans provided information to inform staff about people's care needs and risks to people's health and wellbeing had been assessed to ensure their safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. An adult safeguarding policy and the local authority's safeguarding procedure was available for staff to refer to.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit.

The home adhered to the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the local authority.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

An activities organiser was introducing a varied programme of social events and activities in accordance with people's needs and wishes. This had been well received by people living in the home.

People told us they enjoyed the meals and were able to choose what they would like to eat. People's nutritional needs were assessed and catered for. The menus provided a good choice of well balanced meals.

People and relatives told us they were invited to give feedback about the home through meetings, surveys and daily discussions with the staff.

The culture within the service was and 'open' and transparent. Staff and people said the home was 'well run' and the registered manager approachable.

We observed relatives visiting during the inspection and people told us their relatives could visit at any time. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained.

A complaints' procedure was available and people living at the home were aware of how to raise a concern in the home.

The manager was aware of their responsibility to notify us, the Care Quality Commission (CQC), of any notifiable incidents in the home.

You can see what action we took at the back 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?

Requires Improvement

The service was not always safe.

Suitable systems and processes were not always in place to ensure the premises and equipment was safe and for equipment (call bells) to be available for people when needed.

Medicines were administered safely to people.

Risk assessments had been undertaken to support people safely.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There were sufficient numbers of staff on duty to support people. The registered manager was aware that these needed to be reviewed in accordance with people's dependencies.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff sought consent from people before providing support. Staff had an understanding of mental capacity and how this applied to people who lived at the home.

Staff were supported through induction, appraisal and the home's training programme to carry out their role effectively.

People's nutritional needs were assessed. People told us they liked the food and were able to choose what they wanted to eat from a varied menu

People told us the staff had a good understanding of their care needs.

People had a plan of care which provided detail about their care needs.

People had access to external health professionals to maintain their health.

Is the service caring?

Good

The service was caring.

People's individual needs and preferences were respected by staff.

People at the home told us they were listened to and their views taken into account when deciding how to spend their day.

Peopled told us staff were polite. We observed the staff to be courteous, caring, understanding and sensitive to people's needs.

Is the service responsive?

Good

The service was responsive.

A varied programme of recreational activities was available for people living at the home to participate in.

Care was planned with regard to people's individual preferences and subject to review with individuals and their families.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were a series of ongoing audits and quality checks to ensure standards were being maintained. We found areas that need addressing and further development in respect of checks for the environment and equipment. We have made a recommendation around improving the monitoring arrangements for the home in respect of these areas.

The service had a manager who was registered with the Care Quality Commission.

Staff said they felt supported by the registered manager and that the management of the home was good.

Staff were aware of the whistle blowing policy and were confident in its use.

People living at the home and their relatives were encouraged to give feedback about the home. This included attending resident/relative meetings and completing satisfaction surveys

The Care Quality Commission had been notified of reportable incidents in the home.

Kingsley Nursing 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.

The inspection team consisted of an adult social care inspector for two days and adult social care inspector for part of one day.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR 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 looked at the notifications and other intelligence the Care Quality Commission had received about the home. We contacted the commissioners of the service to see if they had any updates about the home.

During the inspection we spent time with six people who were living at the home. We also sought feedback about the service from two relatives. We spoke with the provider, registered manager, deputy manager, chef, activities organiser and three care staff.

We looked at the care records for five people living at the home, three staff personnel files and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, the kitchen, bathrooms, laundry room, lounge and conservatory.

Requires Improvement

Is the service safe?

Our findings

The PIR informed us of the monthly safety audits for the home. During our visit we conducted a tour of the building. We noted a number of safety issues at the home and lack of maintenance in some areas. We saw that there were seven radiator covers that had were not securely attached and two radiators were not working correctly in people's rooms. We found in general there was poor maintenance and a lack of safety checks for the windows, for example, a cracked plan of glass in one bedroom; some window restrictors were not working effectively (safety bars were however in place across the windows to reduce the risk of falls), one window could not be opened and one had a 'blown' glass pane.

We saw the use of four oil filled portable radiators which people and/or families had requested to use the in colder weather. The oil filled portable radiators were thermostatically controlled. One of these in one person's room was turned on and was warm to touch. There was also an oil filled portable radiator being used in the conservatory and this was hot to touch. There was no risk assessment in place to identify any hazards associated with their use.

The registered manager and provider took prompt action to address these concerns during and immediately after the inspection. Radiator covers were made secure, an audit of the windows that needed repair and a risk assessment for the safe use of portable heating devices (for oil filled radiators) was completed. The registered manager arranged for a glazier and plumber to attend the home to complete necessary work for the windows (including fitting of window restrictors where needed) and a check of the central heating.

The home's health and safety audit has since been reviewed and updated to evidence more robust safety checks for the premises and equipment. The registered manager informed us that a plan was to be put in place to have new windows in the home. We have since received further confirmation from the provider that all radiators are working effectively and the window restrictors are being fitted this week. A further check has also been undertaken of the radiator covers and these are correctly secured.

People had a portable hand held device (call bell) which they activated when they needed staff support. We saw these were placed next to people. There was however one incident where a person did not feel well and they did not have their call bell 'to hand'. The inspectors had to activate the call bell on the person's behalf. This was a concern as if the inspectors had not been present the person would not have been able to call for assistance and this could have had a serious effect on their health. The person received a full health check following the incident and there appeared to be no ill effects. This was brought to the registered manager's attention who looked into this matter immediately to ensure it would not happen again.

These incidences were a breach of Regulation 12 (1) (2) (a)(b)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not always have suitable systems and processes in place to ensure the environment and equipment was safe and used safely.

With regards to other safety checks and service contracts, systems and processes were established for

checking the safety of the water, fire systems and emergency lighting for example. Service level agreements were established for moving equipment, Legionella compliance, heating, lighting, electrical and gas checks. A personal emergency evacuation plan (often referred to as a PEEP) was in place for each of the people living at the home so that they could be evacuated safely and efficiently in the event of an emergency. These were located in the main hallway. There was a fire risk assessment for the premises which was reviewed regularly. We found the communal areas and hallways warm, well-lit and free from trip hazards.

At the time of our inspection there were 22 people residing at the home. On the first day of the inspection the registered manager was on duty along with a registered nurse, deputy manager and four care staff [the registered manager and deputy manager were both registered nurses]. On the second day of the inspection the registered manager was on duty along with the deputy manager and same number of care staff. At night the home was staffed with a registered nurse and two care staff. Staff duty rotas confirmed consistency of staff numbers. There were ancillary staff including, an administrator, chef, maintenance person, activities organiser, domestic and laundry staff.

Staff interviewed confirmed that the home was managed in terms of staff numbers and support though the home could be very busy due to people's current dependencies. Particular reference was made by the staff regarding the number of people who needed support with their meals. Staffing rotas were seen and these confirmed the current staffing numbers. People living at the care home told us the staff were busy and that this could affect the time it took for them to support them though they appreciated the staff did their best. A person said when they called for assistance if staff were busy they still came to tell them they were attending to someone else, and would come to them as soon as possible. Another person said, "I don't feel unsafe, the staffing is okay." During the inspection we did not observe any person having to wait a long time for support.

The registered manager was aware that at different times of the day the home was especially busy, for example, meal times and this could impact on the time for personal care. The registered manager was in the process of making changes to the morning routine to accommodate this. They told us the change was working well and that people's dependencies were also regularly assessed to ensure staffing numbers were adequate.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. An adult safeguarding policy and the local area safeguarding procedure was available in the home for staff to access. Staff had access to an ongoing training programme for safeguarding adults from abuse. A staff member said, "I would speak up if it was wrong even if it was my friend."

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We found medicines were being managed safely. Medicines were securely locked away when not in use and most items were dispensed in blister packs. Blister packs are individual containers of the person's medication.

A medication policy was in place though this did not record information to support and guide staff in administering medicines covertly. This is when medicine is hidden in food without the person's knowledge but in their best interest to maintain health. This information was obtained during the inspection for staff to refer to. Staff were supporting a person with covert medicines. This method of administration was undertaken safely by the staff.

Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures

their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded. This helped to ensure medicines stored in the fridge are used safely.

Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. We checked two controlled medicines and other medicines stored in the home. Stock balances were found to be correct.

Quantities of medicines received into the home were 'checked in' by the staff to provide an accurate stock check. We reviewed a selection of medication administration records (MAR) and found staff had signed to say they had administered their medicines. Medicines were given safely as prescribed.

We looked to see if creams were applied as prescribed. The registered manager had just introduced a cream chart which provided information about the cream and where it should be applied. The cream chart had a body map for staff to refer to. The cream charts were completed in good detail and signed by the staff when they had administered creams. Nutritional supplements and thickening agents added to drinks (for people who had difficulty swallowing and were at risk of choking) were signed for as given as prescribed.

People's care documents made reference to the medicines they had been prescribed. We discussed with the registered manager ways or recording further information in people's plan of care regarding their medicines. Staff demonstrated however a good knowledge of people's medicines to support them safely and in accordance with individual need. Medicines to be given 'when required' (PRN) were monitored by the staff and people had a plan of care and PRN protocol in place for their use.

At the time of the inspection the registered manager informed us there were no people who wished to take charge of their own medicines. The registered manager was aware of the need to complete a risk assessment and plan of care to support this practice if they wished to undertake this practice.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at three staff files, including staff recently appointed. We asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. The files contained two references, proof of identification and had appropriate criminal records checks so that staff employed were 'fit' to work with vulnerable people.

We found during our inspection that people were assessed for any risks regarding their health care needs. These included areas of risk such as falls, scalds, moving and handling, nutrition and skin integrity. The risk assessments were reviewed and the information used to inform the plan of care. These assessments helped ensure people could maintain as much independence as possible whilst promoting their safety.

The registered manager informed us there had been no incidents however accidents, such as falls, were recorded. There was no formal system in place for analysing accidents/incidents though staff were very aware of people who were at high risk of falls. We saw equipment was in place in people's rooms to try and reduce this risk. We discussed with the registered manager ways of using this information to further identify trends or patterns as part of the service's quality assurance system.

When looking round the home we found the home to be clean. Staff had access to gloves, aprons and liquidised soap to help assure good standards of control of infection in the home. People living at the home told us the home was kept clean and tidy.

Good

Is the service effective?

Our findings

We asked people to tell us what they thought about the food. People commented on the quality and quantity of the food. Two people said it was 'delicious', they were served enough and the food was of their liking. One person told us the meals were 'first class'. People confirmed they could request something different if they did not 'fancy' what was on the menu.

We observed lunch and found it to be a sociable occasion. Meals were served promptly and pleasantly by the staff, portion sizes were adequate and the meals were served hot.

The PIR stated, 'A food likes and dislikes form is completed so that the kitchen staff are aware of individual food preferences. Each resident is also given a choice of meals, and the chef is competent in providing a nutritional and well-balanced diet. The resident is assessed on admission as to what consistency of diet is required i.e. liquidised or soft, and also whether their meals need fortifying.'

There was a two week menu and a number of changes had recently been introduced following feedback from people living at the home. People had requested more hot meals in the evenings, chunky soups and fewer sandwiches. We were shown new menus that reflected these changes. There was plenty of fresh fruit and vegetables available.

People were given a choice of meals, deserts and hot and cold drinks throughout the day. The main meal of the day was served at lunch time with a lighter meal in the evening. Some people required pureed meals and these were well presented to ensure the foods retained their colour and texture.

Staff and people we spoke with told us if they did not like what was on the menu then an alternative would be prepared for them. People's preferences and dietary requirements were recorded in people's plan of care and also in the kitchen. The chef had a good knowledge of what people liked to eat.

People had a plan of care to identify care needs. A nursing care plan provides direction on the type of care an individual may need following their needs assessment. Care planning is important to ensure people get the care they need when they are at care home. Care plans covered areas such as, mobility, personal hygiene, falls, sleep patterns, nutrition, care of skin, social care and medical conditions that require clinical intervention.

Staff were providing care for people who required more clinical intervention to maintain their health. For example, pressure ulcer care, fluids given via a specific route to maintain hydration and tube for enteral feeding. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate.

We found people's plan of care was inclusive of all care needs so the staff had the information they needed to provide care and support to people in accordance with their individual need. Talking with staff confirmed

their knowledge of people's care and this was in accordance with people's plan of care.

People's nutritional needs were assessed and people's weight was monitored and action taken if there were any concerns about people losing weight. This meant people were supported to maintain appropriate intake of food and fluids.

We looked at how the uses of fluid thickeners were managed for people who had difficulties swallowing, eating and drinking and therefore at risk of choking. Staff were aware of the different fluid consistencies which had been prescribed for individuals by external professionals, for example, speech and language therapy (SALT) team. This was well documented. A record was kept in the kitchen of the fluid consistencies and staff recorded [using a diet and fluid chart] the use and stage of thickening agents when added to drinks. Thickening agents was also recorded in people's plan of care to help ensure this care needs was met effectively and safely.

Care monitoring charts were kept in people's rooms and these recorded aspects of care and safety checks to ensure people's safety and well-being. For example, fluid and diet taken, re-positioning whilst in bed, a person's output and safety checks for pressure relief mattresses and pressure relief cushions.

People told us they could see their GP when they wanted and that staff had a good understanding of the care and support they needed and wished to receive. We saw evidence of appointments with external health professionals such as, dietician, podiatrist and GP. Their advice had been sought at the appropriate time and recorded.

We looked at staff training to check staff were appropriately trained to care for people safely and effectively. We saw staff were appropriately supported to carry out their roles and responsibilities. Staff had received a good standard of training; on line courses and face to face training was provided. Mandatory courses included, moving and handling, fire safety, infection control, food hygiene, safeguarding, first aid and health and safety. Staff also received additional training in more specific clinical areas such as, diabetes, stoma care, equality and diversity, nutritional awareness, enteral feeding and dementia care. The staff training plan identified the courses undertaken by the staff and certificates for course attendance were kept in staff files. Staff told us they received the training they needed along with regular supervision and appraisal.

New staff received an 'in house' induction and the registered manager told us staff were being enrolled on the Care Certificate. This is 'an identified set of standards that health and social care workers adhere to in their daily working life'. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting. We were shown training details for the Care Certificate for one new member of staff. The member of staff told us the Care Certificate induction which they had commenced.

We saw dates of three monthly supervision meetings held, staff appraisals and further planned training for infection control, Mental Capacity Act 2005 and safeguarding adults. Supervisions are regular meetings between an employee and their manager to discuss any issues that may affect the staff member; this may include a discussion of ongoing training needs. A staff member said, "The matron (registered manager) is great, you get all the help you need."

Formal training in NVQ (National Vocational Qualifications) in Care/Diploma had also been obtained by approximately 65% off staff as part of their learning and development.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act

(MCA). The 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 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Deprivation of Liberty Safeguards (DoLS) had been submitted to the local authority for people living at the home and one DoLS had been approved to date. The registered manager was aware that if authorised we need to be informed in accordance with our regulations. The registered manager was knowledgeable regarding the DoLS and had a good awareness of the principles of the MCA. Where a person was appointed Lasting Power of Attorney [LPA] so they could make decisions on a person's behalf, this was recoded so that staff were fully aware.

Mental capacity assessment had been carried out for people who lacked capacity to consent to their care and we could see that families had been involved in any discussions and agreements regarding care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice. For example, we saw a well-documented and thought out decision around using medication covertly for one person in their best interest. A mental capacity assessment had been undertaken along with holding a best interest meeting involving relevant health professionals, staff and family member to decide whether administering medicine covertly was in the person's best interests. A plan of care was in place to support this practice which was subject to regular review

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) plans were in place for some people. These were in accordance with the MCA and had been coordinated by the person's GP.

During the inspection we found staff regularly asking people for their consent before carrying out any care or assistance. A staff member said, I would check first with someone that they are happy for me to help."

Good

Is the service caring?

Our findings

We asked people if they thought the staff treated them well and they told us they did. People said, "The staff are very nice and polite. They come when I call them", "The staff have been wonderful since I have arrived", "Staff were very good, dedicated, nothing is too much trouble" and "I am more than happy, they are busy but they do their best." A relative told us their family member received a good standard of care by staff.

We observed staff interactions during the inspection. We found the staff to be courteous, caring, understanding and sensitive to people's needs. Gentle encouragement was provided with daily tasks and activities and people were encouraged with their independence.

We saw staff supporting people with their meals and some care interventions. People were not rushed in anyway, staff offered reassurance whilst supporting them, ensuring the comfort at all times. Interactions between staff and the people they supported was very positive. People living at the home told us they were listened to with regard to how they wish to be supported and that the home's routine was fairly flexible in respect of meal times, getting up and retiring at night. People appreciated that the home had a routine however they said the staff did their best to accommodate personal preferences. People went on to say that the staff talked with them about their care and we saw people's involvement in making decisions and planning their care was recorded.

Staff told us people could choose where to eat their meals. We saw that some people chose to eat in their rooms and others in the lounge and conservatory (this room was used as the dining area at meal times). Staff told us the majority of people did not want to sit the dining area as they were more comfortable sitting in an armchair and this wish was respected.

For people being nursed in bed they appeared very comfortable and settled. Staff were vigilant in undertaking 'care and safety checks' to make sure people were safe, warm, not in any pain, to provide fluids and diet and a change of position. When staff entered people's rooms they knocked before entering and waited to be asked in. In all instances the staff talked with people in a gentle manner, explaining what they were going to do, checking on their comfort and not leaving until safe to do so. We saw that staff knew people well and knew how to care for them in accordance with individual need.

Staff told us that people's needs were discussed at daily handovers and these along with the care records provided them with the information they needed to look after people. From the care records we looked at we could see that staff routinely communicated with people living at the home or their families in relation to care needs. People and their family's involvement in the plan of care was documented. A relative told us they were informed of any change in care or if a doctor needed to be called.

Staff were aware of how respect and follow people's choices and wishes for end of life care and when to implement advance care planning to record their anticipated care needs and wishes.

For people who had no family or friends to represent them, local advocacy service details were available

and displayed for people to access. A person at the home was receiving support from an advocate at the time of our visit.

A service user guide was available and this provided information about the home and the services it offered. People also had this information and a menu in their room.

We observed relatives visiting during the inspection and people told us their relatives could visit at any time. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained.

Good

Is the service responsive?

Our findings

People living at the home had individual care plans and we saw some information recorded about people's social care and preferred routine, night care, for example. The amount of information varied and we discussed with the registered manager ways of improving the records to make them more individual to each person. Talking with staff confirmed their knowledge of when people liked to get up to have their breakfast and to get ready for bed at night. A person said the staff knew their routine and how they liked to be helped during the day.

Most care plans we viewed showed that people and their families had been involved in formulating and reviewing their planned care. There was written agreement from people and their families that they had read and understood their plan of care. We saw care documentation was subject to regular review and any change in care of treatment was documented. This helped to ensure that care plans provided clear and accurate information regarding people's current care needs.

An activities organiser was present during the inspection; the activities organiser was new in post and employed three hours each day on a Monday,Tuesday, Thursday and Friday. The PIR told us that life histories were completed regarding people's hobbies. The activities organiser was able to show us a new activity plan based on people's interests and also social activity file which was now in place for each person to evidence their participation. Although they had only recently started working at the home there was evidence of a good programme of events and 'one to one time'. This had been factored in for people who wished to stay in their room or preferred this contact.

The PIR told us that contact would be made with a befriending service for people who did not have any family. Details of this service were displayed on a large activities board in the main hall way. The activities board was colourful and provided details of forthcoming events and some arts and craft work.

The new activities seem to be well received. Social activities included, musical events, singing, feeding the birds in the garden, games and quizzes. The introduction of armchair exercises was also being looked into and a pet therapy session had been booked for this month (bringing an animal in to the care home to provide stimulation and improve people's well-being). People were joining in with a singer/musician who was playing a guitar in the lounge. This appeared to be very much enjoyed by everyone. A person told us how much they enjoyed going into the garden to feed the birds and another person told us they were looking forward to doing more things [social activities]. One person said, I love the chats and we get on to subjects which are really interesting." We saw people were encouraged to be independent and a person told us they went into the village with a friend.

People living at the home that we spoke with were aware of how to make a complaint. We saw the service's complaints' procedure was available in the main hall way so that people could easily access this information. There had been no complaints received, only a few 'grumbles' and these had been recorded and looked into. A complaint form was available should a complaint be received.

The PIR stated, 'All potential service users, subject to practicality, are invited with their relatives to visit Kingsley for lunch and coffee to familiarise themselves with the environment and meet the staff.' A person who had recently moved to the home was complimentary regarding the level of staff support and made reference to the warm welcome they received. We saw the transition between services had been well managed for this person.

Requires Improvement

Is the service well-led?

Our findings

We looked at the quality assurance systems and processes to monitor how the service was operating and to drive forward improvements. Quality assurance systems were in place to monitor standards within the home.

We discussed with the registered manager the maintenance checks and health and safety audits for the home. These included checks by the registered manager, the home's maintenance person and monthly checks by the home's provider. There was evidence of an ongoing programme of decoration, new carpets had been laid and checks on hazards such as trips, falls, hot water, cleanliness of the building and fire safety had been completed. Bedrooms were also now equipped with profiling beds (nursing beds). The current auditing system and health and safety checks for the environment and equipment had however not identified the shortfalls we found during the inspection regarding possible environmental risk. For example, general maintenance and safety checks of windows and the heating, also radiator covers not secure.

We recommend further development of the current auditing system for the environment and equipment to monitor standards and ensure the safety of people living at the home.

There was a clear management structure in place. There was a long standing registered manager in post and they were present on both days of the inspection. During the inspection we spoke with the registered manager and provider regarding our findings in respect of the environment and the need to review and develop more robust checks. The registered manager and provider were responsive and we have been advised of the prompt measures taken to improve the safety of the environment and equipment. We were assured by the actions taken so far.

We looked at other areas of the home that were subject to regular auditing. This included medicines, care, cleanliness of the premises and a weekly care audit. The care audit included checks on care files, making sure staff shifts were covered and arranging meetings. We also saw evidence of a quality control/assurance audit and this provided detailed information about different aspect of the home. This included a review of service/care records, talking with staff, a tour of the building, feedback from satisfaction questionnaires and residents' meetings.

We saw the home had been subject to some external auditing such as, the clinical audit from the commissioners, an audit by the commissioners' pharmacy team and an infection control audit by the local community health team. Any recommendations from the internal and external audits had been acted on and signed off by the provider to improve the service (though as previously stated the internal audit did not include all environmental risks). For infection control the registered manager had introduced a robust audit tool for monitoring standards of cleanliness in different areas of the home. The home scored highly for its control of infection.

The PIR stated, 'There is a good working relationship between the owners, Matron Manager, Deputy Matron and Administrator which ensures that the service is well led and ran in a professional yet friendly manner.'

Feedback from staff, people who lived at the home and relatives was positive regarding the management of the home. We were informed the registered manager was approachable, had a good visible presence in the home and people could speak with them at any time. Staff said there was a very good staff team at the home and staff members were supportive of one another. They confirmed staff meetings were held and they could raise any issue with the registered manager. Staff were aware of the whistle blowing policy and said they would not hesitate to use it; this helped to promote an 'open' culture.

People living at the home and their relatives were encouraged to give feedback about the home. This included completing resident/relative meetings. These were held every six months and we were shown minutes of meetings held. Following the meeting held in December 2016, feedback from people had resulted in a change to the menu (instigated the week of the inspection) and also arranging for a lay service (for people of all faiths) to be held at the home. This service took place during our inspection and a relative said how pleased they were that this had been arranged. People in the home also now had access to Wi-Fi and broadband. It was evident that people's opinions and views mattered; feedback was taken seriously to implement change and improvement in accordance with people's wishes and views.

We saw a number of satisfaction surveys completed by people living in the home and their relatives. These were sent out every two months and comments received were positive regarding the service. Staff surveys provided good comments about the management of the home.

An Environmental Health Officer visited the home in September 2016 and awarded the home five stars for food, (five stars being the best score) based on how hygienic and well-managed food preparation areas were on the premises.

We looked at a number of the home's policies and procedures and saw that they were regularly reviewed to ensure information was current and in accordance with 'best practice'. This meant staff had to up-to-date guidance to support them in their job role.

The registered manager was aware of their responsibility to notify us, the Care Quality Commission (CQC), of any notifiable incidents in the home. Our records confirmed this.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Kingsley Nursing Home was displayed for people to see.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always have suitable systems and processes in place to ensure the environment and equipment was safe and used safely.