Mr & Mrs R S Rai

Kingsley Cottage

Inspection report

40 Uxbridge Street
Hednesford
Cannock
Staffordshire
WS12 1DB

Tel: 01543422763

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Kingsley Cottage is a residential care home providing personal care for up to 17 people aged 65 and over. At the time of our inspection, there was 17 people living at the home, some of whom were living with dementia.

People's experience of using this service and what we found
Audits and quality monitoring were in place, but the recording of actions taken was not always clear; for example, on the outcome of actions taken to reduce accidents and incidents.

People were administered their medicines as prescribed. People's needs and risks were assessed with management plans in place to reduce the risk of harm. Staff knew people well including their likes, dislikes, risks to them and how to minimise them. There were enough staff to meet people's needs safely. Staff were recruited safely to ensure they were safe to work with vulnerable people. Staff and visitors wore personal protective equipment (PPE) in line with government guidance to reduce the spread of infection within the home.

Relatives told us they were kept up to date and informed and felt their family member were safe and well cared for. Feedback was sought from people and relatives. Staff gave mixed views on whether they had regular supervision. The service worked well with other professionals to ensure people's needs were met safely and efficiently.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 January 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for five out of six inspections, with one being rated as inadequate.

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. We are currently gathering and reviewing evidence in relation to this. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of falls. This inspection examined those risks. We found no evidence during this inspection that people were at risk of

harm from this concern. Please see the safe and well-led sections of this full report.

At the previous inspection on 29 November 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

During this focused inspection we checked they had followed their action plan and confirmed if they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kingsley Cottage on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside and meet with the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Kingsley Cottage

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 30 minutes notice of the inspection. This was because we needed to confirm the covid-19 status within the home and check what infection, prevention and control measures were in place.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and three relatives about their experience of care provided. We spoke with eight members of staff including the registered manager, the provider, deputy manager, senior care workers and care workers.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies, procedures and audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who regularly works with the service.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse, Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Staff had a good understanding of safeguarding people from abuse and felt confident reporting any concerns both within the service and external from it. However, some staff told us they were not confident that action was taken when concerns were raised. We raised this with the provider and were assured they had taken action when the concerns had been raised with them.
- At our last inspection, we found people's care records had not been updated and did not reflect current need and risk. At this inspection we found improvements had been made.
- People's needs, and risks had been assessed with risk management plans in place for staff on how to reduce the risk to the person. For example, where someone was at risk of falls, they had equipment in place to alert staff when they got out bed and staff were aware that they needed to provide reassurance during an evening when the person became more anxious.
- When people had accidents, these were recorded at the time and action taken to protect them such as requesting other professionals' guidance. There were internal reviews of the causes of the accidents.
- Staff we spoke with confirmed they knew people and their needs well.
- People told us they felt safe and relatives told us they received good care from staff. One relative said, "Initially [Person] was very agitated but they have settled so well, [Person] always tells me how happy they are".

Using medicines safely

- At our last inspection, we found there were issues with the recording of medicines. At this inspection, we found improvements had been made. However, where missing signatures had been identified, staff had been asked to sign retrospectively. This meant we could not be sure that the Medication Administration Records (MARs) were accurate.
- People were given their medicines as prescribed.
- Where people required time specific medicines, this had been adhered to. People who had as required medicines, had protocols in place with guidance for staff on when to give it.

Staffing and recruitment

- We received mixed views from staff regarding staffing levels. Some staff told us there is not enough staff in an afternoon to meet people's needs safely. We observed care in the afternoon and found there were enough staff. However, we discussed this with the provider who assured us they would keep it under review.
- We found that there was enough staff to meet people's needs safely. People did not have to wait for

support, and we did not see people being left at risk.
● Relatives we spoke with said they felt there was enough staff to meet people's needs.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as required improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At our last inspection we found issues with the some of the audits that were in place for accidents and incidents and medicines. At this inspection, we found improvements had been made but there were improvements which could be made to record the action taken to reduce the risk of reoccurrence.
- The medication audit highlighted missing signatures and action was taken to taken stated that ensure staff had been contacted to check the medicines had been administered and to sign retrospectively. However, this could be improved by recording what was the cause of the omission if it was frequent and the action taken; for example, shadow the administration or provide training.
- There was an audit for accidents and incidents which recorded them and there was evidence that action was taken to prevent further occurrences. However, this was not always consistently recorded in the audit.
- Where concerns had been raised, we could not always be assured what action had been taken as this information was not consistently recorded. For example, where staff had raised concerns, we discussed them with the provider and registered manager who informed us they had verbal conversations regarding these issues, but they had not been recorded. This meant they could not always show the action taken to address concerns.

We recommend the provider continues to embed the processes to assess and monitor the quality of the service to ensure action is always taken to learn when things go wrong.

- The registered manager ensured that notifications were sent to us when required. Notifications are events that the registered person is required by law to inform us of.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff told us they felt confident raising concerns if they had any and staff were given the opportunity to raise concerns during regular staff meetings. However, they felt they were not supported or listened to and that action was not always taken.
● People and relatives were given the opportunity to give feedback and felt changes were made as a result.
● Relatives spoke positively about the registered manager and provider stating they were very "hands on" and "approachable".

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff told us they worked well together as a team.
● Relatives told us that where they had raised concerns, they felt action had been taken. One relative stated, "I have raised a couple of minor concerns and they have been dealt with quickly and efficiently."
● The culture within the home was person centred and staff worked hard to ensure people's needs were met in the way they chose.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and registered manager were aware of their responsibilities under the duty of candour and acted on it appropriately.
● Relatives confirmed they were kept updated and informed where they had been any accidents or incidents and records, we viewed confirmed contact had been made with relatives.

Working in partnership with others
● The service worked well with other professionals. We saw that where there was a need, professionals had been contacted for advice and support to ensure people's needs were met safely. For example, where someone was at risk at falls and had been falling more frequently in a short space of time, a new referral to the falls team had been completed to identify any actions to reduce the risk.