Angels (Kingsleigh) Ltd

Kingsleigh Residential

Inspection report

78 Berrow Road
Burnham On Sea
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Tel: 01278792768

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection was unannounced and took place on 16 September 2016.

Kingsley Residential Home is registered to provide accommodation for older people who require personal care for a maximum of 23 people. The home is set in well laid out gardens and has easy access to Burnham-on-Sea town centre. Some people living in the home were living with a dementia, so were unable to tell us of their experiences.

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

The service was not always safe because staff propped the fire doors into the dining room open. Records of fire drills did not show which staff had taken part. However, staff received quarterly fire training and information was available to guide staff during emergencies. Staff did not have all the information they needed to meet people's dietary needs.

Some areas of the home needed maintenance work. Some people's emergency call bells were out of reach and there were no call bells accessible in some areas of the home.

People had mixed experience during lunch because one person waited 15 minutes and another person was given their medicines during lunch. However, relatives told us there were sufficient staff to meet people's needs. People and relatives told us staff were very kind, considerate and friendly.

Staff did not ensure one person was adequately covered to protect their privacy and dignity when they were hoisted.

People or their representatives were involved in planning their care. Care plans accurately reflected the care people needed.

People's needs were reviewed regularly, and changes made where necessary.

People were given choices, and staff always sought consent before giving people care and support. Staff encouraged people to be as independent as they could be.

Staff received Gold Standard Framework training, which meant people's end of life wishes were respected.

People and relatives were given opportunities to feedback their views about the home and the service. Everyone was very happy with the service they received.

Staff told us they were supported. Staff completed regular training to give them the skills they needed to be able to meet people's needs.

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.

People were at risk because staff did not have all the information they needed about people's dietary needs.

Staff propped the dining room fire doors open. However, staff knew where to access information and understood what they needed to do in the event of an emergency. People had emergency plans in place.

People were protected against the risk of abuse because staff were trained how to recognise and report abuse.

Is the service effective?

Good

The service was effective.

People were given choices of what they wanted to eat.

People and those close to them were involved in their care.

People saw health and social care professionals when they needed to.

Staff who received supervision and on-going training to make sure they had the appropriate skills and knowledge cared for people.

Is the service caring?

Good

The service was caring.

People's dignity was not always respected by staff. Staff did not ensure people were fully covered when moving them.

People were treated with kindness and compassion and encouraged to be as independent as possible.

Staff received specialist training for end of life care and people's wishes were respected.

Is the service responsive?

Good

The service was responsive.

People's care was planned and delivered in line with their current or changing needs.

People and relatives shared their views on the service. People's views and experiences were used to improve the service.

People were confident that complaints would be taken seriously and investigated.

Is the service well-led?

Good

The service was well-led.

People were supported by a staff team who told us the managers were approachable and supportive.

The registered manager checked the quality of the service provided and made sure people were happy with the service they received.

Kingsleigh Residential

Detailed findings

Background to this inspection

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

This inspection took place on 16 September 2016 and was unannounced. It was carried out by an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience was experienced in residential care home inspections and care of people with dementia.

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 looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

Most people were unable to tell us their experiences of living at the home. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We had limited conversations with eight people. After the inspection, we spoke with four relatives. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for five people. During the inspection we spoke with the current registered manager, deputy manager, home co-ordinator, one senior, three care staff and the chef. We looked at records about the management of the service such as four staff files, minutes of meetings, complaints and quality audits.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

Information about people's dietary needs was not always being shared. One person's care plan identified the person was taking a medicine, but did not identify the risks of drinking cranberry juice when taking this medicine. Cranberry juice was available within the home to drink but there was no information in place to inform staff that people taking this medication should not drink cranberry juice. We asked two staff and the chef if they were aware of anyone who may not be able to eat or drink certain things. They told us about one person with a nut allergy and this was clearly identified in their care plan. Staff were not aware of anyone else who needed to avoid any drinks for any reason. This meant staff and the chef we spoke with were unaware of the effect cranberry juice could have on certain medicines. The person may be at risk if they consumed cranberry juice because the medicine might react with it. We raised this with the registered manager who assured us they would follow this up straight away.

People were kept safe from most of the risks of emergencies in the home. However, we saw the fire doors into the dining room were propped open during the inspection. We discussed this with the registered manager and the prop was removed; however the door was seen to be propped open again later. This meant, in the event of an emergency where the fire safety systems should automatically close doors to protect people, people would be at a higher risk because the doors couldn't close. Training records showed staff received fire safety training four times a year which was provided by an external provider. Information we received following the inspection confirmed fire drills had been held regularly, but did not list the names of staff who had participated. This is important because the provider's policy stated staff working days should take part in fire drills every six months, and staff working nights should participate every three months. It would not be possible to see from the information recorded if this was happening. Information was available for staff if they needed to evacuate the home in the event of a fire, including personal evacuation plans for each person. The home had plans in place for other emergencies. Staff knew where to access information and understood what they needed to do. People had their own plans if they needed an emergency admission to hospital, which gave hospital staff the information they needed to be able to provide appropriate support.

There were some areas within the home which required on-going maintenance. We saw the skirting behind one WC was damaged and showed bare wood which would make it difficult to keep clean. In another room, we saw the basin seal had broken and the basin was loose to the wall. This meant debris was able to get between the wall and the basin. In another bathroom, we saw that a toilet riser was soiled. This meant it was difficult to keep these areas clean to ensure they did not pose a risk of infection to people.

In one person's room the window was restricted, but the amount it could open was much wider than other windows on restrictors and posed a limited risk that someone might fall out of the window. A restrictor was missing in another person's room which meant there was a risk the person could fall out of the window. Some electrical items had not been PAT tested. This is a requirement to ensure that no danger results from the use of portable equipment. People would not have been able to use the emergency pull cord in one

bathroom because it didn't reach the floor and was concealed behind the bath lift. We discussed these environmental and call bell issues with the registered manager, who assured us they would be addressed.

Risks of abuse to people were reduced because there was a thorough recruitment procedure for new staff. Staff told us about the recruitment process and explained how they felt supported when they started work. We looked at the recruitment records for four members of staff. These showed the provider had carried out interviews, obtained references and a full employment history. Disclosure and Barring Service (DBS) checks had been carried out which checked people's criminal record history and their suitability to work with vulnerable people) before they commenced employment. New staff were provided with a handbook which gave them information they needed about the policies of the home.

Staff told us, and records confirmed that staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Staff said, "Everything we do here is to keep people safe" and "We've had lots of training, we know how to keep residents safe." Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected. This meant people were protected against the risks of potential abuse.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. For example, where people had specific needs relating to health risks such as mobility and continence we saw there were risk assessments and guidance for staff in place. Staff we spoke with were able to tell us about risks to people and how they kept them safe, and this was in line with the information in people's care plans. For example, staff were able to tell us how they managed the risks for one person around infection.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. Relatives told us there were sufficient staff to meet people's needs. Results of the survey completed in January 2016 showed relatives felt staff were very friendly. Analysis of the survey showed relatives considered the home and staff to be either excellent or good throughout. Comments included, "There is always someone to hand when you need them" and staff were "More than helpful."

There were safe medicine administration systems in place and people received their medicines when required. There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. The home used a blister pack system with printed medication administration records. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored and clear records were in place. We checked records against stocks held and found them to be correct. Some people were prescribed medicines on an 'as required' basis, such as paracetamol. We saw people were asked if they would like pain relief. Staff who were trained to give medicines were assessed to ensure they were competent to give people their medicines safely. This meant peoples medicines were well managed to ensure people received them safely and effectively.

Good

Is the service effective?

Our findings

The service was effective.

Staff told us they were aware of people's dietary preferences. The chef told us they had all the information they needed and were aware of people's individual needs, for example the chef and staff were aware of one person who was allergic to nuts. The chef visited people twice every day and asked people what they would like for lunch and dinner. There were pictures of meals on the notice board which were confusing, because the pictures showed hot meals for lunch, when these were available for the evening meal. This meant people were given confusing information to use to make choices because the information board hadn't been updated. Staff told us people had chosen to have their main meal in the evening because, "People eat more. They might not have had breakfast till late if they get up late." This demonstrated that the service had listened to what people had requested and had changed in line with this.

We observed lunch in the dining room and our observation showed that people had mixed experiences during lunch. Some people were able to engage with other people and staff and enjoyed their dining experience. One person had their dining experience interrupted when a member of staff gave them their medicines before they had finished their meal. We saw one person waited 15 minutes for their lunch because staff were busy serving other people. People were given choices of egg or cheese on toast, sandwiches or soup, followed by apple crumble. A selection of drinks, fresh fruit, yoghurts and cheese and biscuits were always available.

People received care and support from staff who had the skills and knowledge to meet their needs. Staff told us, and records confirmed that staff completed a range of training which included moving people, fire and dementia care. Staff told us their training gave them the skills they needed to do the job and said, "We're doing training all the time" and "Some training is refreshed annually, and other training is done every 6 months." Two staff we spoke with told us they were being supported to obtain nationally recognised qualifications in care. Staff told us they felt their induction and training enabled them to perform their role.

Staff told us, and records seen confirmed they had undergone a thorough induction programme which gave them the basic skills to care for people safely. Staff were able to attend training sessions either in the home or in a sister home, which meant staff were given opportunities to make training as flexible as possible. New staff shadowed experienced staff until they had completed competency assessments to check they were providing care to meet people's needs. After they had completed training, the registered manager assessed staff in areas such as manual handling, safeguarding, personal care, consent and infection control.

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Records confirmed staff had regular supervisions and appraisals. Staff told us they felt supported by the registered manager, deputy manager, and other staff. Comments included, "I can raise anything" and "We're a good team".

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. People or their relatives told us they were always asked for their consent before staff assisted them with any tasks. People told us, "You can choose what time to get up. They come and ask if we are okay, then will bring us a couple of tea and ask if we want to get up."

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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. Relatives told us, where their loved ones were unable to make any decisions for themselves, they were always involved in decision making. Relatives said, "I'm always consulted" and "They always contact me if they need to change something."

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).

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. No-one in the home was subject to any DoLS. Each person had a capacity assessment and best interest profile and each situation which required a decision was looked at separately. Where one person used bed rails to keep them safe, consent had been obtained for these. Staff had received training in MCA and DoLS and were aware of the need to obtain consent from people. Staff told us, "We give people choices by showing them." This meant staff were following the principles of the MCA.

Information in the PIR stated, "Effective care for people is monitored and maintained through care plans which are reviewed monthly or when necessary. Health professional are involved regularly in all aspect of health care such as the weekly GP visit. Residents are referred to the local dietician as and when required via the GP". Records seen during the inspection confirmed these points. We saw people's changing needs were monitored to make sure their health needs were responded to promptly. Care plans were in place to meet people's needs in these areas and were regularly reviewed. People's care records showed relevant health and social care professionals were involved with their care. People were referred appropriately to healthcare professionals such as a dietician and speech and language therapists, if staff had concerns about their wellbeing. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. This meant people's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Good

Is the service caring?

Our findings

The service was caring.

People's dignity was nearly always respected by staff. However, we observed one person being moved using a hoist and sling on two occasions. On both occasions, the person's privacy and dignity had not been fully maintained, because they had been exposed at the back during the transfer, in a public area. Staff had ensured the person was covered at the front, but had not checked the person was fully covered. We discussed this with the registered manager, who assured us they would immediately address the issue.

People were treated with kindness and compassion in their day-to-day care. We observed staff treating people very respectfully. Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. People said, "They're wonderful", "Friends". Relatives told us they knew their loved ones care workers and said, "It's really nice, it's so friendly" and "It's such a nice little home." Relatives told us the deputy manager was very supportive and told us about the support they offered when their loved one was in hospital. They said, "When you're far away it makes a difference". Other relatives told us staff, "go out of their way to be kind." Staff said, "I love them" and "They're my family."

Staff encouraged independence where possible and allowed people to take their time. People told us, "As soon as I ring the bell, they come", "They help me" and "Nothing is too much effort." We saw people were able to make choices about all aspects of their day to day lives. Staff had completed equality and diversity training and we saw they understood what was important to people. Care plans recorded '20 things you didn't know about this resident' which recorded people's likes, dislikes and preferences.

Where people had made advanced decisions these were respected. For example, where people preferred not to be transferred to hospital at the end of their lives, district nurses were involved with making sure people received the care they needed. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. Relatives told us they were able to review their loved ones end of life choices. This meant people and their relatives were given support when making decisions about their preferences for end of life care.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them or their relative to make comments on the care they received and view their opinions. Relatives who did not live near the home told us they were given regular updates and were always consulted.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way.

The provider had signed up to the department of health's initiative 'The Social Care Commitment.' This is the adult social care sectors' promise to provide people who need care and support with high quality services. They had also signed up to the Gold Standards Framework, which gives training to all those

providing end of life care. This meant the provider had signed up to recognised training for staff to ensure better lives for people and recognised standards of care.

Good

Is the service responsive?

Our findings

The service was responsive.

The home had several small animals, including a bird in the hallway, fish in an outside pond and hamsters. People who wished, were able to be involved looking after the animals. People's views on other activities available were mixed. Some people told us they had access to very few activities they could be involved in. People told us, "There aren't many activities, we just sit here", and "I'm bored, there is nothing to do." Relatives told us, "[Name] stays in her bedroom but enjoys one to one's with her carers", "There's a timetable of weekly activities" and "I'm invited to activities such as sing-alongs and quizzes, there seems to be something planned most days." We saw six people in the lounge singing songs from 'The Old Bull and Bush' DVD which was playing on the TV; this provided pictures and music people enjoyed. We saw one person folding serviettes and sweeping up. This person said, "At least I am doing something" and told us this was something she enjoyed doing. Other people were able to read, colour in some pictures or play draughts. A quality report from Care Focus South West said, "Development is needed to ensure daily interactions and choices are offered. Care Focus (South West) is a Community Interest Company set up to undertake reviews to be able to help providers improve. We saw a timetable of activities in place, and these were mostly provided as stated.

There were a selection of 'thank you' cards on display, where families had written comments such as, "It's hard to put into words how much we would like to thank you for the care and compassion you showed", "May we thank you for all the wonderful care and support you've given" and "You did a great job."

We looked at five people's care records. Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care.

Relatives told us they were involved in care planning and were invited for regular reviews. Care plans were personalised and detailed daily routines specific to each person. Speaking with relatives they said, "I'm involved in everything" and "I'm included in all of the decision making." Relatives said, "The care plan is always available" and "I can see the care plan whenever I want." Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. Care plans gave guidance for staff how to meet people's daily needs such as eating and drinking, mobility and continence. The examples seen were thorough and reflected people's needs and choices. For example, where one person's care plan stated they needed to be weighed regularly, we saw this was being done. Where people needed support to manage their emotional or behaviour needs, care plans gave staff the information they needed to be able to meet people's needs. This meant people received care that was responsive to their needs and personalised to their wishes and preferences.

The registered manager sought people's feedback and told us they took action to address issues if any were raised. We saw the results of the last questionnaire completed in January 2016 which showed everyone was

happy, felt safe and felt the staff were excellent. Comments included, "Staff are more than helpful" and "Cannot fault it in any way."

People's needs were reviewed regularly and as required. The home operated a 'resident of the day' system, whereby each person was reviewed on a specific day each month. During this review, the persons care plan, catering preferences and other reviews were carried out. Where necessary health and social care professionals were involved. An example of this was visits from the district nurse to visit people who needed regular blood tests. A GP conducted a weekly visit to the home. Relatives told us, "If [name] ever needs a GP, district nurse, optician; they visit" and "My relative had new glasses as a result of the optician visiting".

We attended a handover meeting between staff. Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Each person was discussed and staff were updated with any changes the person required.

Each person received a copy of the complaints policy when they moved into the home. There had not been any complaints since our last inspection. Relatives told us, "I've not got any complaints" and "We've not needed to." Relatives told us if they raised anything with the staff, any concerns were dealt with straight away. Comments from the January 2016 survey included, "We cannot fault the service in any way" and "Everyone is more than helpful."

Good

Is the service well-led?

Our findings

The service was well led.

There were some quality assurance systems in place to monitor care and plan on-going improvements. Audits had not identified the issues we found, such as the lack of information for staff around the use of cranberry juice, the fire doors being propped open, the lack of accurate records for fire drills, the issues around window restrictors and lack of PAT testing. We discussed these issues with the registered manager, who assured us they would all be dealt with immediately. The registered manager, deputy manager and the home co-ordinator were involved in a variety of audits, for example, checking the quality of care plans and staff development. External auditors completed regular checks for medicines. The registered manager completed an assessment of the home every three months which looked at the kitchen, health and safety and the care provided. We saw that where shortfalls in the service had been identified action had been taken to improve practice. For example, where a medicines audit identified creams needed to be dated, the necessary actions had been completed.

The service worked in partnership with external health and social professionals to ensure people were well cared for. Records were kept when people saw professionals. We saw their advice or guidance was acted upon. The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

Where an error had occurred which meant one person was given the wrong medicine, the registered manager sent us a notification about this. Both the registered manager and the deputy manager had taken appropriate actions throughout their investigation and subsequent action.

The registered manager had a clear vision for the home. Their values were around ensuring staff delivered a quality and efficient service, based on people's best interests. To achieve this, we saw notices to staff where they were reminded to respect people's privacy and dignity and ensure their individuality was maintained. However we observed two instances when one person's dignity and privacy had not been maintained. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Staff received supervisions every six weeks and told us they found these to be supportive.

The service had a positive culture that was person-centred, open, inclusive and empowering. It had a well-developed understanding of equality, diversity and human rights and put these into practice. There was an equality and diversity policy in place and staff knew about this. Staff said, "We're all different and you have to respect that" and "We put residents first." People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Relatives told us they completed an annual survey. Relatives told us the registered manager and deputy manager were

approachable and said, "They're very nice" and "The deputy goes above and beyond what I would expect her to do."

Various staff meetings had been arranged to ensure everyone was involved in the decisions made and to ensure information was shared. Staff told us the registered manager was approachable and supportive. Staff said, "The manager is open minded and we can talk to her no problems." There was a staffing structure in the home which provided clear lines of accountability and responsibility.

Staff we spoke with had a good understanding of their responsibilities for reporting accidents, incidents or concerns. All accidents and incidents which occurred in the home were recorded and analysed. The registered manager audited the accidents and incidents to see if there were any trends or patterns. We saw where people suffered regular falls they were referred to the falls team. Information in the PIR showed that reviews of falls/accidents and incidents were investigated at the time. Action plans were implemented to reduce any risks and care plans and risk assessments were reviewed and updated to reflect these changes.