Christadelphian Care Homes

Kingsleigh House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 04 July 2017 and was unannounced. We last inspected Kingsleigh House in March 2015 and found that the service was meeting regulations and was rated as good.

Kingsleigh House provides accommodation with care and support for up to 30 older people. At the time of our inspection there were 27 people living at the home. There was a registered manager who was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We brought this inspection of Kingsleigh House forward due in part to notification of an incident where a person living at the home was exposed to risk of serious harm. We found that some action was planned and underway to address the provider's failings and shortfalls in areas relating to this incident and safeguarding practices at the home. Staff we spoke with were not always aware of how to identify all types of abuse although recent training had been provided in this area.

People and relatives told us that people were safe living at the home. People were supported to manage their risks safely by staff who understood people's support needs. People were satisfied with the support they received with their medicines although we identified that further areas of improvement were required. Staff recruitment processes were not robust and staff were not deployed effectively to ensure that people's needs were always met in a timely way.

People's needs were met by staff who told us they felt supported in their roles. People's choices and decisions were respected and promoted. Staff demonstrated an understanding of the Mental Capacity Act (2005). People were supported to seek further healthcare support as needed to remain well.

We observed that people and staff had positive rapport and people were involved in their care decisions. Feedback and processes showed however that people were not always supported by caring staff and people's views about their experience of the home were not always addressed. Systems were not robust to capture and improve all people's experiences at the home.

People had access to a range of activities in the home and within the community of interest to them. Almost all people at the home followed the same religious beliefs and practices. This created a sense of unity and informed some activities and routines at the home, which people valued. People's choices in relation to this were respected.

There was a complaints process in place. Whilst people told us that complaints had been dealt with to their satisfaction, complaints were not always investigated in a timely or appropriate way. Quality assurance processes had not identified and addressed all concerns and ensured the quality and safety of the service.

Additional support had recently been arranged by the registered provider to help drive improvements and build on the positive experiences of people living at the home. The home was supported by visitors and volunteers in the local community.

During this inspection, we identified two breaches of legal requirements. You can see what action we told the provider to take at the back of the full version of the report, in respect of one of those breaches of regulation. We are still considering what action we are taking in relation to the identified breach of another regulation and we will issue a supplementary report once this decision has been finalised.

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 consistently safe.

This inspection was prompted in part by an incident where a person living at the home had been exposed to risk of harm.

People told us that they were satisfied with the support they received with their medicines, although we identified that further improvement was needed in this area.

People told us that they felt safe. We observed that some staff took care to ensure some people felt supported and at ease. Staff were not effectively deployed to always meet people's needs. Recruitment processes were not robust.

Is the service effective?

Good

The service was effective.

People and relatives told us that staff understood their needs. Staff had access to guidance and support for their roles.

People were supported to make their own choices and decisions.

People were supported to seek further healthcare support to promote their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported to have their views and concerns heard or robustly addressed.

We observed that people were treated with dignity and respect by staff who were kind and caring. People's feedback did not reflect that this practice was consistent.

People's independence was promoted and their preferences about their care respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints raised by people living at the home had not always been addressed in a robust or appropriate way.

People were encouraged to take part in a range of activities of interest and significance to them.

People were involved in their care planning and decisions.

Is the service well-led?

Requires Improvement

The service was not well-led.

People's feedback was not always addressed and captured through quality assurance processes. There was not sufficient oversight of the service.

Systems and processes were not all robust. Concerns were not always identified and addressed in an appropriate and timely way to ensure the quality and safety of the service.

Additional support had been arranged for the registered manager to help drive ongoing improvements to the quality of care provided.

Kingsleigh House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 of Kingsleigh House commenced on 04 July 2017 and was unannounced. The inspection was brought forward in part by notification of an incident through which a person living at the home was exposed to risk of serious harm. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.
However, the information shared with CQC about the incident indicated potential concerns about the management of risk of safeguarding people from the risk of potential harm. This inspection examined those risks in assessing the safety of the home.

The inspection was conducted by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection, we reviewed the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

As part of our inspection, we contacted the local authority who commission services and the local Healthwatch to seek their feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection, we spoke with 12 people living at the home and four relatives. We also spoke with two visitors and three healthcare professionals. We spoke with three staff members including senior and care, the deputy manager and the registered manager.

Some people living at the home were not able to speak with us. We carried out observations of how people

were supported throughout the day and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. During our visit, we also looked at three people's care records, three staff files and at records maintained by the home about the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

Our inspection of Kingsleigh House was brought forward to 04 July 2017 due in part to notification of an incident where a person living at the home was exposed to risk of serious harm. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. In light of the incident, we assessed the safety of the home and how well the registered provider and registered manager protected people from the risk of potential harm. At the time of the inspection, the registered provider had recognised their failings and shortfalls in these areas and was taking steps to address this. We saw some areas of improvement and received assurance that the registered provider's plans were ongoing to address these failings, including refresher safeguarding training and revisiting safeguarding systems and processes at the home.

Failure to effectively operate effective safeguarding systems and processes is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how they would appropriately raise safeguarding concerns if they felt that people were at risk of abuse. We found however that staff could not describe all types of abuse that people could experience although staff had recently received refresher safeguarding training.

People we spoke with told us they felt safe. One person told us, "I generally feel safe, no concerns." Another person told us, "I feel perfectly safe here." We observed occasions where staff provided people with reassurance and explanations to help them feel safe whilst receiving support. People's risks in respect of their healthcare conditions and associated needs were understood by staff. We observed that people were encouraged to use mobility aids as needed to move safely around the home. This equipment was labelled to ensure that people used their own equipment assessed for their individual needs. Staff offered people reassurance and support to promote their safety and comfort. One person told us, "I'm happy with how they transfer me, it's not rough at all." Staff had access to information about people's risks and support needs. Staff practice we observed, and staff we spoke with demonstrated an understanding of people's needs and the support people required to remain safe and well. Measures were in place at the home and community healthcare professionals were involved in some people's care to help them to manage specific risks and healthcare conditions.

We looked at how the registered provider kept the building safe and clean and found that systems were not always applied effectively. People we spoke with told us that the home was clean, and commented that their rooms were kept clean and their clothes laundered in a timely way. One person told us, "I'm happy with the cleaning and laundry, it's excellent, clean but homely." People resided in a clean and comfortable environment. We found however that although health and safety and maintenance checks were in place, the findings of these checks were not always acted on promptly to ensure the safety of the building. For example, prompt action was not taken to address identified maintenance risks in the environment which could have put some people at risk of potential harm. Fire safety routines were practiced regularly to ensure staff knew how to respond in the event of a fire.

We identified some concerns in respect of staffing availability at the home. Staff were not always available to meet people's needs in a timely way. The majority of people we spoke told us that there were often enough staff available to meet their needs and to respond to their call buttons. One person told us, "They look after me well, I only have to press [call] button and they come." We found however that this was feedback was not consistent and another person told us, "We don't always see carers about in an evening and would like to see someone about more, several of us have mentioned this." We saw that there was no formal system in place to review staffing levels and availability at the home. Staff were not effectively deployed to always take opportunities to spend time with people and on two occasions, staff were not available to respond to a person's needs and signs of distress. For example, we brought it to the attention of the registered manager that one person had been calling out for support from their bedroom. Staff had not been present in a nearby communal area to identify this. Two staff members we spoke with told us that there were not always enough staff during nights and busier periods at the home, for example to prevent people from needing to wait for their assistance which could sometimes cause people to worry.

We looked at processes in place for recruiting staff to the home. We sampled staff files for two staff members who had both been recruited to the home within the last four months. We found that their recruitment checks had been followed appropriately. This had included completing checks through the Disclosure and Barring Service (DBS) and reference checks prior to commencing in their roles. This process helped to reduce the risk of people receiving support from staff who were unsuitable. We found however that these processes had not always been robust. Another staff member's files we had looked at who had been recruited to the home a number of years ago, showed that the staff member had commenced their role prior to completing these necessary checks. At the time of our inspection, the registered provider told us that they were reviewing recruitment processes to ensure that these were always safe and robust to help protect people living at the home.

We looked at how people's medicines were managed at the home. People who required support in this area told us that they received their medicines on time and that they were satisfied with this support. One person told us, "They bring my medication each morning and then I take it." A relative told us, "Medicines are given on time… and staff have a laugh and a joke with my relative [as it is provided]." We observed during our visit that people received their medicines in a way that met their preferences, for example the medicine was placed in the person's hand, or from a spoon or pot as they wished with a drink. Senior staff were responsible for supporting people with their medicines and had received training in this area. Observations of this practice were held informally by the registered manager and staff told us that this had been done recently. A staff member told us that no concerns had been raised about their practice, although they did not receive any specific feedback.

Most medicines at the home were held in monitored dosage systems and records provided clear information to staff about the medicines that people regularly needed. We conducted a stock count of a sample of some people's medicines and found that these correlated with their records. Records did not contain any gaps and reflected occasions where people had refused their medicines.

Although this supported our judgement that those aspects of medicines management were safe, and people we spoke with had expressed satisfaction with this aspect of their care, we identified some further areas of improvement. For example, there were no protocols to inform staff of when people required their 'as and when' medicines, and no system to record the occasions where such medicines had been given to people. We found that one person used prescribed pain relief patches, however records were not in place to ensure staff knew where these should be applied. We observed one occasion where a staff member undertook a separate task whilst supporting people with their medicines. This did not help to minimise the risk of the staff member making errors. Monthly auditing processes and staff observations had not

addressed all of these issues, nor identified issues where some medicines record entries were illegible and not in line with the guidance provided.

Good

Is the service effective?

Our findings

People we spoke with described their satisfaction with their care, and the support they received from staff. One person told us, "The care is very good, they do everything well." Another person told us, "The care is absolutely excellent." A staff member we spoke with told us that they would recommend the home to their loved ones and commented, "The staff are really good, we work well together."

Relatives told us that staff understood the needs of people well. A relative told us, "Excellent care, I can't fault it, there is not one member of staff you can fault." A healthcare professional told us, "They know people well, staff always know about the new person coming in. It's one of the homes where everything runs smoothly."

Staff we spoke with told us that they felt supported and told us that they had received training in core areas for their roles. Staff demonstrated an understanding of people's support needs and wishes. Staff attended handovers where we observed that they received key updates about people and any changes at the home. A staff member told us that they received regular supervision and commented, "It's quite helpful, we share ideas and set goals."

Some staff members had received further support and training in their roles to progress into senior positions at the home. This involved refresher training and receiving guidance from senior staff and management. Records we sampled showed that some staff had been supported to complete the Care Certificate, a set of minimum care standards that new care staff must cover as part of their induction process.

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. Many people living at the home were able to make their own choices and decisions, staff supported people to do so. People moved around the home freely and as they wished. We observed that people were given the information they needed from staff to have their needs met and to make choices.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. We found that a small number of DoLS applications had been made for people living at the home. One person's relative told us that they had been included in discussions about this decision. Staff we spoke with demonstrated an understanding of the MCA and why some people had DoLS authorisations in place to promote their safety. Records showed that some people's relatives had been granted authority to support with the person's decision-making and that this had been recognised by the home. A staff member told us that best interests decisions were made where people were not able to make their own decisions.

CCTV was in use for security purposes outside of the home and to film an area accessible by the home where people frequently attended religious services. Our discussions with the registered manager showed that the use of CCTV helped to promote people's safety and independence. People living at the home could choose to attend the religious service, or watch the live footage of this shown on television in the lounge area. Formal consultations had not been held about the use of this surveillance and the registered manager told us that this would be explored to ensure that people agreed to ongoing use of CCTV at the home.

People's feedback showed that they were given plenty to drink. One person told us, "I have more drinks than I need, there's always water in my room and I have my own kettle." People were also served drinks from a tea trolley by volunteers and staff during the morning and afternoon and had use of a drinks station in a communal area.

Our discussions with people showed that they enjoyed the food at the home. The registered manager was aware of and addressing some recent issues raised in respect of people's meals at the home to ensure that people had a consistently positive experience of support in this area. People were offered choices for their meals and had access to healthy options. Comments from people included: "Meals are excellent," "Meals are very good," and "Meals are beautiful, really lovely." We observed that people ate their meals together at their own pace and had support from staff or through the use of aids as needed to help them eat their meals independently. One person who was assisted to eat their meal was encouraged and offered choices by the staff member supporting them.

People were supported to seek additional healthcare support as they needed. People we spoke with described the range of appointments they were supported to attend to promote their health. A relative told us, "Staff help [people] arrange hospital trips and upcoming appointments, seeing the doctor." We observed that people and staff discussed upcoming appointments and healthcare advice they had been given. These discussions were held discretely and promoted people's choices and involvement in their care decisions. Healthcare professionals were present during our inspection visit. A visiting professional we spoke with told us, "I think [the home] is lovely, the atmosphere is lovely, if you tell them a person is concerned about something, [staff] deal with it." Another healthcare professional we spoke with told us, "They're brilliant, they call us with information to share and let us know if there are any concerns."

Requires Improvement

Is the service caring?

Our findings

We could not be confident that action was always taken to involve people in the running of the home and ensure that their wishes were met wherever possible. People's views and experiences of their care were gathered annually through an anonymous survey. We saw that people's responses had included feedback and suggestions for achievable changes and improvements that they wanted to see at the home. We asked the registered manager about developments that had been implemented as a result. The registered manager was not able to provide examples of how these responses had been actioned and there was no evidence that these matters had been explored in full. The registered manager told us that they had not always taken such action because some people's responses did not contain specific examples. We found however that this had not prompted the registered provider or registered manager to explore people's feedback in more detail, or to review this method of seeking feedback, to ensure that people were empowered to have their views heard and addressed.

Our discussions with people living at the home showed that they could not be confident that steps would always be taken to address their feedback and concerns. One person described the foods they would like to eat at the home and commented, "But no good asking." Another person told us that on recent occasions, people's meals were not always served as requested. The person had raised this concern with the registered manager and commented that, "Most [people living at the home] won't make a fuss." The registered manager was in the process of addressing concerns about food at the home. Residents' meetings were held with the aim for people to receive and comment on developments at the home. Relatives' meetings had recently been introduced to support this practice. One person told us, "I attend residents meetings but don't know if things will change." Another person told us, "I attend residents meetings, most items get dealt with." Although there were monthly review processes in place for people at the home, records we sampled showed that these reviews had produced similar, generic responses on the majority of occasions, and had not captured people's full experiences. The registered manager recognised this as an area of improvement and told us that this would be addressed.

One person we spoke with indicated that people sometimes had arguments at the home. Where it had been identified that one person was involved in arguments and had expressed distress during these altercations, effective action had not been taken to review this person's care to promote their wellbeing and ensure their needs were met. This person expressed to us that they felt lonely at the home and commented, "I can't seem to find a friend here." Records we sampled showed that staff had not always responded appropriately on these occasions to promote caring, inclusive practice. Robust action had not been taken to investigate and resolve these issues and this had negatively impacted on some people's experiences at the home.

A small number of people we spoke with told us that staff at the home were not consistently caring. Comments included:, "Some carers are very nice, friendly and helpful, but there are a couple who aren't;" "The care is first class, everything is fine, I can't fault them, 98% of staff are caring;" and "95% of staff are excellent, one or two are exceptional in how they care, one or two could be more diligent. Staff generally have good attitude and rapport [with us]." We found that on one occasion where the registered manager had been made aware of a poor approach by two staff members, the registered manager had taken no

action to address this concern. This had not promoted consistently respectful and appropriate practice by staff within the home.

Our observations during our inspection visit showed that people were often supported by staff who were kind and caring. We observed that people were at ease with staff and had a positive relationship with them. People were offered reassurance and encouragement, and some people enjoyed a laugh and a joke with staff. A relative told us, "It's a relief to see the loving care of staff," and commented, "The home couldn't do enough for us, they're very patient and caring." One person told us, "Staff are very obliging and helpful, I get on with all the staff, they are all very good, kind and helpful." Another person told us, "The care is wonderful, it's a nice place, staff are lovely."

We observed that staff made visitors feel welcome and all people we spoke with confirmed this. A relative we spoke with told us, "Staff have a cheery hello and lovely system with milk in the fridge and hot water to make a drink anytime." Some people and relatives we spoke with described how they had got to know other people living at the home and their relatives over time. The home was often visited by members of a welfare committee and the local community. The home had a befriending scheme in place which people also valued. One person told us, "Fortnightly, someone comes and takes me out for coffee or shopping."

We observed that people were treated with dignity and respect. Comments from people we spoke with included: "Staff are very respectful," and "[I am] treated discreetly and with dignity." We also observed that people's independence was promoted at the home and people's feedback reflected this. One person was shown how to use their mobility aid correctly by a staff member. We saw that the staff member encouraged them until they were walking safely with it. The person responded well to this and commented, "That's so much better." Two people we spoke with told us that they helped out with some tasks at the home and we saw that they and others at the home, valued this. A staff member we spoke with described offering support discreetly to people to enable them to continue on with tasks independently.

Requires Improvement

Is the service responsive?

Our findings

We looked at how people were supported to make complaints at the home. People we spoke with were aware of how to make complaints and we saw that guidance about how to do so was on display at the home. One person told us, "I have not made any complaints but I would speak to the manager if I needed to." Another person told us that they had raised a complaint which was being dealt with. A third person and a relative we spoke with were aware of the complaints procedure at the home. They told us that they would approach the registered manager if necessary yet they had not needed to make a complaint.

We found that although people were aware of how to raise a complaint at the home, complaints were not always addressed in a robust or appropriate way. One person had issued a complaint in March 2017 about an incident which had highlighted concerns both about staff conduct and the care and support provided to another person living at the home. We found that the person's complaint was not addressed robustly. For example, in response to this complaint, we saw that the registered manager had clarified some details to the complainant to demonstrate that aspects of their complaint were not accurate. The registered manager told us that because staff had denied that their conduct had been inappropriate on this occasion, no further action was taken in response to those specific concerns raised by the person living at the home. The registered manager told us that the outcome of this complaint had been for the staff members in question to meet with this person and to, "Make up and get on." The complaint had expressed the negative experiences on this occasion of two people living at the home, however the registered manager's response did not reflect that this had been fully considered.

Other complaints records we sampled between March and April 2017 showed that some altercations had occurred involving some people at the home. Records we sampled showed that the registered manager had not always investigated those complaints and incidents effectively or in a timely way to help resolve people's concerns. The registered manager agreed with our concern that they had failed to sufficiently analyse and investigate complaints raised at the home and they had failed to use such information to explore possible themes of concern at the home.

Almost all people living at the home followed the same religious faith and practices. A staff member we spoke with told us that one person did not follow this religion and that care was always taken to ensure that people's choices and decisions were respected. People we spoke with showed that they valued this and told us that their religion was an important part of their lives. People regularly attended services together at a church that was accessible from the home. One person told us about daily group readings at the home which people and visitors led. One person told us, "Church is important and we have bible readings every evening. I often read one… it gives you a lovely hope." We observed that one person arranged the seating in a communal area for the evening reading. A staff member assisted the person to do this and followed their instruction for how this was done.

People's choices were respected as to which services they attended and when. Services were also filmed and shown on television in a communal area to enable people to watch and participate in prayer from the home if they wished to do so. One person commented, "For us it's a highlight… We enjoy it, that's our study,

anchor and what we share."

A staff member commented, "It's a very homely home, it's regimented elsewhere, and we need a routine but it's warm and homely here. It's like coming from home to home and I think [it] needs to be that way." We saw that people were dressed individually and in a way that reflected their choices and identity. One person showed us a piece of jewellery that they were wearing and told us that they had purchased this whilst shopping during a group visit. The person commented, "I love jewellery."

People were supported to participate in activities of interest to them within the community and at the home. People we spoke with spoke positively about this. One person told us, "I join in all the activities and am happy with them." Another person told us, "I love reading and watch some television, I play the piano, I go on every trip if they will have me." We saw that a number of people spent time knitting and a staff member told us that there was a knitting group that regularly met. During our visit, a group of people enjoyed a reading session led by a visitor. People smiled and laughed along during conversations and responded to the reader saying, "Oh yes we are enjoying it," and "It's a lovely story."

People were involved in care planning at the home. One person told us, "[My care plan] was updated a couple of weeks ago." Another person told us, "They've got me weighed up, they know me." A third person told us that they were happy with their care and that they had regular care plan reviews. The home had an electronic system for recording people's daily notes and updates throughout the day. These records and care plans provided guidance about people's specific needs and preferences. A relative told us, "[I was] very impressed with the detail of [the care plan]." There was a clear and accessible system for recording people's wishes and how people's daily care needs were met.

Requires Improvement

Is the service well-led?

Our findings

The registered provider and registered manager had not maintained sufficient oversight to ensure the safety and quality of care provided at Kingsleigh House. The registered manager had not robustly addressed concerns they were aware of in relation to some experiences of people living at the home, and the conduct of some staff members. Quality assurance processes were not robust to ensure that people's views and wishes about the home were always addressed. Sufficient action was not taken to ensure that concerns and complaints were responded to and investigated in an appropriate and timely way.

Audits had not identified where some records relating to people's care were not completed as planned. One person had developed sore skin and a wound during their time at the home, which had healed following input and support from community health professionals. Staff we spoke with understood additional action required to help people to manage this risk, however records we sampled for one person failed to demonstrate that they consistently received this support as needed.
In another example, we found that medicines systems had not been effective to ensure that one person had always received the correct amount of pain relief medicine. We spoke with this person and they told us that their pain was not always well managed, and that they had previously discussed this concern with a staff member. Their discussion with a staff member, and routine medicines audits, had failed to identify that this person had not been receiving the correct medicines dosages over a period of time. Whilst it was assuring to note that a recent update at the home had indirectly rectified this matter, the registered manager had not recognised this ongoing concern over a number of weeks. We could not be confident that people had always received their medicines as prescribed. Our inspection findings of medicines audits found that they had failed to address ongoing record keeping issues.

Sufficient action was not always taken to promote the health and safety of the environment. We found that the registered manager had sought and followed guidance from Public Health England in relation to an infection outbreak in March 2017 and told us that there had been a virus at the home prior to this occasion. This outbreak had not prompted the registered provider however to ensure routine infection control checks were in place to promote the ongoing hygiene and cleanliness of the home. Internal and external health and safety audits had been conducted in relation to the safety of the building. We found however that their findings had not always been applied robustly. For example, it had not been identified by the registered manager that action was required to schedule remedial work following an external electrics audit in April 2014. The registered manager assured us that this would be promptly addressed along with the introduction of routine infection control audits.

The registered manager did not demonstrate a full understanding of their responsibilities to the Commission and in understanding the regulations. We identified occasions where notifications had not been submitted as required by law and the registered manager had not updated their knowledge in respect of their responsibilities relating to the duty of candour. We saw that the ratings from our previous inspection were on display. People we spoke with told us that the management team were approachable yet not always available. One person told us, "I know the managers, but I don't see them about the home much, they're usually in the office." Another person commented, "They are always there and I would just go them if

I had a problem and senior staff are very good." It had not been identified that staff training had not all been updated as planned.

Failure to effectively assess, monitor and improve the quality, safety and risks of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Additional line management support had been arranged as of the end of June 2017 by the registered provider. This was because the registered provider had recently identified that systems and processes had not been robust to ensure the quality and safety of the service. We observed that the registered manager had a supportive and caring approach and an interest in ensuring that people felt safe and well. The registered provider demonstrated that learning had been taken and was ongoing at the home.

People, relatives and staff spoke positively about Kingsleigh House. We observed that people were often at ease and content at the home, choosing to participate in tasks and activities as they wished. People had been able to develop a positive rapport with staff and other people living at the home. Volunteers from the Church and visitors from the local community were regularly involved with and present at the home. The home had links with another service under the registered provider and planned annual social events and celebrations together.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to effectively assess, monitor and improve the quality, safety and risks of the service.