

Kismet House Care Home Limited

Kismet House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Kismet House is a residential service providing personal care and accommodation for up to 9 people with mental health support needs. The service consists of an adapted building, which includes individual bedrooms and communal spaces and an accessible outdoor space. At the time of our inspection there were 7 people using the service.

People's experience of using this service and what we found

People and their relatives told us people were safe with the care and support they received from the service. However, despite positive feedback we found we found shortfalls with environmental risks, medicines management, infection prevention and control and quality assurance systems which placed people at increased risk of harm.

Systems in place to monitor the quality and safety of the service were not fully effective in ensuring shortfalls were addressed.

Medicines were not managed safely in line with national guidance. Infection control measures were not fully effective in minimising risks to people.

The provider had systems in place to assess risks to people before undertaking their care and support. However environmental risks including fire safety were not always safely managed.

Appropriate staff recruitment procedures were in place; however, recruitment records were not always well documented. There was enough staff to keep people safe, people spoke positively of the support they received.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The service had a positive culture, staff told us they felt supported and morale within the staff team was good. People and their relatives told us they were satisfied with the service.

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

Rating at last inspection

The last rating for this service was good (published October 2017). There was a targeted inspection since this inspection, published February 2021. This did not change the rating.

Why we inspected

This inspection was prompted by a review of the information we held about this service.

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.

Enforcement

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Kismet House

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 Health and Social Care Act 2008.

Inspection team

The inspection was carried out by 1 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 contacted people's relatives by telephone to request their feedback.

Service and service type

Kismet House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Kismet House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this to plan our inspection.

During the inspection

We spoke with 5 people who used the service and 2 relatives. We spoke with 6 members of staff including the registered manager who is also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 2 people's care records and 6 people's medicines records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service and quality assurance were reviewed including accident and incident records and audits. We sought feedback from professionals who work with the service.

Is the service safe?

Our findings

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

At our inspection published October 2017 we rated this key question good. At this inspection the rating has changed to requires improvement. 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.

Assessing risk, safety monitoring and management

- Environmental risks were not always safely managed.
- Several shortfalls had been identified by the local fire authority during a visit to the service in May 2022. We found the service had not addressed all the actions identified in a timely way, for example the providers fire risk assessment had not been updated since 2019.
- We found people had access to the loft area of the premises which contained tools and other hazards which placed people at risk of harm. Some cleaning products were not stored securely.
- Radiators were found to be mostly uncovered throughout the premises which placed people at risk of burns. The service had a risk assessment in place, however we found it had not been recently reviewed and had not sufficiently assessed people's individual needs and risks.
- The provider had not completed an annual gas safety check of the premises.

We found no evidence that people had been harmed, however the provider had failed to robustly assess and manage environmental risks to people. The concerns identified above placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We raised our concerns with the registered manager and following the inspection the management team confirmed the loft area had been made safe, radiators had been covered and a fire risk assessment and gas safety check had been completed. The provider told us they would address the other outstanding actions relating to fire safety.
- Following our inspection, we contacted the fire authority who told us they would visit the service to check on progress against the actions identified.
- The provider had systems in place to assess risks to people before undertaking their care and support. Care plans contained risk assessments for areas such as skin integrity, mobility and nutrition.
- The service was carrying out other building safety and equipment checks to ensure the safety of people living within the service. For example, legionella and water temperature checks were completed.

Using medicines safely

- Medicines were not managed safely in line with national guidance.
- Where people had been prescribed potentially flammable paraffin based topical creams, the service did not have an appropriate risk assessment in place to keep people safe from the risk of burns.
- Some people had been prescribed PRN 'as required' medicines. However, there were no written protocols

in place for staff to know how and when to administer each medicine.

- Staff administering medication had been trained, however not all staff had their competency assessed within the past year in line with national guidance.
- Hand-written entries on Medicines Administration Records (MARs) had not been signed or checked by another member of staff to ensure the transcribing had been completed accurately.
- Medication was stored securely, however we found gaps in the recording of temperatures within the medicine's storage room. Where required, the date of opening and discard of medication had not been recorded.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, we were sent an action plan detailing how and when the provider would address the issues identified with medicines management.
- MARs were completed with no gaps in recording identified. Stock of medicines held by the service matched records.
- Despite the shortfalls identified, people and their relatives told us they were satisfied with the support provided with medicines. A person said, "Medication has helped me a lot. Yeah, happy with the support."

Preventing and controlling infection

- Infection prevention and control measures were not fully effective in minimising risks to people.
- We found some areas of the service were not clean such as bathrooms and an area of the kitchen. Some kitchen utensils were in need of replacement.
- We found gaps in cleaning records which meant the provider could not be assured cleaning was being regularly completed.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate that risks associated with infection control were safely managed. This placed people at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The management team told us they would implement more frequent cleaning checks and audits to ensure cleaning within the service improved.
- The provider had an infection control procedure in place and staff had completed training.
- The provider supplied staff with personal protective equipment (PPE) such as aprons and gloves to use when supporting people with their personal care. This helped to minimise the risk of infections spreading. A staff member said, "PPE, I always wear gloves and an apron."

Visiting in care homes

- The provider was supporting visits in line with the government's guidance.

Learning lessons when things go wrong

- Systems were in place to report and record accidents and incidents.
- The management team told us about actions taken in response to incidents to manage the risk and prevent re-occurrence, however these actions were not always well recorded.
- We were told lessons learnt following incidents were discussed with staff team, however this was not well

documented.

Staffing and recruitment

- The provider carried out recruitment checks to ensure staff were suitable to work at the service. Checks included completion of an application form, proof of identity, evidence of conduct in previous employment and DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
- However, we identified some examples where gaps in employment history had not been explored and documented. Reasons for leaving previous employment had not always been recorded. We raised this with the management team who told us this would be addressed in any future recruitment.
- People and their relatives told us there were enough staff to meet their needs. Records and our observations confirmed this. A person said, "Yeah, I think so." A relative said, "There always seems to be enough staff. If I ever need someone, straight away someone is available to talk to."
- People and their relatives spoke positively of the support provided by staff. A person said, "Care is excellent, very supportive, very helpful. Staff will help us. No complaints." A relative said, "Staff genuinely care about [person]. I have only ever seen them being kind and patient with [person]."

Systems and processes to safeguard people from the risk of abuse

- Policies and procedures were in place to protect people from abuse.
- People and their relatives told us they felt safe with the care and support they or their relative received. A relative said, "Yes, [person] is safe."
- People told us they could raise any concerns with staff. A person said, "I talk to them, they are nice, I would recommend it."
- Staff had completed safeguarding training and knew how to recognise and report any abuse.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- People's care records documented their consent to care in line with the MCA.
- People and their relatives told us staff sought their consent, our observations confirmed this. A person said, "Yes, they ask me." A relative said, "They are respectful to [person] if he says no."
- Where people were being deprived of their liberty, appropriate referrals had been made to the local authority to ensure this was done lawfully and in the least restrictive way.

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 our inspection published October 2017 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- There were systems in place to monitor and improve the quality and safety of the service. However, these systems were not fully effective in ensuring shortfalls were addressed.
- The provider was completing a regular health and safety audit; however, this audit did not identify and address the issues we found with environmental risks as detailed in the safe section of the report.
- We found gaps in the completion of the daily medicines audit which was part of the services governance system. The service was also completing a 6 monthly medicines audit; however, these audits did not identify and address the issues we found with medicines management.
- The service was not completing a regular infection control audit or checks on cleaning records, therefore the issues we found with infection, prevention and control were not identified and addressed.
- We found lessons learnt following incidents were not well documented. This meant we could not be assured learning was always shared with the staff team.
- There was no formal process in place in capture feedback from people and their relatives. Records showed satisfaction surveys had been completed previously, but not in recent years. A relative said, "I've never had a questionnaire."
- There had been changes in the management structure since the last inspection. Previously there were 2 registered managers for the service, this had reduced to 1 registered manager at this inspection who was also the nominated individual. The other manager had remained working within the service but was no longer registered.
- We received feedback the current registered manager and nominated individual had only a limited presence at the service and governance records we reviewed supported this. This meant we could not be assured the registered manager had effective management oversight of the service.

Whilst we found there was no evidence people had been harmed by the issues identified above, systems were either not in place or robust enough to demonstrate that there was adequate oversight of the service. This placed people at risk of harm to their safety and wellbeing. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- During the inspection, the management team responded promptly to the concerns raised and provided an action plan to address the issues identified. We were provided with evidence of audits and checks being implemented in order to drive improvements.

- The registered manager told us they would improve their management oversight of the service.
- Despite the shortfalls identified, people and their relatives told us they felt the service was well managed. A person said, "I think it's excellent, well managed." A relative said, "My experience says it is a good well managed home, everything runs smoothly."
- Staff told us communication between the staff and managers was good but could be improved through regular staff meetings. A staff member said, "If there was a few more meetings we would all benefit from it." A manager told us staff meetings had been difficult to coordinate, however they would be reintroduced following the inspection.
- Despite a lack of formal processes to capture feedback, people and their relatives told us there was good communication with the service. A relative said, "Communication is excellent, they message me and phone me. If there are any issues, they contact me straight away. They always give me lots of detail about how [person] is."
- Records showed people met with their key worker to discuss their support, however these records were not always detailed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a positive culture within the service, which supported the delivery of person centred care. A person said, "A lovely keyworker [Name of staff] helps with my mobile phone, bends over backwards to help me. They're great, they're alright."
- There was a relaxed and friendly atmosphere within the service. A relative said, "There is a very positive atmosphere in the home. Even if they are busy, they [staff] will find time for you, they are really helpful."
- Despite feedback the registered manager had a limited presence within the service, staff told us they felt supported by other managers and morale within the staff team was good. A staff member said, "Yes, manager is of great support and other staff members." Another staff member said, "Good, we work well as a team."
- People and their relatives told us they were satisfied with the service. A person said, "I Like living here."

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; Working in partnership with others

- The service worked in partnership with health and social care professionals such as social workers, GPs and the community mental health team.
- The provider was aware of their responsibility to act openly and honestly when things went wrong. Appropriate notifications had been sent to the CQC as required.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care and treatment was not always provided in a safe way because environmental risks were not always assessed and mitigated. The provider had not ensured the proper and safe management of medicines. Risks relating to infection, prevention and control were not always managed to keep people safe.</p> <p>Regulation 12 (1) (2) (a) (b) (d) (g) (h)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not always operate effective systems and processes to assess and monitor the quality and safety of the service. The Provider did not seek and act on feedback from relevant persons.</p> <p>Regulation 17 (1) (2) (a) (b) (e)</p>