Robert David White and Lesley Karen White

Kingsley Rest Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

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 Care Quality Commission (CQC) conducted this inspection on the 7 July 2014. At the time of this inspection the registered provider with CQC was Robert David White and Lesley Karen White. Since the date of the inspection a new provider and manager has been registered with the Commission to carry on the service at this home. This report is being published in the name of the provider who was registered with the Commission at the time of the inspection undertaken in July 2014 to comply with its publication duty. All references to the provider in this report relate to Robert David White and Lesley Karen White and the registered manager registered with the Commission at the time.

Our inspection was unannounced which meant the provider did not know we were coming.

Summary of findings

We identified that the provider who was registered with the Commission at the time of the inspection was not meeting the legal requirements associated with the Health and Social Care Act 2008 during an inspection on 17 December 2012. Since that inspection that provider had not made the improvements required to raise standards in the service.

When we inspected Kingsley Rest Home on 30 December 2013 we found that; care was not always delivered in a manner that protected peoples safety and welfare, medicines were administered unsafely, care records did not contain the information required to enable staff to meet people's needs in a safe and consistent manner and effective systems were not in place to assess and monitor the quality of care. The provider made improvements to the way medicines were managed, but the other required improvements have not been made.

Kingsley Rest Home provides residential care and support for up to 12 older people, some of whom may have a diagnosis of dementia. At the time of our inspection 10 people used the service. There was a registered manager in post at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

We found that improvements were needed to ensure people received their care safely. Risks to people's health and wellbeing were not always adequately assessed or recorded, and accurate and up to date information about people's risks was not always available for the staff to follow.

The provider could not show that the required staff recruitment checks had been completed. Therefore they could not assure the people that the staff were suitable to provide them with care and support.

The legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were not being followed. Some people who used the service did not have the ability to make decisions about some parts of their care and support. The Mental Capacity Act 2005 sets out requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. The staff had not received sufficient training to enable them to follow the legal requirements of the Act and the DoLS. The provider told us no one who used the service required a DoLS authorisation. However, we identified one person who was potentially being deprived of their liberty.

Care was not always planned for or delivered in a manner that met people's individual care needs. People's behaviours were not adequately monitored to identify changes and professional advice was not always sought when people's needs changed. This meant people could not be assured that they were getting the right care for their needs.

The staff's development needs were not being assessed or monitored by the provider. Staff had not received the training they required to meet people's needs, and the provider did not have an effective system in place to supervise and support the staff's development needs.

People told us their needs were met in a timely manner with dignity and respect. However some people told us that people who displayed behaviours that challenged others, such as aggression and agitation were not always treated in a caring manner by the staff. This was because the staff had not been trained in how to manage people's complex behaviours.

Staff were aware of people's likes, dislikes and care preferences. However some people's bathing preferences had not been met for a significant period of time because the bath was out of action. The provider had not taken responsive action to ensure equipment and facilities were maintained to meet people's bathing preferences.

The provider had started to involve people who used the service in the evaluation of the care. More improvements were required to ensure people were involved in the evaluation of all aspects of the care and contribute to the development of the service.

Effective systems were not in place to enable the registered manager or provider to assess and monitor the safety and effectiveness of the care. The concerns with the care we identified at this inspection had not been identified by the registered manager or provider registered at the time of the inspection.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Our findings have been shared with the new provider who has submitted a plan to us detailing the actions they are taking to make improvements to care delivery.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Risks relating to the health, safety and welfare of people who used the service and others were not always appropriately assessed and managed.

People were not protected against the risks of receiving care from unsuitable staff, because the provider could not show that the required recruitment checks had been completed.

The staff were not adequately trained to ensure the legal requirements were consistently followed to protect people's rights when decisions needed to be made in their best interests.

Staff knew how to recognise and report abuse, but improvements were needed to make the reporting process more accessible to the staff and people who use and visit the service.

The provider's minimum staffing levels were consistently met.

Is the service effective?

Inadequate

Information and guidance was not always accessible or available for the staff to follow to enable them to meet the individual needs of the people who used the service.

Staff did not consistently receive the training, supervision and professional development opportunities to enable them to work effectively at the service.

People's health and wellbeing were not monitored effectively so that the right support and advice could be requested at the right time.

Is the service caring?

Requires Improvement

People mostly told us the staff were friendly and caring, but some people told us that staff did not always treat people with behaviours that may challenge others in a consistent caring manner.

People were unable to recall if they had been involved in the planning and review of their care and the provider also could not show this.

Staff presented some information to people in a manner that enabled them to understand.

Staff treated people with dignity and respect by promoting people to be independent. People could also access private areas and visitors were free to visit at a time of their preference.

Is the service responsive?

Requires Improvement

Staff were aware of people's likes, dislikes and care preferences. However people did not always have their care preferences met.

Summary of findings

From time to time people were given the opportunity to participate in leisure and social based activities. However people told us that activity provision at the home could be improved.

The provider had begun to seek feedback from people who used and visited the service. Further improvements were required to ensure that more feedback was gained.

There was a system in place to manage complaints.

Is the service well-led?

Effective leadership, management and governance systems were not in place at the service. The provider had failed to make or maintain the required improvements identified during previous inspections. This meant we have taken further action against the provider to ensure the required improvements are made.

Inadequate

Kingsley Rest Home

Detailed findings

Background to this inspection

Our inspection team consisted of two inspectors.

Prior to our inspection we checked the information we held about the service and the provider. We also contacted the local authority, the fire service and the professionals who commissioned people's care. This highlighted multiple concerns. These included concerns about; staff training, staff recruitment, incident monitoring and the quality of people's care records. We used this information to help us plan our inspection.

Before our inspection we asked the provider to complete a provider information return (PIR). The PIR is an important tool we use to help us plan our inspections because when completed it provides us with information about the service. The provider told us they did not receive a request to complete a PIR, therefore we did not receive a completed PIR from the provider. We have asked the provider to provide us with up to date contact details so they can receive correspondence from us.

We spoke with five people who used the service and five people who visited the service. This included people's relatives and friends.

Some people who used the service were unable to tell us about their care. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who cannot tell us about their care.

We spoke with four members of staff and the provider. The providers of the service were two named partners, one of whom was also the registered manager.

We looked at four people's care records to see if their records were accurate and up to date. We looked at records relating to the management of the home. These included audits, health and safety checks and minutes of meetings. We also looked at satisfaction surveys that had been completed.

Following our inspection we shared our concerns about the people's safety and welfare with the local authority and the professionals who commissioned people's care.

Inadequate

Is the service safe?

Our findings

During our inspection on 30 December 2013 we told the provider that improvements were required to ensure that the risks posed to people who used the service were effectively assessed and managed. During this inspection we saw that the required improvements had not been made.

Some of the risks to people had been assessed and managed, for example people's risk of falling. However some of the risks associated with people's mental health needs had not. We saw that one person was regularly aggressive towards the staff. For example during a two week period in June the person was aggressive towards the staff on four occasions. This person also had a tendency to enter other people's bedrooms during the night which meant other people were at risk of harm. There was no record to show that the risks associated with these behaviours had been identified or assessed by the provider. Another person who used the service had diabetes. Their care records did not show that the risks associated with their diabetes had been considered or assessed.

This lack of assessment meant people and staff were at risk of harm because the required risk management plans were not in place to protect them. This meant there had been a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Risks relating to the health, safety and welfare of people who used the service and others were not always appropriately assessed and managed.

We saw that care was not always assessed, planned or delivered in a manner that ensured the welfare and safety of people who used the service. For example, one of the care records we looked at showed that the person had diabetes. We saw that their blood sugar was monitored periodically. We asked a member of staff who was responsible for taking the person's blood sugars what the person's safe readings should be. They said, "I think it's between five and seven but I'm not sure" and, "It was over seven when I took it once". We asked the staff member what action they took when they identified the person's blood sugars were higher than what they thought was their safe range. They told us they made sure the person had no extra sugar that day, but they were unable to confirm what other action may have been required if the person's condition deteriorated. We asked the staff member if the person's care plan contained guidance for staff to follow in the event of a high reading. They could not find this information because the care plan did not show that an assessment of the person's diabetic needs had been made. This lack of guidance meant there was a risk that the person would receive unsafe and inconsistent care. This meant there had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care was not always assessed, planned or delivered in a manner that ensured the welfare and safety of people who used the service.

People were not protected against the risks of receiving care from unsuitable staff, because the provider could not demonstrate that the required recruitment checks had been completed. We looked at four staff files and found that three files contained records showing that a Disclosure and Barring Service (DBS) check had been requested. However the outcome of this check had not been recorded or referenced. The fourth staff file contained a certificate from a previous employer that stated a check had been made but again the outcome of this check had not been recorded or followed up by the current provider. The provider could not demonstrate that the check had been completed and the results had been considered to ensure the staff were suitable to work with people who used the service. This meant there had been a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Adequate staff records were not kept to show staff were safe to work with the people who used the service.

Two of the four files contained no evidence to show that the staff member was of suitable character. This meant there had been a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Adequate checks were not made to ensure staff were of suitable character to provide care and support to the people who used the service, for example, references from similar previous employers.

The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements designed to ensure that decisions are made in people's best interests when they are unable to do this for themselves.

During our inspection staff told us that one person who used the service occasionally attempted to leave the home. Staff confirmed this person did not have the mental

Inadequate

Is the service safe?

capacity to make decisions such as whether it was safe to cross a busy road. There was a coded lock on the front door of the property and a lock on the gate at the rear of the property. The provider told us this was to keep people who used the service safe. Staff told us that when the person attempted to leave the property they would discourage and prevent them from doing this using distraction techniques. We asked the provider if this had been considered as a deprivation of the person's liberty, but we were told it had not. This meant there had been a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The requirements of the Mental Capacity Act 2005 and the DoLS had not been followed. During our inspection we asked the provider to make a referral to the local authority who are the supervisory body for the DoLS.

The training reference chart we were given by the provider recorded that none of the fourteen staff had completed training in safeguarding. Despite this the care staff we spoke with demonstrated they could recognise abuse and they told us they would report safeguarding concerns to the provider. The local safeguarding reporting procedure was not available at the home for the staff or provider to follow. However the provider told us they would ring the local authority in the event of a safeguarding concern to seek guidance. Ensuring the local safeguarding procedure is accessible to staff and people who use and visit the service would empower and enable people and staff to report concerns directly to the local authority if required.

Staff rotas demonstrated that the minimum staffing levels set by the provider were consistently adhered to. During our inspection we were informed that the provider had also started to provide day care. At the time of our inspection one person was receiving day care at the service. We could not see that staffing levels had been reviewed to reflect this change in care provision.

Inadequate

Is the service effective?

Our findings

During our inspections on 20 June 2013 and 30 December 2013, we told the provider that improvements were required to demonstrate accurate records were kept that demonstrated peoples' mental and physical health needs had been assessed and planned for. During this inspection we found that the required improvements had still not been made. For example, we saw that one person regularly displayed behaviours that may challenge others. There were no plans in place that recorded how this person's behaviours should be prevented or managed. The staff we spoke with told us how they managed this person's behaviours, but we could not confirm that the staff were using the correct methods to do this as no assessments or plans for this were recorded. This meant there had been a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This person was at risk of receiving ineffective and inconsistent care because accurate records outlining their care needs were not kept.

We saw that people could access GPs and paramedics when they were unwell. However we could not always see that people were supported to get the right care and support in response to a change in their behaviours or needs. For example one person who used the service regularly presented with behaviours that challenged. Their care records showed that these behaviours were displayed frequently for 27 days over a 37 day period. There were no records to show that the behaviours were being assessed, reviewed or monitored to identify the cause, or to monitor the frequency or severity. This meant there had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People with complex needs did not receive needs assessments and reviews to ensure their individual needs, welfare and safety were met and promoted.

There were also no records to show that advice was being sought in relation these frequent, complex and escalating behaviours. This meant there had been a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Professional advice had not been sought in response to the complex behaviours of the person.

The staff did not get the training they required to enable them to work effectively at the service. At our inspections on 17 December, 20 June and 30 December 2013 we told the provider that some staff required training in the Mental Capacity Act 2005. During this inspection we found that some staff had still not received this training. The training reference chart given to us by the provider showed that seven of the fourteen staff had completed training in the Act and the DoLS. We spoke with four members of care staff about the Mental Capacity Act 2005 and the DoLS. Only two of the four staff members showed a basic understanding of the Act. One staff member said, "I can't really tell you" and, "You asked me this last time (at our inspection on 30 December 2013) but I have still not had the training". Another staff member said, "I'm really sorry, but I don't know".

At our inspection on 30 December 2013 we identified that staff required training in dementia care to enable them to manage some of the complex behaviours people at the home who had dementia presented with. The provider told us that some staff would receive this training in April 2014. During this inspection the staff we spoke told us they had not received this training. The training reference chart given to us by the provider showed that six of the fourteen staff still required this training.

The training reference chart demonstrated significant gaps in staff training and the staff we spoke with confirmed this. For example five of the 14 staff had not received an update in moving and handling practice and 12 staff had not received an update in first aid. One staff member told us, "My moving and handling is out of date and my first aid. I'm worried I will do something wrong if I have to do first aid". This meant the provider could not show that the staff were suitably skilled to meet the needs of the people who used the service.

The staff did not receive the development support they required to ensure they were competent and able to meet people's individual needs. We asked four members of staff if they received supervision and appraisals from the provider. All four staff told us they did not receive supervision and they had not received an appraisal for over 12 months. One staff member told us they had worked at the service for over two years and had never received an appraisal. Another staff member said, "I haven't had an appraisal but I have asked for additional training. I haven't had it yet though". The provider confirmed that no formal supervision took place and the appraisal process was overdue. This meant there had been a breach in Regulation

Inadequate

Is the service effective?

23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff did not receive the training, supervision and appraisals that would enable them to work effectively at the service.

People were supported to eat a balanced diet. One person who used the service said, "We have very nice meals". We observed peoples lunchtime experience. People were served a hot meal that reflected their preferences. The staff asked people if they wanted any more food and provided extra portions at people's request or agreement. We saw the staff assist one person to eat and drink as they were struggling to do this independently.

Requires Improvement

Is the service caring?

Our findings

Some people told us that staff occasionally had difficulties managing the behaviours some people displayed. One person said, "The staff are very good, but they have a lot on their plate". Another person said, "If you behave properly they treat you that way, but if you carry on a bit they tell you off". The provider should address the staff training gaps in dementia care to ensure people with behaviours that may challenge others are consistently treated in a caring manner.

During our inspection we observed staff interacting positively with the people who used the service. For example we saw a staff member gently and compassionately support and encourage one person who was unwell to drink. People who used the service mostly spoke positively about the staff. One person said, "The staff are very good". Another person said, "The staff are very friendly" and, "They made me feel comfortable straight away".

People who used the service told us that staff had asked them questions about their likes, dislikes and hobbies. Staff told us this had been done so they were aware of people's care preferences. However, people told us they were not involved in the review of their care. The provider told us people were involved, but the care records we looked also did not show this. We told the provider at our inspection on 30 December 2013 that improvements were needed to show people's involvement in the review of their care. Further improvements were therefore still required to ensure that people contributed to the development and review of their care.

During our inspection people told us and we saw that care staff treated people with dignity and respect by promoting people's independence. For example people told us the staff supported them to maintain their independence. One person said, "I try and do as much for myself and the staff let me. If I struggle then they come to my rescue".

People were able to access their bedrooms during the day for privacy and relatives were free to visit at a time of their preference. One relative told us, "There are no restrictions on visiting".

At our last inspection on 30 December 2013 we told the provider they needed to improve the way they communicated with people who used the service. We saw that some improvements had been made. Signs located around the home had pictorial prompts to assist people to understand their meaning. We also saw that staff helped people understand their care options by explaining information to people in a manner that enabled them to understand. For example we observed a staff member asking people if they required pain relief in a manner that reflected their understanding.

Requires Improvement

Is the service responsive?

Our findings

At our inspection on 30 December 2013 people told us they were unable to have a bath because the bathing equipment at the home was out of order. At that inspection the provider told us they were waiting for the bath to be repaired.

During this inspection five people told us they would like to have a bath but they had been unable to do this for some time as the bath was out of order. One person said, "I haven't been able to have a bath for about 18 months now. I have to have a shower, there's no choice". Another person said, "I'd like to have a bath, but I've been told the seats broke". The care records of two of these people clearly recorded that they liked baths and disliked showers. This meant there had been a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care was not always planned and delivered in a manner that met people's individual preferences.

We shared this feedback with the provider who told us that the bath could not be repaired and they had been looking into replacing the bath with a shower room. The provider could not confirm that the people who used the service had been involved in the proposed plans to remove the bath despite people's care records confirming their preference to bath rather than shower. This meant there had been a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not show regard to people's views about bathing.

We saw that people's likes, dislikes and care preferences were recorded in the care records and staff demonstrated they had a good understanding of these. For example one person's care record showed they did not like peas. At lunch time we heard the staff say, "We've given you carrots instead of peas because we know you don't like them". However some people told us their care preferences were not always met. For example five people told us they would like to have a bath but they had been unable to do this for some time as the bath was out of order.

We saw that staff responded to people's request to access the toilet in a timely manner and on the whole people told us they did not have to wait to receive the care and support they required. One person who used the service told us. "I've never had to wait longer than a few minutes".

We saw that people were given the opportunity to participate in leisure based, social and spiritual activities from time to time. This included a monthly communion, visits from entertainers and the provision of chair based exercises. However some people told us that activities at the home could be improved. One person said, "The staff don't have time to sit and chat to us". Another person told us, "There's not much going on here".

People were able to maintain their relationships with their family and friends. We saw people visiting throughout the day and the relatives and other visitors we spoke with told us they could visit at any time.

During our inspections on 20 June 2013 and 30 December 2013 the provider was unable to show that they sought feedback from people who used and visited the service about the care. During this inspection the provider showed us they had met with the people who used the service to discuss the food at the home. We saw that a plan was in place to make improvements as a result of this. Further improvements were required so that feedback about other aspects of the care provided is gained.

The provider also showed us the results of a satisfaction survey that had been completed in April 2014. Only three completed questionnaires had been returned, but the provider had evaluated the information and had devised a short action plan that outlined the actions they needed to take. Improvements were required to ensure more people and visitors engage in this process.

We saw there was a system in place to manage complaints. The provider told us they had received no complaints since our last inspection. We asked people and their relatives how they would complain about the care if they needed to. People and their relatives told us they would inform the deputy manager about any concerns or complaints. One relative said, "I would tell the deputy manager and I'm confident something would get done". We asked the deputy manager how they responded to complaints. They told us they would try to resolve complaints informally and would handover formal complaints to the provider in accordance with the provider's complaints procedure.

Inadequate

Is the service well-led?

Our findings

The provider had not consistently made or maintained the required improvements from Regulation breaches identified during previous inspections. This had resulted in people not always receiving care that met their individual preferences or promoted their safety. For example the risks posed to people continued to be inconsistently assessed and managed.

During our inspection on 30 December 2013 we told the provider to make improvements to the way the quality of care was assessed and monitored. We saw that some systems had been put in place to monitor quality, but the provider could not show that these systems were effective. For example care plan audits were now being completed, but these were not effective as they had not identified the on-going gaps we identified in people's care and risk plans. For example, the care records of one person who used the service did not show that the risks associated with their diabetes had been considered or assessed.

We saw that incidents were not being monitored effectively by the provider. The provider showed us a monitoring form that they used to log incidents. We saw that the information and numbers of incidents on the monitoring sheet did not match the records of incidents in people's care records and individual incident forms. This meant the provider could not identify and manage incident trends at the service with robust certainty. This meant there had been a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider was not analysing incidents to identify if changes in care were required.

We were shown a medication audit that was completed in February 2014 by an external company. The audit contained some recommendations for improvements, but no action plan was in place to ensure the improvements were made. We asked the provider why no action plan was in place. One of the partners said, "I didn't think there were any recommendations". This meant there had been a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Effective systems were not in place to regularly assess and monitor the quality of care.

The service was registered with us as a partnership as shown on the front page of our report. We received information from the local authority prior to our inspection that suggested the service was registered with us incorrectly. During our inspection the provider confirmed that they had not completed the required notification and application to update their registration when they changed to a limited company in 2011. This meant there had been a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009. The provider failed to notify us of the change in provider details.

People who used the service were not empowered to be involved in the development of the service. The provider could not always show that people were involved in the planning and review of their care or the quality of the care at the home. Improvements were required to ensure people are empowered and supported to be involved in evaluating and improving the standards of care.