Christadelphian Care Homes

Kingsleigh House

Inspection report

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Date of inspection visit: 7 October 2015
Date of publication: 07/12/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This report provides details from two separate inspection visits which took place months apart. The first inspection was on12 March 2015 and the second inspection visit was on 7 October 2015. We were unable to provide a report from the first visit but felt it valuable to provide summaries of both visits together with the judgements from the most recent inspection visit in October 2015. Both visits were unannounced. Prior to the March 2015 visit we had last inspected this service in December 2013 where it met all the regulations we looked at.

Kingsleigh House is a care home providing personal care for up to 30 older people who may have physical disabilities or dementia. At the time of our March visit there were 28 people living in the home. The home provides care and support within a Christadelphian setting and is situated next to a Christadelphian church.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People were kept safe from the risk of harm. Staff knew how to recognise signs of abuse and to report any concerns to their managers and external agencies. Staff followed specific instructions to minimise known risks to people's health and well being and people were shown how they could assist in minimising risks of harm. Staff supported people to take their prescribed medicines well. Improvements were made in the administration of medicinal creams and liquid medicines and the recording of these administrations between our two visits.

People were supported by enough staff to meet their care needs. Where it was identified that more staff were needed to ensure that people had their care needs responded to in a timely way more staff had been recruited. Staff only started work following appropriate checks and an interview had been completed to ensure they were suitable to work with people who lived in the home. Staff had the skills and knowledge to ensure people were supported in line with their care needs and best practice. Management of the home were working to ensure that staff's induction continued to improve.

The care manager and staff we spoke with were knowledgeable of the requirements of the Mental Capacity Act 2005. Staff sought consent from people before providing personal care and supported them if they did not want treatment.

People were supported to eat and drink enough suitable food to maintain their health. Where necessary health professionals were consulted to identify changes needed to people's care. Records showed that any instructions from health professionals were put into the individual concerned care plan and these were followed.

People we spoke with, their relatives and our observations told us that staff treated people with respect and were appreciative of staff's care. We observed that people were given choices, involved in making decisions about their care and informed about the day to day news of the home. People had opportunities to be with other people who lived in the home or spend time privately in their bedrooms.

People were asked their views about the care they received on regular basis, through monthly discussions, visits from a trustee and from the provider's annual quality checks. They told us they felt able to speak with staff and managers about any complaints that they had and these would be dealt with. People and their relatives told us that the manager led the staff team well and that the home had a good atmosphere.

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?
The service was safe.

Staff were confident to take action if they suspected a person was at risk of abuse.

There were enough staff to keep people safe from the known risks associated with their specific health conditions.

People were enabled to have their prescribed medicines in a timely way.

Good

Is the service effective?
The service was effective.

Staff had the skills and knowledge needed to meet people's specific care needs.

People's consent to care and treatment was sought before any interaction.

People were supported to eat and drink enough to maintain their well-being.

Good

Is the service caring?
The service was caring.

Staff supported people in a kind way giving people options about how their care was provided

Staff took time to sit with people and promote being involved in the home.

Staff knew how to support people's dignity and ensured that people's privacy was maintained.

Good

Is the service responsive?
The service was responsive.

People were supported to contribute to their care plans and staff followed the instructions.

People were supported to raise concerns and complaints and these were managed appropriately.

Good

Is the service well-led?
The service was well-led.

People, relatives and staff were confident about the management team's ability to meet people's care needs.

There were robust processes in place to assess the quality of care people received.

Good

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Our last inspection took place in December 2013 when the service met the regulations that we inspected. This inspection took place over two visits. The first visit was on 12 March 2015 and the second on 7 October 2015. We were unable to provide a report from the first visit but felt it valuable to provide summaries of both visits together with the judgements from the second inspection visit.

Both visits were unannounced. The first visit was carried out by two inspectors and the second visit consisted of 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.

We reviewed all of the information we held about the home. This included statutory notifications received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. Before we returned for our second visit in October 2015, we reviewed the information we had obtained at our first visit in March.

We contacted a local authority for their view about this home. This helped us to identify if the provider had taken action in response to feedback given at our first visit and where to focus our second visit.

During our first visit we spoke with five people that lived at the home about aspects of their care the relatives of one person who used the service and spoke with two health professionals. We spoke with four staff members including care staff, an activity co-ordinator and the cook. At our second visit we spoke to eight people who used the service and three people's relatives and a health professional. We spoke to four staff members including the deputy manager. We spoke with the registered manager at both visits.

We spent time on both visits observing people's care in the communal areas of the home. We used the Short Observational Framework for Inspection (SOFI) on our second visit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us in depth about their care and support.

At our first visit we looked at parts of five people's care records and at the second visit we looked at parts of two more care records. We also looked at other records that related to people's care. This was to see if they were accurate and up to date. We also looked at medication records, staff employment records, quality assurance audits, complaints and incident and accident records to identify the provider's approach to improving the quality of the service people received.

Good

Is the service safe?

Our findings

People told us that they felt safe. Some of their comments included: "I feel safe with the staff including at night" and "[The staff are] as good as gold." A relative said: "They [People who live in the home] are safe and we couldn't want for more" and a health professional told us: "I have never seen anything untoward when I have visited this home."

At both visits staff we spoke with were able to tell us the types of abuse that people should not experience in residential care. They were clear about their responsibility to report any concerns and told us they had opportunities to talk to senior staff privately if they were worried. Staff told us that they had training about how to ensure that people they cared for were protected from abuse. Staff understood the types of abuse and their responsibilities helped to keep people safe. Where concerns had been raised about people's safety the provider had taken appropriate action to minimise the chance of these happening again.

We spoke with people and their families about their known risks such as falling, acquiring pressure area related sore skin, or poor nutrition. People told us that staff supported them to lessen the risks to their safety or that they were independent of the need for support. We looked at three care records for people who had some known risks. We found that these risks had been identified and plans were in place to reduce the risks. These plans were reviewed regularly with the person concerned and where necessary changes were made to reduce the risk further and staff we spoke with were aware of these risks. We saw in one person's care file that staff had found another way to reduce the risk as the person was unhappy with the way their safety was managed.

We observed that staff took their time when moving people with mobility difficulties from place to place. We saw that they spoke with the person about where they wanted to move to and how the person could assist for example by holding onto part of the equipment. We saw that staff gave clear instructions and as a result all these transfers we saw were undertaken safely. We saw that staff were aware of potential risks and intervened where necessary for example where people dropped items to the floor and when unsteady walking independently. These actions helped to lessen the chances of injury to people. Risks to people's health and well being were identified and well managed.

At our first visit two people we spoke with and a staff member commented that there were not always enough staff on the afternoon shift. On this visit the manager told us and staff confirmed that the minimum number of staff available on the afternoon shift had been increased. People told us that staff responded within a reasonable time if they wanted assistance. Our observations found that call alarms were answered promptly and people were not rushed when being assisted. We saw that all staff took time to speak to people when they were passing. This indicated that there were enough staff available to meet people's needs.

There were no new staff on duty during our inspection so we looked at three recruitment records. These records showed that employment checks had been carried out before staff started to work at the home such as police checks and taking up references. We saw that the manager had: taken steps to confirm the identity of applicants, interviewed them and recorded the interview questions and answers. This showed that the provider had taken steps to determine the suitability of applicants to work in the home before they were employed and this helped to keep people safe.

One person told us on our second visit told us: "I take my own [medicines], it is easy they are in blister packs." Another told us: "[My medicines are] explained to me - yes I get them on time." A comment on thank you card received since our first visit said "Thank you to the team who dispensed my medicines they were so patient with me explaining my pills to me several times over." We observed some people being supported to take medicines and found that people were well supported to take them. Staff administering medicines spoke to people about what their medicines were for and asked people who occasionally needed pain relief if they needed it before it was administered.

At our first visit we found that tablet forms of medicines were administered appropriately and people who were able had the choice to manage their own medicines. Some improvement was needed to ensure that liquid medicines were given and medicinal creams were applied. Records were not consistently kept of this. On our second visit we

Good

Is the service safe?

found improvements had been made in these areas. For example the service had added to the design of medicines chart so that full instructions could be included for medicinal creams and there had been an improvement in recording applications. However this should be more consistent. On our second visit the service also had a medication audit from a representative of the pharmacy they used. We heard this representative pharmacist congratulate the staff say the results of their audit of medication were very good. People received their medicines safely and as prescribed.

Good

Is the service effective?

Our findings

People and their relatives we spoke with told us that staff were able to care for people who live in the home appropriately. Staff told us that they received training regularly and that for tasks, such as medication administration and their practice in this and other areas was observed to ensure they were competent. All of the staff we spoke with told us that they had undertaken a formal qualification in health and social care and some care staff were also starting qualifications in leadership and management. Staff we spoke with were knowledgeable about the care that specific people needed.

The managers of the home had information about the care certificate now required for new care staff. They were in process of ensuring that the existing staff group undertook a self assessment of their learning so that any gaps in their knowledge could be addressed. The managers had ensured that there were sufficient staff with in depth knowledge were available for each shift. For example some staff had undertaken the first aid at work training to make sure people's emergency health needs could be responded to quickly. Managers were undertaking in depth training on dementia care and this was going to be introduced at different levels for all care staff so that more individualised care and response could be given to people with dementia.

We observed during both of the visits that people were asked to consent before any assistance was given. People's care plans indicated that they had been asked whether they consented to aspects of their care. For example people were asked if they would consent to have their photograph taken. We found that people that did not want treatment, for example from dentists or opticians, had signed to confirm this. We also saw that people were allowed to put further information on their agreed 'do not resuscitate' forms if these were completed to state in what circumstances they did not want resuscitation. This ensured people did not receive treatment against their will. Some people's capacity to understand varied but we found that there discussions and records of where staff acted in the best interest of a person.

We asked the manager how they ensured that people's rights to access their money was maintained. We found that people mostly had arrangements with the home and family members so that their immediate needs were met. There were few records of where relatives had legal powers over a person's finances and / or care and this would help if decisions needed to be made.

Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for permission to deprive someone of their liberty in order to keep them safe. We were aware prior to inspection that the provider had not made any applications to restrict people's liberty. We asked if people felt restricted in any way in their care in the home. People we spoke with told us they could go out into the garden independently if they wanted to go out and that they went out with relatives and / or staff. During our visit nobody said or showed that they wished to leave the home or told us they felt safer going out with staff. However two staff told us about one new person who, at times, tried to leave the building and that they went with them when possible. The manager was considering whether an application for a DoLS should be made for this person.

People we spoke with were happy with the food provided. We saw that people were asked to make a choice of food at meal times and given options of where they wished to eat their meal. We observed people having their breakfast meal at a time they wanted and being responded to when they asked for more. At the lunch time meal on both visits we saw that people were offered well presented plated meals and the tables were dressed for the meals. People were able to help themselves to gravy and sauces and had access to condiments and napkins.

Drinks were available throughout the meal and throughout the day. We saw that arrangements were in place for people who spent time in their bedrooms to ensure that they had enough to drink. People were offered suitable food and drink in appropriate, relaxed and comfortable settings.

A person told us about the special arrangements that had been made to meet their nutritional needs. We found that people had been offered assessments from appropriate health professionals such as speech and language therapists where needed. The professional's recommendations were part of the detailed care plan for the individual person. Staff we spoke with knew what they needed to do to minimise the risks to specific people we asked about. As a result of this records we looked at showed that achieved the necessary increase in weight.

Good

Is the service effective?

People were supported to access other health care services. A health professional told us that staff asked for advice appropriately when they visited the home and acted upon any recommendations they made. Records showed that people were regularly supported to meet their routine health care needs such as attending appointments with chiropodists, opticians and dentists when they wished.

Good

Is the service caring?

Our findings

People and relatives of people we spoke with told us that staff were caring and understood them. People's comments included: "They (staff) always chat, they are very good" and "They sang happy birthday and made me a cake." A relative told us: "They know what [my relative] likes."

During our observations we saw that care staff, managers and catering staff spent some time with people having conversations. Staff acknowledged people when walking through communal areas. People we spoke with told us sharing their home with other people was: "Alright," [People were] nice and friendly," "Okay" and "I do not always join in." Nobody expressed any concern about other people living in the home affecting their comfort. We observed that there was a friendly calm atmosphere during each visit. A visitor commented: "It is like visiting your own home."

We observed that staff communicated well with people assisting people to make decisions giving time, suggesting options and consequences of choices in a way that promoted people's independence. We saw that staff took time to explain to people how they were cared for. For example we saw staff explaining to a person how a hoist worked, why they were supporting a person with it and the checks they did to make sure the person in the hoist was safe. At the same time talking with the person being supported. This showed that staff were able to help people understand how and why people were supported in the way they were. As a result of this the person was reassured and said: "Well that is very good." Staff at lunchtime updated people with news of the home, this included details of our visit, updates on staff issues and events. This helped to ensure that people were included in the life of the home.

People living in the home had their own ensuite rooms at the time of the visits although two of the rooms were registered as doubles each of these were only occupied by one person. This allowed people to have time in their own rooms privately if they wished. A person told us: "I like to stay in my room and join meal times down stairs." We found that the majority of people wanted to retain this level of independence. Another told us: "The staff know there are some things that I can do by myself."

People told us that staff treated them with respect. One person told us: They care for me with respect and dignity, they knock on the door [before coming into the room] and they make sure they shut it [the door]." We observed throughout our visits that staff knocked on doors and waited for a response before they entered people's rooms. We found that staff spoke respectfully about the people they supported and were able to tell us how they maintained a person's dignity when providing personal care.

People told us that visitors were made welcome at any time. Their comments included: "[You can have visitors] anytime you wish" and "You can get as many visitors as you want." Visitors told us the service was: "Very flexible" and "You come anytime." This ensured that people had access to important people in their lives helped to prevent people from feeling lonely. Volunteers and friends from the church also visited.

The care records we looked at showed that people had been asked about the arrangements they wanted when they died. There was a good amount of detail to assist relatives and ensure that their wishes could be acted upon.

Good

Is the service responsive?

Our findings

People we spoke with knew they had care plans and records showed that where possible they signed care plans to say they agreed with what they said. People told us that were able to get up and go to bed when they wanted. Care plans contained instructions to staff that were individual to the person. Where we looked at this personalised information we found that these instructions had been carried out. For example a person liked the radio playing in their room and this was found to be on and playing the correct radio station. There were specific instructions about how a person with sight loss could be helped to retain their independence with a task and we found that care staff had carried out these instructions. Staff we spoke with were knowledgeable about the people they supported. They knew about people's life before living in the home and about the people important in their lives.

People living in the home chose it because of its Christadelphian ethos. Although there were one person who lived in the home who were not Christadelphians they understood that the home offered people this experience. People were supported, if they wanted, to attend the Christadelphian church next door the home or if they wished they could listen to services and bible studies that were relayed to the television in the main lounge.

People were supported to take retain hobbies and interests they liked. A person told us that there were things going on most days. We saw that there were planned activities but also the activities coordinator was able to tell us of the support they gave to people to enjoy individual activities. We saw during our visits some people enjoying a group exercise session, some people listening to classical music, a person discussing a recent shopping trip with staff, people knitting, reading and doing crosswords. There was also evidence that people who wanted to were assisted to go out.

People we spoke with told us they knew how to complain if they were unhappy with the care they received. They told us that they would tell relatives, care staff and/ or the manager and all thought their concerns would be looked at. We looked at information we had received and looked at the home's complaint records. We saw that there was information available for visitors to raise concerns if they wished. Visitors told us either that they had not had reason to complain or that they were able to raise concerns with any of the managers. We saw that there were few complaints and that there had been more compliments about the care people had received.

Good

Is the service well-led?

Our findings

All of the people we spoke with were happy with the support and care they received and expressed no concerns with how the home was managed. Relatives indicated that the management of the service were available when needed. Comments included : “The manager has an open door policy,” “You can speak to management at anytime” and “We had a meeting at the beginning when [my relative] came to live here.” People who we spoke with were able to point out the manager and one told us: “They talk to me,” another person said “He is lovely - he always chats to me and asks how I am getting on.” Staff we spoke with were happy about working in the home and about the level of support they received. This echoed a comment we received: “Staff are happy it cascades [to people who live in the home.]

Some of the people we spoke with were able to tell us how their views about their care were collected. They told us: “They listen to my requests and changed my meals,” “Each one of us has a coordinator who asks questions like you (the expert by experience and inspector) are doing” “Yes I get asked “ and “The coordinator comes round about every month with questions about food, activities or if you want to speak about something in private.” On our first visit we found that that although these conversations were recorded the action taken by staff was not. On our second visit we found there had been an improvement in this area. We spoke to a committee member and they told us that the manager always responded to any committee suggestions for improvement.

The provider undertook an annual audit to assess the quality of the home and to see where further improvements could be made. This included a survey of people and their relatives which was returned directly to the provider. In addition one of the trustees regularly visited the home on a regular basis, approximately monthly. They spoke with people who lived in the home and staff as well as looking at records such as complaints. Any recommendations made by the trustee were acted upon. Staff also told us that they were able to raise issues in supervisions and in staff meetings. One member of staff gave us an example of how the manager had acted on a concern they had raised in a staff meeting.

Prior to our first visit a representative from the fire service had visited the home and made requirements in respect of fire safety. On our first visit the date of meeting the requirements had yet to expire. On our second visit we found that this work had been carried out. The provider and manager were reviewing how the fire risk assessment had not found these failings.

At our first visit we reminded the manager of their duty to inform us of any specific events the that they were required, by law, to notify us about. At this inspection we found that the service had no events that it needed to tell us about.

There were systems in place to review people’s care records and check they were up to date and identified people’s current conditions. This was effective as all the care records we looked at had been reviewed and information was current. The home had computerised records and we observed a staff handover meeting where the night records were used to let staff know about the health and comfort of each person. The staff had access to information which enabled them to provide a quality of care which met people’s needs.