David John Taylor & Mrs Virginia Taylor

Kingsgate Residential Home

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

Summary of findings

Overall summary

This inspection took place on 9 and 10 May 2017 and was unannounced.

Kingsgate residential home provides accommodation and care for up to 33 people, many of whom would be living with dementia. At the time of our inspection 29 people were living in the home.

A registered manager was in post, who was also the provider. 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.

During this inspection, we found that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

We found that there was a breach of the regulations because there were no in depth audits of people's medicines and staffs' competency was not regularly assessed in this area. The registered manager was also in breach of the regulations because risks to the environment were not always monitored and people's individual risks were not always documented in their care records. There were plans in place to address these concerns and the registered manager was already in contact with a management consultant in health and safety.

A further breach of the regulations was found because the registered manager did not notify us of significant events relating to the people who lived in the home. A notification is information about important events which the provider is required to tell us about by law.

During our inspection visit we found that there was a lack of effective systems in place to monitor and assess the quality of service being delivered. There was a lack of auditing in a number of areas such as health and safety, people's care plans and medicines. Since our visit improvements have been made with regards to auditing.

There were no meetings for people who lived in the home but the registered manager would speak with people and people felt able to approach staff if they had any concerns or suggestions about the service. Staff meetings did not take place regularly but there were plans to implement more regular meetings.

Accidents and incidents were recorded appropriately and the necessary post-accident observations took place where people had suffered an accident.

Staff knew what constituted abuse and what procedures they would follow if they were concerned that someone was being abused. There were safe recruitment practices in place and all staff had the relevant

safety checks to ensure that they were suitable to work in a caring environment.

All new staff completed an induction to their role and there was ongoing training for all members of staff. Staff were further supported through regular supervisions and appraisals.

Mental capacity assessments were not always in place for those people who lacked capacity but we saw that no one was being unlawfully deprived of their liberty. Staff understood the principles of the Mental Capacity Act 2005 and had received training in relation to this.

People were able to make choices about how their care and treatment was delivered. Where people needed support with decision making, staff would support people with this.

People were supported to maintain a healthy intake of food and fluid and people were consulted about what meals they would like to eat. People were able to choose where they would prefer to eat their meals.

Where concerns arose regarding a person's health or wellbeing, prompt advice and referrals were sought from the most relevant healthcare professional.

Staff were kind and attentive to people's needs. Staff knew people's care and support needs well and supported people to access and maintain their interests and hobbies. People's privacy was respected and their dignity was consistently upheld.

No complaints had been made about the service but there was a complaints procedure in place and people felt able to make a complaint if needed.

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.

Risks to people's health were not always identified and risk assessments were not always in place to mitigate any identified risk.

People's medicines were not administered in a safe way. Regular checks of people's medicines were not carried out.

Staff knew how to identify and report any concerns of abuse. Safe staff recruitment was in place.

Is the service effective?

Good

The service was effective.

Staff received training relevant to their role and regular supervisions.

Staff understood the principles of the Mental Capacity Act (2005) and no one was being deprived unlawfully of their liberty.

People were supported to maintain a healthy intake of food and fluid.

Timely referrals were made when people required an appointment with a healthcare professional.

Is the service caring?

Good

The service was caring.

Staff treated people in a kind and compassionate way and people felt listened to.

People were involved in planning their care and their wishes and preferences were respected.

People's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

People's care records did not always reflect people's most current care needs but staff knew how to support people with their individual physical and wellbeing needs.

There were a range of activities for people to join in and people could access the local town.

People felt able to raise a complaint if needed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of systems in place to monitor and assess the quality of service being delivered.

The registered manager did not always notify us of significant events.

The registered manager was approachable and people felt able to speak with them.

Kingsgate Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 10 May 2017 and was unannounced. It was carried out 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.

During the inspection we spoke with six people living in the home and the relatives of three people. We made general observations of the care and support people received throughout the inspection. We spoke with the registered manager, office manager, four members of care staff and one member of kitchen staff. We also looked at other information we held about the service, including any statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

We reviewed five people's care records and three people's medicine and administration record (MAR) charts. We viewed three staff files in relation to recruitment as well as induction, training and supervision records. We also looked at a range of quality monitoring reports undertaken by the manager and office manager.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed and administered in a safe way. We noted that a member of staff who was administering people's medicines signed that a person had taken their medicine before they had given it to them. We saw that another person had a pot of pills next to them that they had not taken. We asked them if they got their medicines on time, they told us, "[The staff] bring my pills and I know what they're for. There's been one or two occasions when I've reminded [the staff] I need my pills." Another person said, "I have pills brought to me four times a day, [the staff] leave them in a pot for me to take."

We looked at three people's medicine administration record (MAR) charts and looked to see if people had the correct amount of medicines in stock. We noted that a record of how many medicines people had in stock was not kept. Therefore, it was difficult to ascertain whether people had the correct amount of medicine needed. People's medicines were not audited regularly. Such checks on people's medicines would highlight any errors in the safe storage, administration and management of people's medicines.

Staff we spoke with told us that they had received training in administering people's medicines and many staff were due to attend a refresher course. Whilst staff received training in this area, their competency in medicines management was not assessed annually. It is good practice to regularly test staffs' competency in this area. staff had not received an annual update and assessment for competency, in line with NICE (National Institute for Health and Care Excellence) guidelines. This would involve regular observations of staff giving people their medicines and asking them about the types of medicines people are taking. This would address any gaps in their knowledge and practice. After our inspection the office manager informed us that they have contacted a member of the local prescribing team about helping staff to develop a system for auditing people's medicines.

Risks to the environment at Kingsgate were not always documented or monitored. There was a lack of risk assessments to potential hazards within the home. For example, there were no regular checks of people's bedrooms to ensure that they were free from trip hazards and that there were no other potential dangers in the room. Regular health and safety audits were also not being carried out. This meant that anything in the home that could pose a risk to people living, working or visiting there would not be identified in a timely manner. Following our inspection, we were contacted by the office manager, who sent us some of the updated risk assessments for the home to show us that they were addressing this issue.

Risks to people's health and wellbeing had also not been identified in some cases. For example, we saw from one person's care record that they were at risk of falls but there was no risk assessment in place to explain how their risk of falls could be managed to reduce the chance of further falls. Another person had a pressure ulcer and this was being treated by the district nurse, however, we did not see any risk assessment about how to manage the person's risk of pressure ulcers. There was one person who was at risk of choking and there was no risk assessment for this.

These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We addressed our concerns with the office manager and they informed us that they were planning on conducting monthly health and safety audits. We saw from a list of planned audits that an in depth audit of health and safety relating to the home's environment was planned.

We saw that utilities in the service were regularly serviced. However, the service did not have a current gas safety certificate. The registered manager told us that this was because a pipe leading to the kitchen was too small under new gas safety regulations and the gas inspector was unable to issue a certificate due to this. The registered manager told us that there were no issues regarding the safety of the gas. Hoisting and lifting equipment was regularly serviced as were the fire alarms and fire-fighting equipment.

Accidents and incidents were recorded appropriately. We saw that where people had sustained an injury, the care and support provided was documented along with any changes to the person's wellbeing. Accidents and incidents were monitored monthly and so any patterns could be identified. This would allow for the registered manager to take any preventative action.

People we spoke with told us that there were enough staff to meet their needs safely. One person's relative told us, "There seem to be enough staff here, if [relative's name] needs help, it doesn't seem to be a problem." Staff we spoke with agreed that there were enough staff on duty. We looked at the past four weeks of the staff rota and noted that there were consistently enough staff on duty. The registered manager told us that they liked to ensure that they have too many staff than too few.

People we spoke with told us that they felt safe living in Kingsgate. People and their relatives told us that staff were on hand when they rang their call bell. One person told us, "I will use my call bell, I might have to wait a minute or two but never more than five minutes." One person's relative explained, "I think it's safe here, they have a call system if [relative's name] needs help and there's a book for visitors to sign in and out so they know who's here in case of fire." People told us that they felt comfortable with raising any safety concerns with a member of staff or the registered manager.

Staff were able to tell us what the signs of abuse were and what they would do if they suspected someone was being abused. Staff told us who they would report the abuse to and external agencies they could also contact. Staff told us that they had received training in this subject and training records confirmed this.

Good

Is the service effective?

Our findings

Staff we spoke with told us that they received training relevant to their role. We saw from staff training records that they had completed all of the training essential to their role such as fire safety, health and safety and moving and handling. In addition to this, staff told us that they were able to access other training related to their role. This included national vocational qualifications in health and social care. Staff told us that they were further supported in their role through regular supervisions and some staff told us that they had recently had their appraisal.

We noted from staff personnel files that staff received an induction upon starting their role. This covered aspects such as the policies and procedures of the home through to being introduced to the people who lived in the home. One member of staff told us how they shadowed a more experienced member of staff before they worked independently.

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.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

No applications had been made to deprive people of their liberty. The registered manager told us that this was because no restrictions were being placed on people's liberty to keep them safe. For example, there was no need to restrict people from leaving the home of their own free will.

Where people lacked capacity, this was not always noted in their care records. There was no MCA assessment in one person's record despite being told that they lacked capacity. Their care record stated that they had 'little understanding of information given to them'. There was also nothing to show how staff were delivering care and treatment to the person in their best interests. We saw from another person's care file that they had a MCA assessment and this detailed why the person lacked capacity to make certain decisions. Again, there was no best interests decisions noted in this person's care record.

Staff we spoke with understood the principles of the MCA and how they would offer people choices. They also understood the principles of making decisions in people's best interests. One staff member we spoke with told us how they would speak with people's family and GP if they wanted to make a decision in a person's best interests.

People we spoke with told us that they were offered choice about their care and how they chose to live their

life. One person explained, "I like to use the stairs rather than the lift. I know there is a small risk so I am careful. Also, I always tell a member of staff when I am going upstairs." We observed that staff would always ask people before doing anything for them.

We noted from one person's care record that they were underweight and we saw that they had not had their weight regularly monitored. Staff were monitoring their food intake on a chart. . We spoke with the registered manager about this and they told us that staff and the kitchen staff were working with the person to encourage them to eat. The registered manager told us that they had purchased the person's favourite food and they were starting to eat more. We noted from another person's care record that their risk of malnutrition was also not scored. We raised this with the registered manager and they informed us that they had raised it with the staff and would be monitoring people's care records on a regular basis to ensure that they were accurately completed.

People we spoke with told us that they enjoyed the food. One person commented, "I really like it, I get enough to eat and it's tasty." People told us that if they did not like what was on the menu then they could ask for an alternative meal. We saw that the tables were laid out nicely and people were served their meals in a timely manner. Some people chose to eat in their room and that one person liked to eat their meal in one of the lounges. Kitchen staff prepared trays with condiments and drink to take to people who chose not to eat in the dining room. We noted throughout the communal areas of the home that there was always jugs of water and squash available to people. Staff would also regularly offer people hot drinks. One person told us, "There's plenty to drink, [the staff] bring soft drinks, tea or coffee, more than I want really."

People were able to access healthcare professionals when they wanted. One person told us, "[The staff] are very good you know, if you have a hospital appointment [registered manager] books a taxi and a member of staff comes with you." One person's relative we spoke with explained how their relative came out of hospital with an infection and they were not feeling any better. They told us, "Within two days of coming here [the staff] had arranged a visit by the district nurse and she's getting better." We saw from people's care records that where people had asked to see a healthcare professional, staff arranged the appointment and we saw that people were seen in a timely manner. Staff kept a note of any appointments people had with other healthcare professionals and detailed any guidance or advice given during these appointments.

Good

Is the service caring?

Our findings

The service was caring. We observed staff interacting with people in a kind and compassionate way. One person we spoke with told us, "The girls, that's what we call them, are so kind and sometimes they have time for a chat." We saw on a number of occasions that staff would be sat talking with people. We could see by the way people engaged with staff that they felt comfortable in their presence and enjoyed the company of staff.

We saw that staff were constantly engaging with people. We heard one staff enthusiastically speaking about a dress that one person was showing them for an upcoming wedding. Staff displayed genuine interest in people and what they were saying. We saw that staff were patient and encouraging towards people. When one person was walking to the dining room a member of staff was walking with them and encouraging them, the person had a new walking aid and was unsure of using it but staff were patient with them as they walked together.

People and their relatives told us that they felt cared for in Kingsgate. One person's relative said, "There is a real sense of community here, the staff are good and the residents also look after one another." Another person's relative told us how their relative wanted their armchair from home moved into their room. They explained that they were unable to get it through the door to the room so they had to leave it until they could work out what to do. They told us by the time they visited again the maintenance man had managed to get their relative's chair into their room.

People we spoke with told us that they were involved in planning their care and making decisions. One person explained to us how they liked the staff to help them with their personal care. They told us, "I have to rely on the carers for help with most things because I am unable to walk now but I wash as much of myself as I can and the carers help with the rest." Another person explained, "I like to sit in the lounge where the birds are, the office is nearby and I like watching all the coming and going."

There were a number of communal areas in the home. There were two lounges with a television and two without. This meant that people had a choice of rooms where they could socialise with other people and their relatives.

People were supported to be as independent as possible and we saw that some people had mobility aids to help them mobilise independently. We also saw that some people had adapted crockery which enabled them to eat and drink independently. One person required their food to be cut up as they were at risk of choking. Staff told us that they would cut the person's food up in the kitchen before serving it to the person as they did not like their food being cut up in front of other people.

Staff respected people's privacy and treated everyone with respect. We saw that staff would knock on people's doors and wait for an answer before entering. Staff we spoke with told us how they maintained people's dignity when supporting them with personal care. This involved closing the door and curtains and covering people when providing care.

People were able to have family and friends visit without restriction. We saw a number of people had visitors during our inspection visit. We saw that people's visitors were welcomed by staff. One person's relative told us, "I try to avoid mealtimes simply because I know the staff are very busy But I know I can see [relative] at any time." Another person's relative explained, "I find it reassuring that there's an open door policy here. To my mind, it means [the staff] are very confident and that there's nothing to hide, if there was, they wouldn't let me come and go as I please."

Good

Is the service responsive?

Our findings

People's care records were not always complete. We saw that two people were at risk of falls but there were no care plans in place to show how they could be supported with their mobility. There was no guidance in the person's care plan to detail the steps needed in order to manage this risk. In another person's care plan we saw that they were at risk of choking. There was also no guidance in the person's care plan about how to manage this. However, we did note that there was guidance from the speech and language therapy team in their care record. This detailed how to minimise the risk of choking. We spoke with the registered manager about this and they told us that they were aware of the shortfalls within people's care records and they were in the process of addressing this issue.

Some people's care records were complete and gave some detailed information. For example, one person could become anxious at times and would become distressed. Their care plan detailed what support they needed and how staff could reassure them. We also saw that there was detailed guidance for staff about people's daily routines. This included how people liked their personal care to be delivered and what support they would need from staff.

Despite the lack of information in people's care records, staff knew people's care needs well and they were able to tell us what people's individual care needs were and how they support people with their individual needs. People we spoke with told us that they spoke with staff about their likes and dislikes. People told us they felt listened to by staff. One person we spoke with commented, "I wanted a bigger room with a toilet. I asked the manager and when one was available [the staff] moved me to a new room. Then I changed my mind because I really liked the view from the window of my old room and I asked if I could go back, so they moved me back here."

We observed a staff handover. A member of the senior care staff sat with the other staff coming on duty and spoke about each person. They handed over relevant information relating to people's care. We saw that detailed information was discussed and this included preparing for someone who was being discharged from hospital later on that day.

Staff were attentive and responsive to people's needs. We saw one person start to get up without any assistance. A member of staff was walking by and noticed the person trying to get up. They asked the person if they would like any help.

We saw another person say to a member of staff that they had missed the morning drinks round. The member of staff replied, "Don't worry, I will go and get you a cup of coffee." As well as the arranged drinks rounds people were able to always have a drink of their choice at any time.

There were a range of activities on offer in the home for people to take part in. One person told us, "There are quite a few things to do here and at least we're in the town so when the weather's good we can go out." There was a reminiscence afternoon every Wednesday and once a month there was a Church service in the home. We noted that there was a large garden with plenty of tables and chairs. The registered manager told

us that on warmer days people could sit outside and have their meals if they wished. One member of staff we spoke with told us that they were planning on doing regular arts and crafts with people. They were in the process of purchasing some materials for this.

One person told us they liked to read. They explained, "I've always got a book on the go and [staff member] brings books in. We swap books, I got two new books from them this morning." Kingsgate was located near the coast and was within walking distance to the local town. One person commented, "I like to go and see the boys at the lifeboat station."

People told us that they knew who to make a complaint to if needed and staff told us the procedure they would follow if someone wanted to make a complaint. There were copies of the complaints procedure displayed throughout the home. The registered manager told us that they had not received a complaint in the past 12 months but they had received a number of compliments. We looked at the letters and cards addressed to the registered manager and staff who worked in Kingsgate. The main theme of the compliments was the good care that people's relatives had received at Kingsgate and there were many compliments about the kindness shown by all who worked in Kingsgate.

Requires Improvement

Is the service well-led?

Our findings

By law, registered managers are required to notify us of significant events. We noted during our inspection that we had not been notified of significant events in the home. We spoke with the registered manager about this and informed them that we should be informed of such events in a timely manner. The registered manager was aware of what they were required to report to us but agreed that they had not sent us notifications as required.

The registered manager did not inform us of changes to the partnership and this constituted a breach of Regulation 15 of the Care Quality Commission (Registration) regulations 2009.

The registered manager also failed to notify us of the death of a person who used the service. This was a breach of Regulation 16 of the Care Quality Commission (Registration) regulations 2009.

We were not informed of one person who had been admitted to the home with a grade three pressure sore. This constituted a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.

There was a lack of systems in place to monitor and assess the quality of the service being delivered. Health and safety audits were not carried out regularly, risk assessments for the home had not been completed since 2015 and people's care plans and medicines were not audited. We spoke with the registered manager about this and they told us that they knew which audits needed to be completed, and they were aware that a number of audits had not been carried out recently.

Both the registered manager and the office manager were able to show us a schedule they had developed for carrying out in depth audits across all areas of the home. This programme of audits was already underway and we saw that people and their relatives had been asked for their feedback on the service via a quality survey. A number of these surveys had been returned and the feedback was mostly positive. We asked the office manager if there was an action plan in place to remedy some of the shortfalls identified from the surveys. They informed us that this was not in place yet. However, we could see that the office manager was in the process of identifying some key themes from the feedback.

The registered manager told us that they had a contract with a company who could provide consultancy regarding health and safety issues. They were going to undertake a full audit of the home and make recommendations based on any shortfalls that may be found. In addition to this, the company would also provide an employee assistance programme. This would give staff an independent and confidential source of support in relation to any personal or work related problems they may need assistance with.

Throughout our inspection visit we noted that the registered manager was a visible presence in the home and was aware of the day to day activity with the people who lived in the home and the staff. Staff we spoke with told us that the registered manager was approachable and supportive. One person's relative we spoke with told us, "The manager has been brilliant, really helpful. They are approachable and made getting [relative] here far easier than I thought it would be."

People we spoke with told us that there were no formal meetings where people could get together with the staff. One person we spoke with told us, "The staff are quite approachable, most are friendly so if you want something I think you'd be listened to." There had also not been a staff meeting for around two years but staff explained to us that there was frequent communication from both the registered manager and office manager. All staff we spoke with told us that they felt that they were kept informed of any changes within the home. We noted that there was a staff meeting arranged a few days after our visit. The registered manager told us that they would like to implement more regular staff meetings.

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 15 Registration Regulations 2009 Notifications – notices of change The registered person failed to notify the CQC of changes to the partnership. Regulation 15(1)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered person failed to notify CQC of the death of people who were using the service. Regulation 16(1)(a)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify CQC about important events that affect people's safety. Regulation 18(2)(a)(ii)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate steps to manage and mitigate risks to people's health and wellbeing had not been taken and there was a lack of systems to

monitor and assess risks to people and the environment. People's medicines were not managed in a safe way.

Regulation12 (1) (2) (a)(b)(d)(g)