Kingsley Nursing Homes Limited

Kingsley Nursing Home

Inspection report

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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

Summary of findings

Overall summary

An unannounced comprehensive inspection took place of Kingsley Nursing Home 7 & 8 February 2018.

We carried out an unannounced comprehensive inspection of this service in January 2017 when a breach of legal requirement was found. We found a breach in regulation regarding the service not having suitable systems and processes in place to ensure the environment and equipment was safe and used safely. We undertook a focused inspection on 12 April 2017 to check that they had they now met legal requirements. On the inspection of 12 April 2017 we found improvements had been made and the service was now meeting requirements. While improvements had been made around monitoring the home's environment we had not revised the rating for this key question. To improve the rating too 'Good' would require a long term track record of consistent good practice. We reviewed our rating for 'well led' at this inspection and the rating was changed to 'Good'. The overall rating for this service is now 'Good'.

Kingsley Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Kingsley Nursing Home is a care home in the Birkdale area of Southport. The service offers accommodation, support and nursing care for up to 25 older people. The nursing home is accommodated across two Victorian houses that are connected through an internal corridor. Car parking is available at the front of the building and there is a garden to the rear of the building.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at the care home and that they received a good standard of care from a kind, approachable and caring staff team.

Staff were aware of what constituted abuse and how to respond to an actual or alleged incident. Policies and procedures were in place to protect people from abuse.

Staff we spoke with were able to describe how they protected people's dignity and right to choose how they wanted their care delivered. Our observations showed staff provided care in accordance with assessment need. Staff were considerate and polite when supporting people.

Ways in which people communicated were recorded to help make their needs known. With regards to the people we discussed, staff had a good knowledge of how people communicated their needs and how they wished to be supported.

At the time of our inspection there were sufficient numbers of skilled and experienced staff to support people. The provider has agreed to provide extra care hours each day for staff to support people with social activities. The activities organiser had left recently and the provider had advertised this position.

Staff recruitment procedures were robust to ensure staff could work with vulnerable people.

We found the home was operating in accordance with the principles of the Mental Capacity Act 2005 [MCA]. Staff sought consent from people before providing support.

The registered manager had made appropriate referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards [DoLS]. DoLS is part of the MCA and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

Risks to people's health, safety and welfare were assessed and measures were put in place to reduce risk, whilst being mindful of people's rights to independence. Risk assessments were linked to people's plan of care.

Staff received end of life training and people's wishes were recorded regarding the provision for end of life care.

Risk assessments, service contracts and safety checks of services, such as the gas and electric supply, and various equipment were in place. This helped to ensure the environment was safe and well maintained. A plan of refurbishment and decoration was on-going.

People had a plan of care which was based on individual need and drawn in consultation with the person concerned, their relative and/or health professional. People's consent to their plan of care was sought and people and their relatives were involved with care reviews.

People had access to external health and social care professionals to help maintain their health and wellbeing. People told us they could see their doctor when they wanted and staff were prompt in making appointments for them.

Staff received training and support to help ensure they had the knowledge and skills required to meet people's needs effectively and safely.

People told us they enjoyed the meals and there was plenty of choice. People's dietary needs were assessed and dietetic advice sought appropriately.

Medicines were administered and managed safely. People had a plan of care for their medicines and this included the use of as needed [PRN] medication.

People had access to complaints' procedure. There were no recent complaints recorded. People and their relatives felt confident in raising concerns with the registered manager.

We found the home to be clean with good adherence to the control of infection

Opportunities were available for people and relatives to provide feedback regarding the service through meetings and satisfaction questionnaires. Changes were made following feedback to help improve the

service.

People and their relatives spoke positively about the overall management of the service. Quality assurance systems and processes were in place, including audits of the service. These helped to monitor standards and drive forward improvements.

Staff and the registered manager clearly understood their roles and responsibilities to provide a well-managed service.

The registered manager had notified the Care Quality Commission [CQC] of events and incidents that occurred at the service in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

The provider's arrangements to manage medicines were consistently followed. Medicines management was safe.

Recruitment processes were robust and helped ensure staff were fit to work with vulnerable people.

There were sufficient numbers of skilled and experience staff to support people safely and to ensure their care needs were met.

Risks to people's health and wellbeing and the environment were recorded and monitored.

The home was clean and we found systems in place to manage the control of infection.

Staff received safeguarding training and were able to tell us about the types of abuse and what actions were needed to report actual or potential harm.

Is the service effective?

Good

The service was effective

Staff supported people with their health care needs and sought advice from external professionals when needed.

Staff understood and were following the principles of the Mental Capacity Act [2005].

Staff were supported through induction, appraisal and the home's training programme.

People were supported to maintain a healthy diet in accordance with their needs and preferences.

Is the service caring?

Good

The service was caring

People's care and support was delivered in a caring and respectful manner.

People told us they received a good standard of care from the staff and that the staff team knew them well.

People and relatives were involved with care decisions and staff informed them about change to care and treatment.

Is the service responsive?

Good

The service was responsive

Social activities were limited at this time as the service did not have an activities organiser. Care staff were however supporting people as best they could to take part in social activities.

Care records contained information relevant to each person with reference to personal preferences and choice. This helped to provide an individual approach to care.

Staff received end of life training and documentation was in place to support end of life care.

A process for managing complaints was in place. People we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

Is the service well-led?

Good

The service was well led

The service had a clear management structure and a registered manager was in post.

People living in the home, relatives and staff were complimentary regarding the overall management of the home.

Quality assurance systems and processes were in place to monitor the service to and to drive forward improvements.

Feedback from people was sought so that the service could be developed with respect to their needs and wishes.

Kingsley Nursing 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.'

The inspection took place on 7 & 8 February 2018. The inspection team consisted of an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had expertise in older people and dementia care.

Before our inspection we reviewed the information we held about the home. This included notifications we had received from the provider about important events which the service is required to send to us by law, such as incidents which had occurred in relation to the people who lived at the home. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We used all of this information to plan how the inspection should be conducted.

During our inspection we spoke with eight people using the service and six relatives. We spoke with five care staff, the registered manager, two nurses, a laundry assistant and cook. We contacted health and social care professionals before and after the inspection to gain their views of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, including three care records, three staff files, medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service. This included reviewing procedures to ensure the environment and equipment was safely maintained.

Good

Is the service safe?

Our findings

We asked people and relatives if they thought the home provided a safe service. Everybody we spoke with said they felt the service kept them/their relative safe and that they didn't feel afraid of anything or anybody. People's comments included, "There's no reason to feel unsafe. The staff are lovely and work hard to look after us all" and "I feel absolutely safe at all times, yes. The staff keep a really good eye on you and on everything that happens here. The front door is coded and you know that nobody can get in without someone on this side letting them in." A relative said, "Yes, [relative is] very safe. I come in every day and at all times; [the staff] never know when I'm coming and I have never seen anything that would worry you. I absolutely know I can trust every single member of staff" and "Yes I feel is a hundred percent safe, I have no concerns."

At the time of the inspection 21 people were living at Kingsley Nursing Home. We looked at the current staffing levels; the registered manager was on duty with two nurses [one nurse had come in on the day of the inspection to help support the inspection process] four care staff, a cook, a domestic member of staff and a laundry assistant. At night people were currently supported by a registered nurse and two care staff. The registered manager told that staffing numbers varied depending on the number of people living at the service and their needs. We saw the staff providing care in accordance with people's needs and wishes.

Staff told us that staffing levels were satisfactory though with the activities organiser leaving before Christmas, they informed us this placed extra pressure on them to provide time for social activities This view was shared by a number of people living at the home and relatives though no one raised any formal complaints with us regarding this. People said, "Good staffing in the home for nights and days", Most of the time there are enough staff but sometimes I find it hard to get their attention" and "I think yes, mostly enough staff, but they're always busy." Relatives reported, "The staff do the best to come and chat but time is short as they are very busy", "We miss the activities lady and staff don't have time really to sort out the social side, they do their best" and "There seem to be enough staff and they're always very kind and patient even though they're so busy."

Staff told us that the deputy or the registered manager would take turns to be 'on-call'. This meant they were available for staff to contact in case of emergencies and for 'out of hours' cover.

We looked at how staff were recruited within the home and found that records, although available, were not very organised. The registered manager said they would look to improve record keeping for the staff files. Staff records contained a minimum of two references, photographic identification and an application form. There were disclosure and barring service [DBS] checks on file. DBS checks consist of a check on people's criminal record and an additional check to see if they have been placed on a list for people who are barred from working with vulnerable adults. These checks helped to ensure employees were suitable to work with vulnerable people. The registered manager informed us they were recruiting for an activities organiser and hoped to fill this post as soon as possible.

We spoke with staff about adult safeguarding and how to report concerns. All staff we spoke with were

aware how to raise concerns and were familiar with the safeguarding process in relation to their role. When talking with staff about what actions they would take if someone was mistreated, a staff member reported, "I would whistle blow". They told us about the training they received and being aware of the whistle blowing policy. A policy was in place to guide staff on the appropriate actions to take around how to whistle blow and in the event of any safeguarding concerns being raised. Details of the local safeguarding team were displayed for people to refer to. We looked at the records about a recent incident which had been subject to a safeguarding investigation. This evidenced appropriate actions taken by the staff and liaison with external professionals to ensure the person's safety and wellbeing.

People's records were kept secure and were accessible to the staff. Incidents and accidents were recorded and managed appropriately. We saw that appropriate actions had been taken in respect of a recent serious incident which affected a person's safety. Following discussion with relevant parties and the person concerned extra measures had been put in place to ensure the person's safety. This included frequent safety checks and also the use of equipment, for example, a sensor mat. These were documented in detail in the person's plan of care and actions and lessons learnt had been shared with staff to minimise the risk of re-occurrence. The registered manager showed us a report for analysing patterns or trends following incidents. We discussed with the registered manager ways of improving the detail of the information recorded as this was minimal.

The care files we viewed showed that staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, scalds associated with bathing, nutrition, mobility and skin integrity. These assessments had been reviewed to ensure any change in people's needs was identified in accordance with the plan of care. For example, when people were identified as being at risk of falls, there was equipment available to help support them such as, hoists and walking aids.

We were provided with evidence that service contracts and safety checks were completed for the service and equipment. For example, electric, lift and gas safety, Legionella compliance, and fire prevention. These had been conducted by an external professionals and their visits supported by an appropriate certificates. We also saw evidence that 'general' maintenance and internal checks for areas such as, fire safety, hot water and use of window restrictors were carried out as required and actions required were completed in a timely manner.

We saw people had a personal emergency evacuation plan [PEEP] for use in the event of any major incidents/emergencies. These helped to ensure staff knew what level of support each person needed. PEEPs were available in prominent places and also the service's grab bag. A grab bag is a bag of essentials that is easily grabbed in the event of a fire evacuation. A copy of each person's PEEP was also being placed in their care file for reference also. Staff told us they knew about the first evacuation procedure and confirmed they received fire prevention training.

We reviewed the storage and handling of medicines as well as a sample of Medication Administration Records [MARs], stock checks and other records for people living in the home. The PIR informed us staff received medicine training. Nursing staff confirmed this and told us about the ad hoc observations carried to ensure they were administering medicines safely.

Medicines were stored in two locked trolleys. We observed part of a medicine round and medicines were administered safely. The temperature of the medicine fridge was monitored and recorded daily and we saw that these were within safe ranges. If medicines are not stored at the correct temperature, it can affect how they work. Controlled medicines were stored in a separate locked cupboard in line with legislation. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and

associated legislation.

MARs we viewed contained photographs of people to assist with accurate identification, as well as information regarding any allergies that people had and the charts had been completed fully. We checked the stock balance of three medicines including a controlled medicine and they were accurate. When reviewing the MARs we noted a date discrepancy; the registered manager informed us that there had been a printing error for the MARs and they had to be reissued by the home's pharmacy supplier. Appropriate actions had been taken by the registered manager to resolve the issue and ensure medicines were given safely.

We reviewed how thickening agents were given by the staff. Thickening powder can be prescribed to thicken people's drinks when a person may have swallowing difficulties to accept fluids and reduce the risk of choking. The number of scoops of thickening powder required to ensure the correct consistency of fluid for each person was recorded on the person's fluid chart. This instruction was in accordance with the instructions from the speech and language therapy team [SALT] and prescribed on the MARs. We saw that topical preparations such as creams, were recorded when given and a body map identified the areas where the cream was to be applied.

We saw evidence of PRN [as required] protocols and records in place. PRN medicines are those which are only administered when needed for example for pain relief. We saw guidance regarding administration of these medicines was recorded within people's care plans. There was no one administering their own medicines or receiving their medicines covertly at the time of our inspection.

People told us they had no concerns regarding the administration of their medicines and when they required medicines such as painkillers these were provided promptly. This was a view shared by relatives we spoke with.

We found the home to be clean and the service had adequate measures in place to protect people from the risk of infection. Bathrooms contained liquid soap and paper towels and we observed staff wearing personal protective equipment [gloves and aprons] in accordance with infection control guidance A person said, "There are always cleaners around and they come in [to own room] every day and give it a good once-over."

Good

Is the service effective?

Our findings

People and their relatives told us that staff knew them well and were effective in meeting their needs. Their comments included, "No concerns about the care" and "I think I've seen the doctor twice since coming here and they always come very quickly. I see the chiropodist every couple of months and the staff here have made me dentist appointments." Relatives said, "[Relative] has gone right from needing very little support to being very frail. The staff talk me through all of it and give me valuable advice. Risk assessments etc. they talk through with me and write them all up" and "and 'I can see a difference in [relative] in just a week. They are more alert because the staff make the effort to bring them [residents] to the lounge instead of leaving them [residents] in bed."

The PIR informed us how people's needs were assessed. We found information regarding people's needs and preferences was gathered and recorded to help provide effective care based on individual need. Staff told us the service worked together with external health and social care professionals such as, occupational therapists, falls team, speech and language therapists, palliative care team, doctors and dieticians to support people to lead healthy lives. We saw evidence of relevant appointments and these were arranged at the appropriate time. During the inspection a number of external professionals visited the home to consult with people following appropriate referral. A health care professional informed us that the staff provided good care and were responsive to people's change in needs.

Staff recorded people's diet and fluids and completed turning charts [when people need to be moved in bed to prevent their skin from becoming red or broken] according to assessed need. Staff told us how these provided safety checks of people's care and assurance for relatives regarding the care provision. The charts seen were completed in good detail and helped to monitor and provide an evaluation of care. For meeting specific care needs such as wound care, staff completed wound assessments and followed a treatment plan which evidenced the progression of the wound.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager informed us three DoLS applications had been authorised; information pertaining to the authorisations were reflected in people's plan of care. Seven applications were awaiting a decision. We found that DoLS applications had been made appropriately.

People were consulted with regards to their care and support needs and when able, people signed to show their consent to their care and treatment. When there were concerns regarding people's capacity to consent to care or make decisions, mental capacity assessments were completed. We saw 'do not attempt cardio

pulmonary resuscitation' [DNACPRs] in people's care files and people had been involved with this decision. We saw a record of a 'best interest' meeting held with relatives and other interested parties where a person lacked capacity to consent to their care and treatment and the decisions needed to support them safely in the least restrictive way were recorded. The registered manager informed us about a best decision made for another person with the consent of their relative however there was little information recorded around this. We brought this to the registered manager's attention and they advised us this would be recorded in more detail. The relative informed us they had met with the registered manager and were in full agreement with the decision.

The service ensured that all newly appointed staff were assessed in line with the Care Certificate. The Care Certificate is an identified set of standards that care workers have to achieve and be assessed as competent by a senior member of staff. Staff had completed an in house induction and two new staff were being enrolled on the Care Certificate. A number of staff had a National Vocational Qualification [NVQ] in in Health and Social Care to enhance their learning.

We saw staff had access to e-learning and also face to face training. A training matrix evidenced completed courses and certificates for training completed were seen in staff files. Staff told us they undertook training in areas such as, moving and handling, infection control, dementia awareness, mental capacity and DoLS, safeguarding adults, food hygiene and fire safety. A small number of staff required fire safety training as they had not attended the most recent training. A date for this was arranged during the inspection. Other training included nutrition, equality and diversity, lesbian, gay, bisexual and transgender [LGBT] and basic life support. To support end of life care, staff were attending 'The Vigil' at a local hospice later on this year. We saw the service had appointed a 'champion' for promoting dignity and a 'champion' for infection control; the staff responsible for these roles had received more in depth 'train the trainer' training. The service's training programme ensured that all staff had the skills and knowledge to support people safely.

With regards to staff support, staff attended supervision meetings and had an annual appraisal. Staff told us that they could go the registered manager for support if needed and were confident that they would be listened to.

The registered manager told us that along with people's physical needs a number of people had a diagnosis of dementia. When we toured the home we noticed patterned carpets. Some people with dementia can find patterned carpets difficult, as they may see things such as swirls move. We also found a lack of signage in communal areas and hand rails to support people move around the home and help orientate them with their surroundings. We suggested that the registered manager complete an environmental assessment tool to look at the home from a dementia-friendly perspective and the use of aids/tools to promote this. No one raised any concerns regarding the environment though some relatives felt the home needed painting due to 'general' wear and tear. The provider was able to confirm they were obtaining quotes for painting and decoration. There was also a plan in place for replacing windows and bedroom carpets with suitable flooring. This we saw when touring the home.

The menus were displayed on a noticeboard however this was in small print and therefore would have been difficult for people to view. People were informed of the choice of meals and offered hot and cold drinks and snacks throughout the day. People's comments included, "The food is all right; not what you'd get at home, of course. We do have some choice; they come around mid-morning to tell you what's on the menu and you choose" and "The food is first class and you do get a choice. I get what I want, if I don't like the choices that are on. Yes, there's enough, and plenty of drinks – too many sometimes." A relative said, "They're really good at getting [relative] to eat. They respond to [kitchen staff member] very well; they gave [relative] their lunch today. The other day, [relative] had chosen something they didn't like, so [carer] got something they knew

[relative] would like. The staff here are incredible."

We saw lunch being served onto individually named trays and in many cases the meals were then taken upstairs by staff for people to eat in their own rooms which they preferred. Most people needed some support and many people had their food blended. Staff were patient and kind in their support, offering food without any haste, and talking to the people they were supporting, telling them what they were eating. We found people were supported to maintain a healthy diet in accordance with their needs and preferences.

Good

Is the service caring?

Our findings

People all shared a view that they were treated with compassion and kindness by all staff. Their comments included, 'I'm very happy with the attention I get. They [staff] are very friendly", "They [staff] treat you like one of the family" and "Definitely. There's never anything other than politeness and kindness in the way they [staff] treat you." Relatives said, "Yes, they [staff] are incredibly patient, kind and caring" and "The carers are very supportive, polite and kind."

The PIR informed us that staff 'follow the six core principles for privacy, dignity, independence, choice and rights'. Our observations showed at all times staff's interactions were kind, attentive and patient towards people. There was no undue sharing of information or assumptions made about a person's wishes or views; all were treated with equal dignity and respect. When supporting someone in transferring, staff used what seemed to be a familiar set of statements to enable people to respond: 'A nice big stand; one, two, three and a little turn to me.' People appeared very reassured by these words. When transferring people from or into their chair, staff ensured that people were not unduly exposed, adjusting clothing as needed. We also noticed that when people were asked if they needed the toilet or a change of clothing, staff spoke as quietly and confidentially as possible to the person concerned so as not to be overheard. During the lunch period staff similarly spoke individually to the people they were supporting, and focused on these people, supporting an air of privacy even in a shared space [the lounge].

During the inspection we observed staff asking people about immediate wishes, such as offering drinks, checking they were warm and comfortable. People told us the staff listened to them and if they wanted to go to bed or to the bathroom then the support given was always carried out in a dignified and unhurried manner. A member of the domestic staff was clearly familiar to and welcomed by people in their own rooms and in the lounge. We saw them and other staff knock on people's doors and waited to be asked in. People said, "The staff knock and if their hands are full they say 'knock knock' and wait for me to say 'come in' and "They [staff] pull the curtains before giving personal care and they [staff] always knock on the door and wait." A staff member told us that gender preference was taken into account when giving personal care and they respected people's wishes if they preferred a female carer to support them.

It was evident that visitors were able to come at any time during the day, with no restrictions. The registered manager confirmed this. A relative told us that when visiting staff would say, "Would you like some private time, would you like us to take [relative] to their room?" One relative told us that they came in at all times, even sometimes in the middle of the night, in response to phone calls from their relative. They told us they were always made welcome. Another visitor said that they could have lunch with their relative which they enjoyed.

Staff spoke fondly about the people and relatives they supported and it was evident through discussions with them they knew people well. Care staff held a key worker role which meant they were responsible for a small number of people to help them to get to know them in more depth and to promote people's engagement. Care files contained information regarding relationships that were important to people and their support needs. This helped staff to understand the background of the person and promote effective

relationships based on trust and knowledge.

Staff confirmed that communication was good within the staff team and changes to people's care and support was always cascaded to them. Staff encouraged people to communicate effectively in order to ensure their needs were known and could be met. Staff told us how they picked up on non-verbal signs which some people displayed when they needed support. Staff told us how they simplified questions and used clear, slower speech to enable people to understand what was being said, "You can see by their reactions if they've [people] understood or if you need to try again in a different way." This we observed during the inspection.

Staff told us this was people's home and they did their best to ensure there was a friendly and 'homely' atmosphere at all times. This was evident during the inspection. The atmosphere was very relaxed and people appeared very comfortable with the staff. A person told us how reassured they were as the staff were always there to help them and make sure they had everything they needed.

We saw people being encouraged to be independent and staff told us how this was encouraged when supporting people with daily tasks such as, walking and transferring with the aid of equipment. This was reflected in the care plans we looked at. A person said, I can do what I like really, they know how I like to spend my day and I like this independence." Staff helped to arrange social visits outside of the home and a person went out with their relative for lunch during the inspection.

There was plenty of information in people's rooms and on display in the main hall for people to read about what to expect from the service. This included the complaints policy, menus, the name of the dignity champion for the home and safeguarding information. Information regarding advocacy services was also available to support people who did not have friends or family to assist them with decision making. The registered manager informed us that one person received support from an advocate and they told us how the person benefited from this contact.

We saw that people's confidential information within their care files was stored securely in order to maintain people's confidentiality in line with the Data Protection Act.

Good

Is the service responsive?

Our findings

People told us that staff provided them with care and support based on their individual need and preference. People said, "I think they all know my ways and so on". [The person went on to tell us about a specific activity they liked doing each day which was accommodated by the staff] and "The carers know what I like to eat and when I like to go to my room." A relative reported, "They know [relative] very well indeed, and are in no doubt of what they like and don't like."

We looked at people's care documents and found consent forms completed by people and their relatives and evidence of their inclusion with care reviews. Care records showed individual plans around people's health, their care needs and a 'life story' in respect of family back ground, preferred interests, likes and dislikes and routine. We saw that people's communication was assessed and recorded in their plan for care along with reference to an impairment or sensory loss. The registered manager informed us that information such as, care documents could be provided in different formats if requested. For example, large print and pictorial charts to help people make their needs and wishes understood.

A number of care plans were completed in good detail, however, we saw a care plan which was generic [pre populated information] and was this not particularly person centred; care plans based around people's preferences, needs and wishes help staff understand the level of care and support to be provided and in what ways to suit the needs of the person. We discussed this care plan with the registered manager who confirmed the care plan would be reviewed and updated.

For the person who had been involved in a recent incident their plan of care had been reviewed immediately. The staff had acted appropriately and instigated changes to the person's plan of care to ensure their on-going safety and well-being; this included the provision of regular safety checks. For people whose dietary needs were subject to change, staff told us how they sought external support from a dietician and how foods were blended or drinks thickened in accordance with their assessed need. Discussions with staff confirmed their knowledge regarding people's care and support.

During the inspection we saw that technology was used when required to help support people and help maintain their safety. For example, people who were at risk of falls had a falls sensor in place in their bedroom. This alerted staff when people mobilised, so that they could provide support in a timely way and help prevent falls. People also had access to a call bell. This helped to ensure that people's needs could be met in a timely way and this we observed during the inspection. A person said, I sometimes have to wait but they [staff] come as soon as they can, I am never left worrying."

We were informed that the home's activities coordinator had left two months previously, and several people referred to the activities and opportunities that had previously been available. A person said, "There used to be a lady here that did painting, took us out etc. She was very good and she also got a load of people in to do things, such as her granddaughter singing. I hope they can find somebody to replace her". Likewise a relative reported, '[Relative] is a lot more alert when sitting in the lounge than in their own room. The staff do try to involve them in the activities. There's a super man who comes in and sings." The registered manager

also told us about two visiting musical entertainers, who people enjoyed seeing. There were no activities on the day of our visit; the television was on in the lounge.

Our observations showed staff worked hard throughout the day to meet people's needs and ensure their comfort. We saw staff sitting with people during the afternoon, encouraging them to take part in a game, or just talking quietly. This included one person who was unable to communicate verbally being supported by staff in watching whilst other people played the game. There was however little time to engage people with meaningful social activities. Religious services took place at the home which a number of people told us they enjoyed. One person told us how they enjoyed going in the garden each day and the staff facilitated this.

We spoke with the registered manager and provider regarding the provision of social activities. Following our discussion the provider informed us that until a new activities coordinator was employed an extra two hours a day would be made available for a member of the care team to support people with their social interests. This was instigated the week after the inspection.

The PIR informed us the service had an 'open' door policy regarding complaints. We saw that the provider had processes in place to receive and act on complaints. There had been no recent complaints and people said, "I haven't got any but if I did, I'd tell the matron" and "I have no concerns but I know I could tell [manager] or any one of the staff and they'd deal with it". Complaints were recorded in a bound book rather than using the complaint forms which were available. We discussed using the complaint forms as these would provide a more formal record. The registered manager said they would implement these in the future.

We looked at how people were supported for end of life care. Staff received end of life training and people's wishes were recorded regarding the provision for end of life care. During the inspection advice was sought from a palliative care specialist with regard to the care and support for a person who was approaching end of life. The registered manager was instigating the appropriate documents and liaising with the family to ensure the person's needs and wishes were fully met at this time.

Good

Is the service well-led?

Our findings

There was a registered manager in post and they were on duty at the time of the inspection. We asked people and relatives to share their views of how the home was managed and feedback was positive. The majority of people knew who the registered manager was, either by name or by sight. All said that they felt the registered manager and deputy manager were approachable and responsive. People's comments included, "[Manager] – lovely. I can talk to them and to the deputy manager about anything. They sort things out for me", "The matron is really good and all the staff work well together", "I reckon it's the best managed home in town. I give it 20 out of 10","It couldn't be any better managed" and "Yes, if there's anything wrong it's sorted out, and in the right way." Relatives said, "I feel a really lucky person that [relative] is here" and "The home seems very organised and things get sorted."

The PIR informed us about the good working relationship between staff and management. Staff spoke positively about the registered manager and cited a consistent and caring approach as an important factor. Staff told us the registered manager had a visible presence and had an 'open' door policy. Staff comments included, "Really good manager", "Very supportive" and "You can talk with [manager] at any time, [manager] always makes time for you." Staff informed us they attended staff meetings and were able to put forward suggestions to help improve the service. We saw minutes of meetings held.

Through discussion with staff and our observations, it was evident that the needs of the people living at the home came first and staff were committed to providing a 'homely' environment where people felt safe and well cared for. Staff told us they all worked as a cohesive team and did their best to provide a warm, supportive and comfortable place for people to live. A staff member said, "We try to make it just like someone's home and the residents are our family too."

We looked at quality assurance systems and processes to help monitor standards and drive forward improvements. The registered manager and staff were aware of their responsibilities and there were clear lines of accountability. The registered manager reported day-to-day issues to the provider so they had a good knowledge of how the home was operating. We saw the provider was supportive and a report of their findings was recorded following their monitoring visits. These reports included speaking with a number of people living at the home, conducting a tour of the building and checking various aspects of the service provision for 'matters arising'. A report from January 2018 recorded positive comments from people. For example, "The staff do the best they can, it's a lovely room and I'm quite cosy." Where a person requested input form an external health professional to support their mobility, this was actioned promptly by the registered manager. We noted that these reports provided information in respect of on-going improvements to the environment, including replacing windows and refurbishing rooms. Quotes were also now being sought to paint the main hallway and other areas of the home. The registered manager and provider appreciated the need to look at the environment in terms of supporting people with memory loss, as an area of further development. The provider stated that the provision of hand rails in the hallway would be actioned and clearer signage would be made available for communal areas and bathroom/toilet facilities.

Audits [checks] of the service were completed and this included areas such as, medicines, falls, incidents,

care plan reviews, care audits, infection control, staffing, staff training and health and safety. These checks were current and any actions completed in a timely manner. A recent internal infection control audit provided a score of 95.7% for cleanliness.

The PIR informed us that resident/relative meetings were held and a suggestion box was available at the home. We saw people and relatives were invited to share their views by attending meetings with the staff and also the provision of satisfaction surveys. The registered manager informed us they sent out four satisfaction surveys every two months for people living at the home and their relatives and for the staff. Not everyone we spoke with could recall completing a satisfaction survey however people told us they felt confident in speaking up and sharing their views. The satisfaction surveys we looked at provided positive feedback. We saw changes had been made to the menus following comments made and people told us the menu choices were now much better. Feedback from a relative recorded the following, "My mum and my family have been shown nothing but exceptional care in every aspect. Thank you for everything."

The registered provider had a range of policies and procedures in place for staff reference, such as, equality and diversity, safeguarding, infection control, medicines and missing person's policy. Policies and procedures support decisions made by staff because they provide guidance on best practice and current legislation. We discussed with the registered manager a recent incident in the home and how this had been managed. The staff had acted and managed the incident appropriately however following the event the registered manager had discussed the incident with staff including lessons learned to help improve practice.

We saw evidence that the service worked effectively with other health and social care organisations to achieve better outcomes for people and improve quality and safety. The professionals we contacted did not express any concerns at the time of our inspection.

The registered manager had notified CQC [Care Quality Commission] of events and incidents that occurred in the home in accordance with our statutory notification requirements.

From April 2015 it is a legal requirement for all services who have been awarded a rating to display this. The rating from the last inspection for Kingsley Nursing Home was displayed for people to know how the home was performing including the provider's website.