Kingsley Care Homes Limited

Allonsfield House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Allonsfield House is a residential care home providing personal and nursing care for up to 53 people. The service provides support to older people and those living with dementia. At the time of our inspection there were 48 people using the service.

Allonsfield House accommodates people across three separate units, each of which has separate facilities. Allonsfield Suite was the residential wing, Ashfield was the nursing wing and the dementia unit accommodated people living with dementia.

People's experience of using this service and what we found
People were not always supported to take part in activities which were relevant to them, in particular people living with dementia. We observed people left unsupported for extended periods of time which meant they engaged in self-soothing activities.

The decoration and furnishing of the dementia unit was not designed to support people living with dementia. The decoration in the Allonsfield Suite was tired and in need of improvement. Improvements in this area were included in the service improvement plan.

There were sufficient staff to meet people's needs. However, they were not always deployed effectively. We observed periods where people in the dementia unit were left without staff support. There was not always staff available in the dining rooms to support people if needed.

People were supported by safely recruited staff who had received training in how to support them safely and effectively. Staff were aware of the risks to people and were kept up to date with changes in people's care needs. Where accidents and incidents took place, appropriate actions were taken and reported on. Staff had received training in how to recognise signs of abuse and were aware of their responsibilities to report any concerns they may have. People were supported to receive their medication as prescribed.

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

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

Rating at last inspection
The last rating for this service was requires improvement (22 October 2022).

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe.	**Good**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was caring.	**Good**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not always well-led	**Requires Improvement**

Allonsfield House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors and a dementia specialist. An Expert by Experience spoke with relatives by telephone after the inspection visit. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Allonsfield House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Allonsfield House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

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

Notice of inspection

This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During our inspection visit, we spoke with 5 people and 5 relatives. We observed staff interactions with people, such as at lunchtime and when medicines were being administered. We spoke with 8 staff members including 2 operations managers, the registered manager, nursing staff, care staff, and administration staff.

We reviewed a range of records, including 6 people's care records, medicine records, 3 staff recruitment records and staff training. We also reviewed records relating to the management of the service including policies and procedures and audits.

After our visit we spoke with 8 people's relatives on the telephone.

Good

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people were safe and protected from avoidable harm.

Staffing and recruitment

- There were enough suitably trained and competent staff to keep people safe and meet their needs, but they were not always deployed effectively. We observed lengthy periods of time when people in the dementia unit lounge had no supervision or interaction with staff, although staff were in the unit carrying out other tasks.
- Relatives told us that staffing levels and consistency of staff had improved in recent months.
- Records showed staff were recruited safely and checks included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse.

- People told us they felt safe living in the service.
- Staff said they were trained in safeguarding adults. They knew what to do if they were concerned about the well-being of the people who used the service.
- Systems and processes were in place to safeguard people from abuse. Incidents were investigated appropriately, reviewed by the registered manager and overseen by the providers management team.

Assessing risk, safety monitoring and management

- Risks to people's health and safety were monitored and managed safely. Care records included essential guidance for staff about keeping people safe.
- Care records included risk assessments relating to areas such as falls, pressure ulcers and nutrition.
- Where risks to people had been identified actions were put in place to manage the risks. For example, people who were at risk of falling had sensor mats in their rooms. The sensors let staff know when the person was moving around so they could go and offer support.
- Records were inconsistent regarding the checking of some equipment, some sensor mats were checked weekly, others daily, some without a pattern. We were told by the regional quality manager this was because they were checked by different people, sometimes care staff, sometimes maintenance. When a sensor mat was found to be not working it was not clear how this had been resolved.

Using medicines safely

- The services used an electronic medicines system. This was well managed, and people received their medicines when they should.
- Our previous inspection raised concerns regarding the application of topically medicines. These had been addressed and people now received these as they should.

● Medicines were received, stored, administered, and disposed of safely. Staff were trained and assessed as competent to support people with their medicines.
●Staff were aware of time specific medications, including those used to treat Parkinson's disease and ensured people received these on time according to their individual schedule.
● People were observed to receive their medications in a dignified way. Staff sought consent, explained what each medication was for and assisted them in the way they preferred, for example, from a spoon or cup.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Relatives told us they were able to visit when they wished. We observed a number of people visiting relatives on the day of our inspection visit.

Learning lessons when things go wrong
● The provider had an electronic system to monitor incidents and ensure lessons were learnt and shared should a concern arise.
● The registered manager carried out a root cause analysis of serious incidents.
● The providers quality lead told us that any lessons learnt from an incident in one of the providers homes was shared across other services.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs

- There were communal areas for people to sit and spend time with friends and family throughout the service. However, in the dementia unit these had not been adapted to support the needs of people living with dementia.
- We observed some people spent most of their morning in the dementia lounge. For extended periods there were no staff and nothing to stimulate people in this room.
- There were no books, magazines, or dementia specific items such as twiddle muffs. This meant that people used self-soothing actions such as rocking in their chairs, pulling at their clothing, fiddling with the loops on their hoist slings, repeatedly standing and sitting, and calling out.
- A secure garden was accessible for people. However, this had not been adapted to support people with dementia. The registered manager told us that they were planning to purchase some birds to engage people.
- The service also had its own farm adjacent to the service. On the day of our inspection, a rabbit was brought into the service for people to pet. However, the potential for the farm to support people's well being had not been fully realised.
- In the Allonsfield Suite dining room the decoration was quite dark and tired. The registered manager told us this was currently under review and on the service improvement plan.
- People's rooms had been personalised with their own furniture and photographs.

Supporting people to eat and drink enough to maintain a balanced diet

- We observed the lunch time meal in the 3 units.
- The menu was printed on a single A4 sheet by the door, people were walked or wheeled past, no one was shown the menu, and no one was able to read it independently.
- In the dementia unit it took over 30 minutes to assist everybody to move to the dining room, during this time there was little supervision or interaction with the people already waiting. We observed 1 person attempting to stand and rocking their wheelchair backwards. A person fed another person with a drink of juice, this person was unable to refuse the drink, they then shared the glass of juice.
- There were no adaptions for people living with dementia in the setup of the dining room of the dementia unit. Tablecloths and napkins were both the same colour, a similar colouring to the flooring, this made it difficult for people with visual spatial difficulties to see their napkins and people used the tablecloth to wipe their hands and faces. The hospitality manager said they was looking to replace the linens.
- People were not consistently supported to prepare for lunch in a dignified way. We observed people's

hands were washed using wet wipes by staff who simply lifted their hands and wiped them without informing the person what was happening. Similarly, aprons were placed over people's heads without their consent.
● People living with dementia were shown two plates of food so they could choose which they preferred. However, there was no offer of condiments and all portions served were the same size.
● In the Allonsfield suite no member of staff stayed in the dining room once people had been served their meal. This meant no member of staff was immediately available if there was an incident such as choking.
● People and their relatives were complimentary about the food. A relative told us, "The menu is good and I see a good variety and choice, you don't see the same things."
● People confirmed their individual dietary needs were met. A relative said, "[Relative] does not eat meat and has specific needs, is given fish and plenty of vegetables, always gets the right food, [relative] weight is stable."
● Where people required assistance they were supported by staff to eat at their own pace and with dignity.
● Where people were identified as being at risk of malnutrition and dehydration care plans showed they were monitored through being weighed regularly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care needs were assessed by the registered manager before they started using the service to ensure they could be met.
● People who used the service, their relatives and other professionals were involved in the assessments to ensure they fully reflected people's needs.
● Protected characteristics under the Equality Act 2010, such as religion and culture were considered during the assessment process, this information was then used to inform care planning.
● Care plans were detailed and included information about family, social history, children, childhood and siblings.
● Care plans detailed people's physical needs, including communication, moving and handling, eating and drinking, oral health and continence needs.
● Risks in relation to people's care were identified using standardised tools such as the Barthel Index, Waterlow and Malnutrition Universal Screening Tool (MUST), this ensured staff could monitor people's changing health status and adapt their care accordingly.

Staff support: induction, training, skills and experience
● Staff were provided with appropriate induction and support. Staff said they felt competent and confident in their roles. People said they felt staff had the right skills to look after people.
● Nursing staff told us had they access to a range of relevant Continuing Professional Development (CPD) opportunities provided in-house by the provider and externally through links with the wider NHS multidisciplinary team. They felt well supported to ensure their clinical skills and competencies were up to date and in line with best practice.
● New care staff went through an induction process which included the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff training was recorded and monitored to ensure that all staff maintained up to date training.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The district nurse visited during our inspection. They told us staff were always knowledgeable and helpful during their visits.

● The registered manager told us they had developed a good relationship with the local GP practice and had regular meetings to discuss people's care.
● Care plans demonstrated that referrals were made to external services when required.
● Relatives told us they were confident that people received support from outside agencies such as GP, dentist and optician when necessary.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider was working within the principles of the MCA and had applied for DoLS where required.
● Staff had received training in the MCA.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Relatives told us that staff were kind and caring. One relative said, "Staff are brilliant, they are kind, residents are given time, they walk around with them." Another relative said, "On the whole they are caring, I have seen a lot of carers and time is given when functional things are going on."
- Language used in care records did not always value people. For example, people were described as 'suffering from', and 'agitated'. Language used in care records did not always value people. For example, people were described as 'suffering from', and 'agitated'.
- We observed mostly kind and caring interactions between people and staff but we also observed some interactions which were perfunctory and task led. For example, we observed 1 interaction where a member of staff extracted a tissue from a person's sleeve, wiped their nose and face without speaking to the person at all.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives confirmed they were aware of their care plan and reviews. The clinical lead told us that care plans were reviewed with the involvement of people and their relatives if appropriate. A relative said, "Care plan, they do tell me when something is new or updated, they send it to me and if I agree I sign it." Another said, "I have seen it and contributed a couple of times."
- People were supported to make day to day decisions about what care they received, and support plans were regularly reviewed.

Respecting and promoting people's privacy, dignity and independence

- Bedroom doors were closed so that people were not observed when having personal care. Staff knocked on doors and waited for a response before they entered the room.
- Staff spoke to people politely and referred to people by their preferred name.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● A varied programme of activities was displayed at various points in the service. However, although it contained some symbols, the size of the poster and the printing on the document meant that not everybody could read it. Following our inspection visit the provider has told us that the font size has been increased.

● It was not clear how these activities included or were adapted to people living with dementia. For example, on the morning of our inspection visit there was a coffee morning held in the lounge of the Ashfield Unit. Only 1 person from the dementia unit attended the coffee morning.

● People and their relatives expressed mixed views about the activities in the service. One person said, "Independence is promoted but they could do more as [relative] likes to keep busy, they get bored, [relative] would like to clean their own window, make a cup of tea, give them a purpose like to wash up."

● People living with advanced dementia or who were nonverbal were not offered any form of structured or unstructured activity in the morning of our inspection visit. We observed one person occupying themselves by trying to pick a spot from the floor. 2 others had a minor confrontation when trying to access the garden.

● The activity log in people's care plans did not describe what activities they had taken part in or may benefit from.

● In the afternoon staff in the dementia unit assisted people to play games including velcro darts and Jenga.

● Each person was allocated a member of staff as a key worker. The keyworker role focused on ensuring people's room and belongings were well kept and highlighting if anything, such as new toiletries were needed. It was not clear that there was a daily keyworker system to monitor individual people's wellbeing.

● There was wi-fi throughout the service which supported those who were able to stay in contact with family and use electronic devices such as smart speakers.

●The registered manager told us there was a full-time activities co-ordinator, but they were not working on the day of our visit. We were shown examples of a variety of organised activities such as a celebration of the Chelsea flower show and building bird boxes.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care plans were person centered and detailed the care and support they needed or preferred. The care summary pages gave care staff a good overview of how to support each person with their daily needs and wishes.

● Care delivery was recorded on an electronic system, this sent alerts when care was due and where delayed. Staff completed their notes on the system, and these could be referred to which supported continuity.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were assessed.
●Staff adapt their communication to the needs of the person. Where people had sensory impairments, staff used a range of communication strategies to support effective communication.

Improving care quality in response to complaints or concerns
● The service has a complaints procedure and policy.
● People told us that the service responded to their complaints and concerns but that improvements were not always sustained.

End of life care and support
● The service was not supporting anybody with end of life care during our inspection.
● Where people had expressed preferences for their end of life care these were recorded.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- On the date of our inspection there was a registered manager in post. They had been in post for 3 months and recently registered with the CQC. They were the fifth manager to be registered with CQC since 2020. Although complimentary about this manager relatives raised concerns about the previous high turnover of managers and care staff.
- The was not a clear system to ensure people's wellbeing was checked regularly throughout the day. People who remained in their rooms had welfare check tasks included in their daily care plan, but people who moved about the home or remained in the lounge did not have the same checks in place.
- There were quality assurance system in place. However, these had not identified all of the concerns identified above.
- The registered manager and senior staff told us they felt supported by the providers management team.
- There was an improvement plan for the service which the registered manager told us they had developed with the provider. This identified areas for improvement and actions to be taken with timescales.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We received mixed feedback from relatives as to how well the service communicated with them. A relative told us, "Communication of events, what is going on like the relatives meeting today was only on face book not everyone has access to social media why can't they do email as well." Another relative said, "There used to be regular relatives' meetings last one was standing room only it was so well attended and now look [indicating few relatives at coffee morning]. It is the communication you don't know what is going on." However, another relative said, "With new manager things have changed a lot and changed for the better, she communicates directly, she is great, it has improved."
- The service had recently recruited an activities co-ordinator and people were complimentary about changes they had made and the activities they were providing. However, outside of these activities the service was not always inclusive. For example, people living with advanced dementia or who were nonverbal were not offered any form of structured or unstructured activity in the morning
- The service held regular meetings for relatives however but were not held at times that were always convenient for some people to attend. A relative said, "Monthly relatives meeting you can go and chat but I am not able to go, no minutes so I don't know what is discussed but would like minutes."

Continuous learning and improving care

● The daily staff meeting with senior staff from each department ensured information was shared effectively and the home manager was kept updated with events.

● Information following incidents and accidents was reviewed for any trends and outcomes used as part of continuous learning. Learning was shared across the providers services.

Working in partnership with others

● We received positive feedback from local healthcare professionals regarding recent improvements in the service and how they worked in partnership with them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their responsibilities under the duty of candour and the requirement to act in an open and transparent way when concerns were raised.