Balcombe Care Homes Limited

Kingswood Court Care 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

The inspection took place on 21 November 2017 and was unannounced.

Kingswood Court Care 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. At the time of our inspection there were 40 people at the home.

At our last inspection we found two breaches that related to medicines and consent. At this inspection we found actions had been taken to ensure the regulations had been met and the service had improved.

There was not a registered manager in post. The provider had recruited a manager who was in the process of registering with the Care Quality Commission to carry on regulated activities at the home. 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 and their relatives told us they felt the service was safe and they were complimentary about the staff and how caring they were. They stated that staff were very kind and they had no concerns about their safety. Staff had received training in relation to safeguarding and they were able to describe the types of abuse and the processes to be followed when reporting suspected or actual abuse.

Staff had received training, regular supervisions and annual appraisals that helped them to perform their duties. New staff commencing their duties received induction training to help prepare them for their role. Staff told us that they worked with another member of staff until they and their registered manager felt they were competent to work on their own.

There were enough staff to ensure that people's assessed needs could be met. It was clear that staff had a good understanding of how to attend to people's needs. The provider had carried out full recruitment checks to ensure staff were safe to work at the home. Risks to individual people had been identified and written guidance for staff about how to manage risks was being followed.

Accidents and incidents were recorded and monitored by staff at the home to help minimise the risk of repeated events.

Medicines were managed in a safe way and the recording of medicines was completed to show people had received the medicines they required. Staff were knowledgeable about people's medicines and explained to people what their medicines were for.

The environment was very clean and tidy there were no malodours at the home. Staff followed good practice guidance in relation to infection control to minimise the risk of cross infections.

Where there were restrictions in place, staff had followed the legal requirements to make sure this was done in the person's best interests. Staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure decisions were made for people in the least restrictive way.

Staff supported people to eat a good range of foods. Those with a specific dietary requirement were provided with appropriate food. People had access to external health services and professional involvement was sought by staff when appropriate to help maintain good health.

Staff showed kindness and compassion and people's privacy and dignity were upheld. People were able to spend time on their own in their bedrooms and their personal care needs were attended to in private. People took part in a variety of activities that interested them. People's relatives and visitors were welcomed and there were no restrictions of times of visits.

Documentation that enabled staff to support people and to record the care they had received was up to date and regularly reviewed. People's preferences, likes and dislikes were recorded.

A complaints procedure was available for any concerns. This was displayed at the service. No complaints had been received, but the registered manager and staff had received many letters complimenting them on the care they provide to people.

Staff and the provider undertook quality assurance audits to ensure the care provided was of a standard people should expect. Any areas identified as needing improvement were attended to by staff. People, relatives and associated professionals had been asked for their views about the care provided and how the home was run. Regular resident and relatives and staff meetings took place.

Interruption to people's care would be minimised in the event of an emergency. The provider had Business Continuity Plan that detailed how staff would manage the service in the event of adverse incidents.

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.

Staff were knowledgeable about the process to be followed if they suspected or witnessed abuse.

There were sufficient staff deployed at the home to meet people's needs.

Risks to individual people had been identified and written guidance for staff about how to manage risks was being followed. People were kept free from infection because staff understood the infection control processes to prevent cross infection.

Accidents and incidents were recorded and monitored by staff at the home to help minimise the risk of repeated events.

The provider had carried out full recruitment checks to ensure staff were safe to work at the service.

People's medicines were managed, stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and had opportunities to meet with their line manager regularly.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance.

People's nutritional needs were assessed and individual dietary needs were met. People could choose what they ate.

People had involvement from external healthcare professionals and staff supported them to remain healthy.

Is the service caring?

Good

The service was caring.

People's care and support was delivered in line with their care plans.

People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

Staff respected people's privacy and dignity and made them feel that they mattered.

Is the service responsive?

Good

The service was responsive.

Where people's needs changed staff ensured they received the correct level of support.

Activities were appropriate to the needs of people and they were able to take part in activities that interested them.

Information about how to make a complaint was available for people and their relatives

People received good end of life care that ensured their final days were peaceful and dignified.

Is the service well-led?

Good

The service was well-led.

People and their relatives had opportunities to give their views about the service.

Staff felt well supported by the manager.

Staff met regularly to discuss people's needs, which ensured they provided care in a consistent way.

The provider had implemented effective systems of quality monitoring and auditing.

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

The inspection took place on 21 November 2017 and was unannounced. This was a comprehensive inspection carried out by two inspectors, a specialist nursing advisor 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.

Before the inspection we reviewed the information we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law.
We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with two people who lived at the service and three relatives. We spoke with the Director of Operations, the manager, two registered general nurses (RGN), six staff and the chef. We looked at the care records of six people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at five records relating to staff recruitment, support and training. We also looked at records used to monitor the quality of the service, such as the provider's own audits of different aspects of the service.

Good

Is the service safe?

Our findings

At our last inspection of August 2016 we found that the provider did not have effective medicines management systems in place, there were gaps of signatures on the medicine administration records (MAR) sheets and there were no written PRN (this is medicines that were to be given 'when required.') protocols for medicines when needed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the provider had addressed our concerns and was meeting the legal requirements of this Regulation.

Medicines were administered, recorded and stored safely. People and their relatives told us they always received their medicines on time and they had not experienced any concerns in relation this. Records were in place to ensure that people received their medicines as prescribed by their GP. We observed that only the registered general nurses (RGN) administered medicines to people and records showed that they had training and their competence had been assessed. We observed that the correct procedures had been followed when administering medicines and signing the Medication Administration Records (MARs).The MARS sheets were up to date and had been properly completed. Homely remedies were available as required. PRN medicine protocols were in place for those people who required them. This showed us that people could be assured they received their medicines as prescribed by their doctor. Staff told us that they had learned from the issues identified at the last inspection and they had worked together to make improvements in these.

People felt safe living at the home. People and their relatives were very complimentary about the care provided by staff. One person told us, "I feel absolutely safe here." Another person told us, "Oh I do, yes, I do feel very safe." Relatives told us that their family members were safe living at the home. One relative told us, "We walk out of here feeling that mum's safe and they [staff] care".

People were protected from abuse because staff understood their roles in keeping people safe. Staff had a good understanding of the procedures to follow should they witness or suspect abuse. The staff told us they had undertaken adult safeguarding training within the last year and records maintained confirmed this. Staff were able to correctly identify categories of abuse. They understood the correct safeguarding procedures to follow should they suspect or witness abuse. Staff were aware that a referral to an agency, such as the local Adult Services Safeguarding Team could be made, in line with the provider's policy. One staff member told us, "I would tell the manager if I thought someone was being abused." The provider had a detailed safeguarding policy that provided guidance to staff about the types of abuse and the reporting procedures to be followed. It also provided the contact details for the local multi agency safeguarding hub (MASH) so staff, people and visitors could contact them if they had not felt the appropriate action had been taken by the management team at the home. Staff told us they had read and understood this policy. During our inspection, one person told us about an incident in which they alleged they'd received verbal abuse from a member of staff. We discussed this with the manager who immediately took action and followed the provider's procedures and made a referral to the local authority safeguarding team.

Risks to people's safety were identified and control measures implemented to keep them safe. Staff were

aware of the risks and the appropriate actions to be taken to protect people to keep them safe. Risk assessments were in place and included moving and handling, falls, waterlow, skin integrity and bed rails. For example, one person was at risk of developing pressure sores. We noted that the risk assessments had been made concerning the person's skin integrity, in addition to possible contributory factors, such as mobility, continence, nutrition and hydration. The person had been placed on an air mattress, the pressure of which was calibrated and regularly checked. The staff were knowledgeable about this person and their care requirements.

Interruption to people's care would be minimised in the event of an emergency. The provider had Business Continuity Plan, which was up to date and accessible. It contained detailed and relevant information concerning the safe management of adverse events such as fire, flood, staff shortages and power cuts. These included emergency contact numbers and alternative accommodation arrangements.

The premises were not purpose built and as such presented significant difficulties in evacuating people in the event of an emergency. Individual Personal Emergency Evacuation Plans (PEEP) were written and kept in people's care plans and in the manager's office. These outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood. The provider's Business Continuity Plan contained detailed and relevant information concerning the safe management of adverse events such as fire, flood, staff shortages and power cuts. These included emergency contact numbers and alternative accommodation arrangements.

People were supported by sufficient numbers of staff. The home comprised of two units and the main house. The main house had three floors and each unit had two floors. A dependency tool was used monthly to calculate staffing numbers. The manager told us that three RGNs and nine care staff on duty each shift during the day and three RGNs and two waking night staff each night. These staffing numbers were confirmed through discussions with staff, looking at the duty rotas and our observations. Staff told us there were enough staff on duty to provide safe and effective care. One staff member said, "Yes, definitely enough staff. If we don't have enough, the manager will always get agency staff." Another staff member told us, "I have enough time to spend with people. I can laugh and joke with them; it's no problem." A third staff member said, "Yes, I do spend time with people. Sometimes it's busy in the mornings but there is enough time in the day."

When people had accidents or incidents these were recorded and monitored by the registered manager. Records of accidents and incidents were detailed and included the action staff had taken, the outcome and any lessons learned. For example, documentation related to falls, accidents and incidents. These were accurately recorded and subject to monthly audits. They contained detailed information concerning the frequency, time and place of incidents, in addition to staff actions. The audits enabled the provider to identify trends with a view to reduction or prevention. There was also detailed action planning in the documents, outlining a decided course of action and a named member of staff to carry it out. For example, a new body map for staff use had been designed to allow staff to indicate bruising as well as skin breakdown in care plans.

People were protected from the risk of infection. The environment was very clean and tidy there were no malodours at the home. Staff used personal protective clothing (PPE) which they changed after they had attended to each person's personal care. Domestic staff told us that they had undertaken training in regard to infection control and were aware of the procedures to help prevent the spread of infection. Staff told us they had undertaken training in infection control and were aware of their responsibilities in this regard. There was detailed infection control policy that staff told us they had read.

Good

Is the service effective?

Our findings

At our last inspection of August 2016 we found that the provider did not meet the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that the provider had addressed our concerns and were compliant with this Regulation.

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 procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and we found that any conditions to authorisations to deprive a person of their liberty were being met. Best interest meetings had been undertaken with relevant parties and referrals for DoLS authorisation had been applied for when necessary. These were 'decision specific' and outlined clearly why authorisation was being sought. Staff were knowledgeable about the MCA and the processes to be followed. They were aware that they had to assume that people had the capacity to make their own decisions unless they were assessed otherwise.

People and their relatives spoke positively about staff and told us that they believed staff were skilled to meet people's needs. One person told us, "Staff know what they are doing and they are trained appropriately to carry out their roles." Another person told us, "Staff are very good, they do know what they are doing."

People were supported by trained staff who had sufficient knowledge and skills to enable them to provide effective care for people. Staff told us they had the training and skills they needed to meet people's needs. Staff told us about their experience of induction when they first arrived to work at the home. One member of staff told us, "It (induction) was very good. I did training and it lasted two weeks. I worked with other staff until I felt comfortable to work on my own." Another member of staff told us, "The training is good here." The provider told us in their PIR that staff had received the mandatory training as required and we found this to be the case. The training record provided to us confirmed that staff had received training in areas such as moving and handling, food hygiene, infection control and safeguarding. Other training had included equality and diversity, choking and prevention and dementia.

People were able to discuss choices and preferences in regard to their treatment, support and care. Pre-admission assessment processes were being followed prior to admission and this was confirmed during discussions with relatives. People and their relatives confirmed they had been involved in care planning. Staff had a good understanding of people's needs and how they preferred staff to support them. For

example, one person required a percutaneous endoscopic gastrostomy (PEG) feed. This is an endoscopic medical procedure in which a tube is passed onto a person's stomach to provide a means of feeding. The RGN was very knowledgeable about this and we then observed them undertaking this process. The RGN was very kind and caring throughout the procedure and talked with the person the whole time, telling them what was happening and just having a general conversation with them. Although the person was unable to verbally communicate back, they responded with positive vocalisations.

People were supported by staff that had supervisions (one to one meetings) with their line manager. Staff told us that they had regular supervisions and an annual appraisal. One staff member said, "Yes, I can always speak my mind in supervision." Another member of staff told us, "The communication is good here. The new manager is very approachable." Records of supervisions and appraisals were maintained. Topics discussed included training, self-assessments, constructive feedback and learning objectives.

People were supported to ensure they had enough to eat and drink to keep them healthy. People's dietary needs and preferences were documented and known by the chef and staff. . The chef was aware of people's preferences and kept a record of people's likes and dislikes. For example, people who had swallowing difficulties had pureed food. The pureed food was served in different colours to depict the different types of food. For example, meat, broccoli, carrots and mashed potatoes. The chef produced a four week menu and choices were available for each meal. People told us they were happy with their food and there was always a choice of meals on the menu. One person told us, "The food is good here." We observed lunchtime and noted that care staff sat with people and supported those who required 1-to-1 help with their meals. People were given choices and were supported with their meals in a dignified way.

People's weights were checked and recorded monthly within the care plans. Care plans and the MARs included evidence of interventions by dieticians and GP's that ensured that when there were concerns regarding weight this was addressed with supplements in a timely way.

People were supported by staff who worked well with other organisations to deliver effective care and ensured that people's healthcare needs were met. Care plans had records of regular meetings and consultations with people's GP, Dietician, Tissue Viability Nurse and Hospital Consultants. The RGNs spent time with people and worked with care staff that ensured that their care, treatment and support was provided as recorded in the care plans.

People lived in an environment that that was been adapted to meet their needs. All equipment used at the home was serviced in line with the manufactures guidance to ensure they remained in a good state of repair and were safe for people to use. Signage to assist people with visual and cognitive impairment had been added in a subtle way that enabled people to navigate their way around the home. The home had a quiet lounge that had been adapted and furnished as a reminiscence room.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People told us that staff were kind, caring and respected their dignity. People were relaxed and conversing with each other and with staff in a friendly manner. One person told us, "The staff at Kingswood are competent, thorough, good humoured and good natured". Another person said, "Yes, there's some `standouts' of staff here." Relatives spoke in glowing terms regarding the high level of care that their family members had received at Kingswood Court Care Home. One relative told us, "Staff are so kind. When we need someone to talk to or give us a cuddle or even to have a cry they're here. They treat [family member] with so much dignity and kindness."

People felt empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skills and experience to manage situations as they arose and meant that the care given was of a consistently good standard. Staff were attentive to people throughout the day, they stopped to chat with people and asked if they were okay. The interaction between staff and people was really positive. We observed care to be safe and appropriate with adequate numbers of staff present. There was good, positive interaction with people and staff consistently asked permission before they assisted people. There was a high level of engagement between people and staff.

People's privacy and dignity was respected by staff. Staff told us that they ensured all personal care was undertaken in the privacy of people's bedrooms with the doors and curtains closed, which matched our observations on the day. We also observed staff knocking on people's doors and waiting to be invited into their rooms. Staff were respectful and kind to people living at the home. We observed many instances of genuine warmth between staff and people.

Staff told us that people were encouraged to be as independent as possible. Staff said that they encouraged people to wash themselves but they would support people as and when required. For example, one person was finding it difficult to hold their cup of tea. A member of staff said, "what have you got to drink? Can I help you with it?" The person responded and declined the offer of help and persevered to drink independently. The member of staff sat with the person to make themselves available to provide support if the person changed their mind.

There was a calm and inclusive atmosphere in the home. The staff we spoke with were knowledgeable about the people they were caring for and were able to explain to us people's individual needs and requirements. We asked staff if they thought the home was a caring place. One staff member told us, "I wouldn't work here if it wasn't." Another staff member said, "It definitely is. I think it is very caring and people are very well looked after."

Care plans and risk assessments were reviewed regularly by staff. Records of contact with family members were kept and people or their representatives were involved in the care planning and reviews. One relative told us that they were fully involved in the planning and reviewing of their family member's care. They said, "I couldn't wish for more to be done."

Good

Is the service responsive?

Our findings

Staff were responsive to people's needs. People, due to their memory problems, could not recall if the had a care plan, however relatives told us they were involved with the writing and reviewing of their family member's care plans. Care plans had been produced from the pre-admission assessments, were person centred and reviewed on a monthly basis. The care plans contained detailed information about people's care needs and actions required in order to provide responsive care. Staff were knowledgeable about people's needs and how to attend to them. For example, one member of staff was able to describe a person's eating needs. They told us that the person required a dish with a wide lip that helped to keep the bowl stabile whilst the person ate independently. We observed this during our visit. A relative told us that staff responded well to their family member's needs, they told us, "Nothing is too much trouble. My [family member] has been cared for in bed for several years now and I've never known them to have any bed sores." Other information in people's care plans included information about people's choices and preferences, social histories and how people preferred their needs to be met. It was possible to 'see the person' in care plans.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. Care plans contained advanced wishes and an end of life plan and many of the MAR sheets had the medicines that would be required in place. The RGNs were knowledgeable about end of life care. The provider was not working to a recognised end of life care accreditation system; however they worked closely with the team from the local hospice.

During our visit one person told an RGN that they were in pain. The RGN was able to assess what was causing the pain and asked the person if they would like some pain relief. This person said yes and this was administered to the person without delay. The RGN monitored the person through regular checks to ensure they were pain free.

People told us that there were activities they could take part in, however they were concerned that there no external outings were arranged. One person said, "Can't we have some arrangements to go out." Another person told us, "I would like to go out." The activity coordinator was aware of this and told us that they were planning for trips out of the home in the future.

People had a range of activities they could be involved in.There was an activity coordinator employed at the home. Daily activities took place for people to take part in and included people's interests and hobbies. For example, reading, flower arranging, music, films of people's choice and seasonal activities. There was a reminiscence room at the home that included games, toys and objects from the past that could help people to relate to. The director of operations told us that this room was used five times a week and helped people with dementia remember things from their past. For example, they provided a theme based on the seaside and had old suitcases and toys such as bucket and spade. This helped people to remember about packing their suitcases and recall their journeys to the seaside for their school holidays. We noted that one-to-one activities took place for people who chose to stay in their bedrooms due to their healthcare needs. This

meant that people were not at risk of isolation.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been three complaints since the last inspection and these had been investigated thoroughly and the outcomes were clearly recorded. Staff were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures. Staff told us that complaints were discussed during staff meetings so they could learn from them. People and their relatives told us they knew how to make a complaint.

Good

Is the service well-led?

Our findings

People and their relatives told us they thought that the service was well led by the new manager. The manager had been in post for seven weeks. Comments from people and relatives included, "I'm absolutely confident in this new manager," "As far as I can see the new manager is highly qualified and motivated, and she not only has the credentials but the manner and personality to go with it," and, "I have full faith in the nursing staff and care staff."

Staff told us that they thought the new manager was leading the team in a professional manner. One member of staff told us, "We all work as a team and give good care. The manager is always around." Another staff member said, "The manager is new. We have had some who didn't stay before. I hope this one will; she is very good."

The service promoted a positive culture. There was a staffing hierarchy at the home and all staff knew what their individual roles were and the duties they were to perform. The provider had a set of values that included providing person centred care, promoting people's privacy, dignity and independence and to respect people's right to live a full and active life as possible. We observed staff working within these values throughout the day. For example, we observed staff knocking on bedroom doors and waiting for people to respond before walking into their rooms. Staff would not just do things for people, they allowed people to do as much as they were able to before they asked if they would like some help.

Quality assurance systems were in place to monitor the quality and running of service being delivered. Audits were undertaken by the provider. We noted a wide variety of these were in place, used to give an overview of the running of the home to the manager. There were up to date and relevant audits in the areas of infection control, dignity, choice and independence, care planning, falls, accidents and incidents in addition to medicines management and a monthly quality assurance assessment by the provider's director of operations. Information from these audits informed the provider's quality assurance action plan. We looked at the latest of these, dated 6 November 2017. We noted information gathered was analysed, with a view to finding areas for improvement. This led to an action plan which contained timelines and a nominated staff member to ensure its prompt completion. The provider kept a record of call bell response times and subjected them to regular audit.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. We looked at a range of surveys carried out to gauge the views of people and their representatives. A satisfaction survey was conducted by way of questionnaires sent to people living at the home in July 2017. It revealed a high level of satisfaction, particularly in the timing and quality of care, in addition to staff attitudes.

A separate survey conducted in September 2017 asked people their opinion of care given by night staff. The findings were similar, with in excess of 90% happy with care, particularly in the promotion of dignity and respect. People were also happy with the maintenance and decoration of the home, food and drink and the promotion of people's independence. In addition to this, regular residents meetings were held. We looked at

the minutes from the meeting of the 15 August 2017. We found evidence that people were able to influence the day to day running of the home and suggestions made were considered and acted upon.

The provider sought the views of relatives and representatives through the use of surveys. The latest of these, published in April 2017 revealed a 97% satisfaction rate with the quality of care; the same figure felt involved in affairs related to the running of the home. In addition, meetings were also held for relatives and representatives to attend. We noted these were well attended and issues such as catering, decoration of the home and internet access were discussed with actions agreed.

The provider and staff worked with other related agencies that ensured people received joined up care, treatment and support. Records maintained at the home evidenced that staff work closely with the local safeguarding team, adult social care teams and all healthcare professionals. For example, GPs, occupational therapy, physiotherapy and dieticians.

The provider was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. Notifications had been received in a timely manner which meant that the CQC could check that appropriate action had been taken.