Grandcross Limited

Kingswood Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service because we had received some information of concern and we wanted to investigate this. We have only looked at the areas of Safe, Effective and Responsive as the concerns sat within these areas.

This report only covers our findings in relation to these specific areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Kingswood Court' on our website at www.cqc.org.uk.

Kingswood Court Care Home is a care home with nursing for up to 66 predominately older people. At the time of this inspection the service was supporting 53 people . The service had a registered manager who had worked at the home for 4 months. 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 and associated Regulations about how the service is run.

At this inspection we looked at risk assessments, staffing levels, protecting people from harm and abuse, staff training and the nutritional needs of people. In addition to this we looked at people's care plans and whether these were person centred and whether staff were providing care in a manner which maintained people's dignity and respect. We also looked at whether there were sufficient activities for people and if complaints had been dealt with appropriately.

Improvements were required with how risk assessments were recorded and how risks to people were managed. The use and training of agency staff required reviewing. This was to ensure people received care which was safe, from staff who knew them well and the potential for risks being mismanaged was reduced.

Improvements were required with how the service trained staff to ensure they were aware of what the provision of person centred care entailed and to ensure people were supported in accordance with their preferences. We found people had sufficient levels of food and drink and had choice as to what they wanted to eat at meal times.

Improvements were required to ensure people's care files were complete and contained relevant information which was current to enable staff to fully understand people and provide a high level of person centred care to meet their needs. Improvements were required to ensure staff fully understood what is meant by dignity and respect and enable them to provide a service where they maintain people's dignity and respect. Improvements were required to ensure activities were suitable and people found these to be fulfilling. We looked at the complaints procedure and felt this was appropriate.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements were required to ensure everyone's risk assessments were up to date and actions identified in the risk assessments were undertaken by staff.

Improvements were required to ensure the number of staff available were sufficient to respond to people's needs.

Improvements were required to ensure agency staff were suitably skilled to support people and had a good level of knowledge of people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received any training around person centred care.

People had sufficient to eat and drink.

People appeared to have a choice of meals and desserts at lunchtime.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support which was personalised to their specific needs. This also meant people were not always treated with dignity and respect by staff.

Complaints had been managed appropriately.

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 was carried out to check on information we had received and to see if the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also checked the overall quality of the service, and reviewed the rating for the service under the Care Act 2014.

We undertook a focused inspection of Kingswood Court on19 October 2016. We inspected the service against three of the five questions we ask about services: is the service safe, effective and responsive. The inspection was undertaken by two adult social care inspectors.

We spoke with 14 people who lived at Kingswood Court and six members of staff as part of the inspection. We also spoke with the registered manager and looked at the care records of ten people living at Kingswood Court. We spoke with four social care professionals to obtain their views on the service.

Requires Improvement

Is the service safe?

Our findings

At our last full inspection of this service in April 2015 the service was rated as good in this area. We had looked at how the service protected people from being harmed or abused, how they managed any risks to people's health and welfare, whether sufficient staff were employed and how medicines were managed.

Professionals we spoke with prior to the inspection had raised concerns regarding the accuracy of people's risk assessments. They informed us that where people required their weight or skin condition to be monitored, the appropriate documentation was not always completed to indicate this had been done.

At this focused inspection we have found that although some people had risk assessments in place, this was not the case for everyone. We could not be satisfied that where risks were identified, appropriate action had been taken to minimise these risks. For example, a number of people had been identified as being at risk of malnutrition and their weight needed to be monitored on a monthly basis. However, when looking at their records, there were a number of gaps in their weight monitoring. A number of people's records which we reviewed showed people had not been weighed for a number of months.

One person's care file identified that they were at risk of developing pressure sores and skin breakdown. Their risk assessment required a monthly review of their skin condition and pressure relieving equipment. However, when we looked at the records, no review had been completed in five of the past 12 months.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

It was evident from speaking with people living at Kingswood Court that there was an increased use of agency staff. The staff we spoke with also confirmed there was an increased use of agency staff due to shortages of staff. People told us they felt this had compromised their care needs being met and one person told us they did not feel safe with the increased use of agency staff. A number of people living at Kingswood Court and members of staff told us they felt the increased use of agency staff had a negative impact on the provision of individual and personalised care.

It was evident from our observations that people's requests for support were not always met in a timely fashion. For example, we observed one person calling out for help for approximately 10 minutes and no staff were available to support them. When we heard their calls, we tried to locate staff on the floor and could only find one member of staff available at that time. We also heard a number of people using their call bells to request support and these were not always responded to in a timely manner. A number of people we spoke with confirmed to us they had to wait for a significant amount of time before their call bells were answered.

The professionals we spoke with also confirmed the use of agency staff was impacting on the quality of care provided to people. For example, one professional told us how they had been in to visit a person living at Kingswood Court to review their care assessments and it was difficult for them to locate a member of staff

who knew this person's needs well. The professional informed us they did not have confidence that staff knew people's needs as well as they should.

We discussed the staffing difficulties with the registered manager who informed us they were aware of the problems and were running recruitment campaigns so that they could appoint permanent members of staff. The registered manager informed us one particular challenge was the recruitment of appropriately skilled staff to the advertised posts. The registered manager informed us the recruitment campaign would continue until they had recruited staff to all of the available posts. These vacant posts included roles for care staff and an activities co-ordinator.

The lack of staffing also resulted in very little stimulation for people. We observed during the morning of the inspection, a number of people were sat in the dining room but had very little stimulation. Some music was being played but when the CD ended, no staff were available to change the CD. We observed staff coming in to offer drinks to people but other than this, there was very little communication between staff and people. This resulted in people sitting around looking at each other without any stimulation. From our observations, people appeared to be bored and not interested in what was happening around them as a result of a lack of stimulation.

We recommend the provider reviews its process for new and agency staff to ensure staff are aware of people's needs so that they can provide personalised and safe care.

The provider had implemented a robust safeguarding procedure in the home. Staff were aware of their roles and responsibilities when identifying and raising safeguarding concerns. The staff felt confident to report safeguarding concerns to the registered manager. Safeguarding procedures for staff to follow with contact information for the local authority safeguarding teams was available. Staff had received training in safeguarding. Safeguarding issues had been managed appropriately. One relative we spoke with informed us they felt confident the staff 'knew what to do' if they had any concerns regarding their parent.

The rating for this key question has been revised from Good to Requires Improvement because of the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At our last full inspection of this service in April 2015 the service was rated as good in this area. We had looked at staff training and how staff were supported, how the service complied with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We had also checked that the service met people's food and drink requirements and ensured their healthcare needs were met.

At this focused inspection, we have only looked at staff training and whether people's nutritional needs were being met.

It was evident from our observations and from speaking with staff that there was a lack of training and knowledge around person centred care. When we spoke with the registered manager, they informed us no staff had received any training around person centred care at the time of the inspection. Not all staff had received training around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager confirmed this had only recently commenced for care staff.

The lack of staff training around person centred care was evident in their approach to supporting people. For example, there were people in one of the dining rooms who were sat around a table in wheelchairs. We observed that staff did not ask any of these people if they would like to transfer to a chair to have their meal and assumed they preferred to remain in their wheelchair. When we looked at the records of these people, one person's care plan clearly stated they were able to transfer and should be supported to move over to a chair at lunchtime. However, from our observations it appeared staff were unaware of this and did not take time to ask this person what their preference was.

In another dining room we observed a number of staff who were unaware of which people they were supposed to support to come down to the dining room. We observed one member of staff saying to a colleague "I don't know who is meant to come down". There was a general sense of confusion and disorganisation in this staff group until another more experienced member of staff arrived after approximately 15-20 minutes who was then able to direct the staff appropriately. One person who ate their meals in their room had not been served by 1:40pm whereas lunch had started being served at 12:30pm. By this time, other people had all been served their lunch. When we enquired, they informed us they had requested a salad but this had not arrived. When we enquired from the staff, they informed us they had forgotten about this person's request.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People's daily records detailed what meals and drinks they had during the day. The daily notes also recorded how much of their meal people had consumed. We observed people having a choice of meals and desserts at lunchtime. People we spoke with informed us they liked the food at Kingswood Court. One person we spoke with said "I like the food. It is good and I get a choice". Other people we spoke with also commented on how they felt the meals served at Kingswood Court were of good quality.

The rating for this key question has been revised from Good to Requires Improvement because of the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

At our last full inspection of this service in April 2015 the service was rated as good in this area. We had looked at how people received personalised care that was responsive to their needs and how the service listened to them and took account of their views and experiences.

At this focused inspection we have looked at people's care plans and whether these were person centred, whether staff were providing care in a manner which was respectful towards people and maintained their dignity and whether there were sufficient activities for people. We also looked at whether complaints were dealt with appropriately.

The registered manager informed us the provider had introduced a new format for people's care files in the past 12 months which would make them more person centred and easier to access information about people. When looking at the care records we found that although the format used lent itself to a holistic approach to care, a lot of the sections were either incomplete or blank. For example, some people's end of life care preferences; their preferences in relation to their social needs or their emotional needs were not recorded. Each care file contained a 'My journal' book at the start which was meant to be used to record what activities people had engaged in as well as their changing interests. We found a number of these had not been completed or had not been updated to reflect peoples changing needs.

Each care file contained a 'My choices' page which was used to record people's personal preferences but these were either incomplete or blank. We also found where people's preferences had been recorded on the 'My choices' page, this was not mentioned anywhere else in their care plan. For example, one person's record stated they found prayer to be 'comforting and helpful' but there was no mention of this anywhere else in their care file.

When looking at the care files, we observed that where people had been diagnosed with specific health conditions such as dementia, asthma or diabetes there was no care plan around how to manage these conditions. This meant there was a risk of people not receiving care appropriate to their personal circumstances.

We found it was not always easy to find relevant information easily in the care files. We felt a lot of information could be archived in order to reduce confusion or things potentially being missed. A number of staff we spoke with informed us they found it hard to find relevant information within the care files and felt the files would benefit from a summary section of people's needs. Some staff informed us they did not always have time to read people's care files and as a result they felt they could not always provide a good level of person centred care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care.

It was evident from our observations throughout the inspection that there were some aspects of care where

people were not treated with dignity and respect. For example, during lunchtime we observed one member of staff supporting a person with their meal. Whilst this person was sat, the member of staff remained standing throughout whilst they supported this person with eating. Another member of staff referred to people who required support with their meals as 'feeds'. We observed another member of staff blowing on a person's food when supporting them to eat without asking them if this is what they wanted to be done.

We observed another incident where a person who was supported in bed had been incontinent in and it was clear their clothing and bedding was wet. However, when a member of staff went into this person's room to give them their meal, they did not offer to support this person to change their clothing or bedding. In another room, a person had been left without their trousers on. When we went to speak to this person, they informed us their legs were cold. We offered this person a blanket which they accepted. When we raised this with staff they were unaware the person had been left in this state.

People who received their meals in their rooms informed us they were served their mains and pudding at the same time. One person stated "I'm not sure which one I should eat first as they will go cold". This was done consistently for all of the people who received their meals in their rooms. When we offered to put the pudding back in the heated trolley for a couple of people they accepted this. Following this, we requested the staff to go around to people's room and ask them if they wanted their pudding to be put back in the heated food trolley.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.

There were a number of activities taking place in the home such as bingo, darts, exercise, music and skittles. We received mixed feedback regarding activities. Some people living at Kingswood Court and their relatives informed us they found the activities to be stimulating and felt they had sufficient activities. However, other people who were unable to attend communal areas informed us they did not always receive support to engage in activities in their room and stated they had very little to do. Some other people who were able to attend the activities informed us they found the activities to be boring. A number of professionals also informed us they felt there could be more activities for people. The registered manager informed us they only had one activity co-ordinator in post and were recruiting to employ another activity co-ordinator. The registered manager also informed us they were developing plans which would see more activities being introduced for people in the home.

There was a complaints policy in place which contained a detailed procedure for managing complaints. Where complaints had been made, we were shown evidence that these had been addressed and resolved to a satisfactory conclusion.

The rating for this key question has been revised from Good to Requires Improvement because of the breach of Regulation 9 and Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans contained a lot of sections which were either incomplete or blank. People's preferences in relation to their support were not always recorded. Care plans did not provide staff with guidance on supporting people with specific health conditions. Regulation 9 (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care staff did not always maintain people's dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Although some people had risk assessments in place, this was not the case for everyone. We could not be satisfied that where risks were identified, appropriate action had been taken to minimise these risks. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received training around person centred care. This meant they were unable to provide support to people, which was specific to their individual needs and preferences. Regulation 18 (2) (a)