Firstsmile Limited

Kibworth Court

Inspection report

Kibworth Court Residential Care Home
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Date of inspection visit:
23 June 2021
02 July 2021

Date of publication:
13 September 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Kibworth Court is a residential care home providing accommodation and personal care to 29 people aged 65 and over at the time of the inspection. The service can support up to 45 people accommodated over two floors.

People's experience of using this service and what we found
The service did not have robust systems and procedures in place to ensure the quality and safety of the service was maintained.

The safety, equipment and cleanliness in several people's bedrooms placed them at risk of infection including COVID-19. There was not enough staff to ensure the required cleaning and maintenance of bedrooms was undertaken frequently enough.

Environmental safety concerns were found in communal areas. A cupboard and hair salon were not secured. These rooms presented risks to people's health because of the products contained within them and their poor state of repair.

The provider was responsive to our concerns and took immediate action to address the concerns we identified.

People and relatives had not been offered opportunity to feedback on the quality of the service. Relatives were not always involved in the development and review of their relatives' care needs.

People, their relatives and staff were complimentary about the registered manager who listened and communicated well with them.

Whilst several relatives raised concerns over staffing levels, we found there were enough experienced and qualified staff to safely meet people's personal care needs, which were assessed and monitored well. Where people's needs changed, prompt action was taken to ensure their health and well-being were maintained.

People were supported by safely recruited staff who were kind, considerate and knew them well. Staff understood and recognised signs of abuse, and how and who to report any concern to.

People received their medicines when they needed them, and accidents and incidents were reported and acted on.

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 good (published 3 January 2018)

Why we inspected
The inspection was prompted in part due to concerns we received in relation to safe care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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.

Whilst we found no evidence to support the concerns, we received prior to the inspection we did find concerns in other areas of the service during our inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kibworth Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches of regulation in relation to infection control, environmental safety and the governance arrangements at this inspection. We issued the provider with a warning notice relating to governance arrangements in place. Please see action we have told the provider to take at the end of the report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Kibworth Court

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 Care Act 2014.

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 undertaken by two inspectors 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.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. 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 took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and nine relatives about their experience of the care provided. We spoke with 11 members of staff including the two directors, the registered manager, senior care workers, care workers and the chef and domestic staff. We also spoke with a visiting social worker.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Not all infection prevention and control (IPC) practices were effective. We saw several mattresses, pressure cushions, bedding and wheelchairs were dirty and stained. This meant people were not protected as far as practicably possible from the risk of infection including COVID-19.
- People were not always protected from the risks associated with the environment. There was unrestricted access to a cupboard and hair salon.
- The roof space and electrical wiring from the light in a cupboard were both exposed, and alcohol and an unidentifiable liquid in a pressure sprayer were stored. The hair salon contained products potentially harmful to people's health if ingested, and the surrounding area to an electrical socket had marks surrounding it suggesting a liquid spillage had occurred.
- Wardrobes were not secured to the walls in several people's rooms. A bedroom radiator cover was not attached to the wall and could be removed if pulled, meaning that there was a risk there could be exposure to a hot radiator if not properly secured. There was an unsecured access panel in one person's bedroom leading to a decommissioned laundry chute. The risks identified in these rooms placed people at risk of harm.
- Three pressure mattresses and cushions were worn and degraded. We undertook a hand compression test on one person's mattress to test its integrity. The bed frame could be felt through the mattress which indicates the mattress was no longer fit for purpose and should be condemned.
- Lessons were not always learnt when things went wrong. When shortfalls in infection control procedures were identified by the registered manager and provider, their action plan to make the required improvements were not fully implemented or monitored effectively. This meant the shortfalls remained and people remained at risk.

We found no evidence that people had been harmed, however, robust arrangements were not in place to ensure all aspects of infection control and environmental safety were safely managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. All the concerns we found were addressed; equipment was either replaced or effectively cleaned and the environment made safe.

- Risks to people's individual health and wellbeing were assessed, managed and regularly reviewed. People's care plans contained detailed information on how staff should manage risks specific to individuals.

Staff were able to tell us what support people needed to reduce the risk of avoidable harm in relation to people's health and wellbeing.

Staffing and recruitment

● Not enough staff were deployed to ensure people's bed linen was changed when needed. Whilst domestic staff were responsible for the majority of cleaning, the care staff were tasked with changing people's bed linen. One staff member told us, "Although we have enough time to support people with their care needs, having to change people's bed linen as well is an issue."

● Care records showed there were vast differences in timeframes between people's bed linen being changed. For example, one person had no recordings for the previous 23 days to our inspection and another person had 18 recordings. This meant the service did not effectively deploy enough staff to ensure all domestic duties were undertaken when required.

● Several relatives raised concerns over staffing levels. One relative said, "There aren't enough staff. Staff are stressed out and worn down. They seem to be busy all the time." Another relative told us, "They all seem to be busy and probably could do with more staff." Despite relatives' feedback we observed people's care needs being met in a timely way.

● Following the inspection the provider told us all cleaning would be now undertaken by domestic staff. They placed an advert for a 'Head Housekeeper' on a recruitment website to increase the staffing level and ensure there was day to day oversight of cleanliness of the service.

● Staff were recruited safely. For example, Disclosure and Barring Service (DBS) checks and previous employer references were obtained. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● The service had safeguarding and whistleblowing policies in place. There was information on notice boards relating to safeguarding and whistleblowing processes. Records showed safeguarding concerns were reported to the local authority and CQC.

● Staff had received safeguarding and whistleblowing training and knew how to identify potential signs of abuse and report their concerns. Staff said they were confident if they raised a concern they would be listened to.

● All relatives we spoke with told us their family members were safe. One relative told us, "[Name] seems quite happy and safe". Another relative said, "I have no reasons for any concerns about [Name]'s safety. The staff have the skills to keep [Name] safe."

Using medicines safely

● Medicines were managed safely. Medicine administration records (MAR) were in place, and people received their medicines as prescribed. One relative told us, "[Name] gets their medicines when they need them."

● We observed a medicine round and the correct procedures were undertaken. For example, staff locked the medicine cupboard between administrations and completed records after people had received their medication. This reduced the risk of misadministration and recording errors.

● When people were prescribed medicines 'as and when required' (PRN), the correct protocols were in place to inform staff when to administer these medicines. Most records confirmed when and why staff had administered PRN medicines.

● Staff were trained in the safe handling of medicines. One staff member told us, "I have attended medicines management and administration training, and had my competency assessed recently."

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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; Continuous learning and improving care

- Systems and processes to continually monitor the cleanliness of the service were ineffective. Shortfalls in cleanliness both the registered manager and provider previously identified remained. For example, their cleaning audit in May 2021 had identified shortfalls in cleanliness and a provider internal visit on 22 April 2021 reported 'standard of cleanliness in the service to be varied'. The report concluded 'this would affect the service's ability to evidence good infection control procedures. During the inspection we found bed frames, mattresses and linen together with wheelchairs and pressure cushions were worn and not cleaned to a satisfactory standard.
- Robust systems and processes were not in place to ensure environmental safety was monitored and maintained. Health and safety checks and audits had failed to identify the shortfalls we found during the inspection. This meant people were exposed to unnecessary risk.
- A cupboard and hair salon were unlocked and contained products potentially hazardous to people's health including a risk of electrocution from exposed wiring and/or water damage surrounding electrical sockets. Furthermore, we found wardrobes not secured to walls; a radiator cover fell off when inspected; and a panel to cover a decommissioned laundry chute was insecure.

We found no evidence that people had been harmed, however, systems and processes were either not in place or robust enough to demonstrate the quality and safety of the service was effectively monitored or managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A director told us they did not dispute some of our findings and were unaware of the shortfalls relating to these matters. They responded immediately during and after the inspection. They confirmed and provided evidence that demonstrated the shortfalls and associated risks identified had been addressed.

- Other audits of the service, including but not limited to, accidents and incidents, medicines and people's care plans and risk assessments were in place and effective.
- There was a registered manager in place who was registered with the CQC. All legally required notifications were submitted to CQC as required, and CQC's rating of performance was displayed at the location and the providers website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People's dignity was not always upheld due to the shortfalls identified in cleanliness of people's bedrooms.

● People were supported to choose how their care was delivered, and to remain as independent as possible by staff who knew them well. For example, people were encouraged to choose what they wore, when they wished to get up and go to bed, where they ate and who with and what activities they wished to participate in. One person preferred their relative to wash and style their hair and they told us the registered manager supported this.

● Staff treated people with kindness when supporting them with their care needs. For example, people and relatives used 'kind', 'cheerful', 'attentive', 'friendly and enthusiastic' to describe staff. One relative told us, "They [Staff] chat with [Name] and give them privacy when showering and using the toilet by discreetly keep an eye on them to ensure they are ok." Another relative told us, "Staff respect [Name) choices. If they refuse care, they do not force them but try again later. Staff contact me If this persists and we work together to try and improve things and I am welcomed into the home to support [Name] too."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● None of the 11 relatives we spoke with said they had been given opportunity to formally feedback their views of the quality of the service, however, the majority told us they would recommend the service and could contact the registered manager when they needed to.

● We received mixed feedback from relatives on their involvement with their family members care needs. One relative told us, "I'm not aware of a written care plan nor has a discussion took place with any of the family." Another relative told us, "[Name] has a care plan and it is discussed with me."

● All of the people and relatives we spoke with knew the registered manager, held a positive relationship with them, and spoke of how approachable and friendly they were.

● Staff told us the registered manager was supportive and listened to their concerns. One staff member told us, "I have supervision, and this helps me to talk about any mistakes made."

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 to be open and honest with people when things went wrong. A complaints policy was in place and openly displayed throughout the service.

● All the people and relatives we spoke with confirmed they had never raised a complaint but were confident if they did it would be taken seriously and investigated. One relative told us, "I've made no complaints. If I did, I think the manager would listen."

Working in partnership with others

● Staff had effective working relationships with professionals such as community nurses and GPs in order to improve people's outcomes and ensure they received holistic care. One relative told us, "They [Staff] have involved the district nurse when needed."

● Relatives told us the registered manager contacted health services promptly when concerns for people's health developed. A relative said the registered manager reported concerns about a person's diabetes to their GP which led to a diabetic specialist being involved in their care.

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 12 HSCA RA Regulations 2014 Safe care and treatment Robust arrangements were not in place to ensure all aspects of infection control and environmental safety were safely managed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not ensure systems and processes were either in place or robust enough to monitor the quality and safety of of the service.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant by 15 October 2021.