Amber ARC Limited

Kimberley Care Village

Inspection report

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Date of inspection visit:
28 February 2017
01 March 2017

Date of publication:
30 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 28 February and 1 March 2017 and was unannounced.

The home is registered to provide residential care for 68 older people or people living with a dementia. The home was split into four areas called The Willows, The Beeches, The Laurels and The Oakes. Two of the areas were specifically for people living with a dementia and had secure access so people could not leave independently. There were 54 residents living at the home on the day of our inspection.

There was a registered manager for 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 home is run.

We have made a recommendation about ensuring the audit system is effective.

Staff were supported to develop the skills needed to provide safe care. There were enough staff to provide person centred care for people during the day, however at night care became more task focused and did not fully support people. The registered manager had appropriate systems in place to ensure staff were safe to work at the home and staff had received training in how to keep people safe from abuse.

Most risks to people had been identified and care planned to keep people safe. However, people's care needs around their skin were not consistently recorded. While most medicines were safely managed there was a lack of consistency and recording around medicines prescribed to be taken as required. People were supported to access a choice of food and drink but people's fluid intake was not consistently recorded.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. The registered manage had made appropriate referrals to the DoLS authority for people who were unable to make a decision about where they lived. In addition staff supported people to retain their independence and make decisions for themselves. Where this was not possible they protected people's rights by using capacity assessment and best interest decisions in line with the MCA.

There were kind and caring relationships between people who lived at the home and the staff. Staff supported people to make choices about their everyday lives and to maintain their independence. People were supported with some activities but the registered manager had identified that this needed improvement and had taken steps to increase the activities available to people.

The registered manager was approachable for people living at the home and staff. They had taken steps to

improve the culture of the home so that staff were more confident in their roles and felt more able to raise concerns. People were happy to raise complaints and the registered manager dealt with them in line with the provider's policy.

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 not consistently safe.

Most risks to people had been identified but there was a lack of consistency in the care plans around keeping people safe from skin damage.

There were enough staff to keep people safe but at night care became task focused instead of person centred to help staff manage the workload.

People's medicines were safely managed. However, there was inconsistent recording of why medicines prescribed as required had been administered.

Staff had received training in keeping people safe from abuse and knew how to raise concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were happy with the quality and choice of food offered. However, there were not always effective risk assessments in place regarding people's ability to maintain a healthy weight and fluid intake was not accurately recorded.

The registered manager ensured that people's rights were protected under the Mental Capacity Act (2005).

Staff received training and support which helped them to provide safe appropriate care to people.

People were able to access health care professionals when needed.

Is the service caring?

Good

The service was caring.

There was a kind and caring relationship between people living at the home and staff who cared for them.

People were offered opportunities and support to make decisions about their everyday lives.

People were supported to maximise their independence.

Is the service responsive?

Good

The service was responsive.

The registered manager completed assessments before people moved in to the home to ensure staff were able to meet their needs.

People told us that the care provided met their needs.

Activities were available to people and the registered manager was in the process of providing more support for activities.

People knew how to complain and the registered manager investigated and responded to complaints in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a suite of audits in place to monitor the quality of care people received. However they had not identified concerns with medicines, monitoring of fluids.

People living at the home and staff found the registered manager approachable and willing to listen to concerns.

The registered manager worked to improve the quality of care provided.

Kimberley Care Village

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 February and 1 March 2017 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people who lived at the service, three visitors to the service and spent time observing care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with a senior care worker, two care workers, two heads of care and the registered manager.

We looked at five care plans and other records which recorded the care people received. In addition, we examined records relating to how the service was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

Most risks to people had been identified and care was planned to reduce the risk of people experiencing harm. For example, where people needed to be supported to move using equipment such as a hoist there were clear instructions in their care plan on what sling should be used. Care plans also included information on how staff should support people who became distressed. We saw staff calmly stepped in when people were distressed and redirected their attention to something they enjoyed to do.

However, in one of the five care plans we reviewed there was no risk assessment on the person's ability to maintain a healthy skin. In addition, in two care plans which showed the person was at high risk there was no corresponding care plans to show how people were protected from developing pressure ulcers. We discussed this with staff who explained that people's skin was monitored when they received personal care. They told us if they had any concerns they would contact the community nurses and arrange for appropriate equipment and care to be put in place. This meant that staff reacted to skin problems instead of working to prevent them occurring in the first place. Following the inspection the provider wrote to us and told us that audits showed that there had been no recorded pressure ulcers developed while people were living at the home in the previous six months.

Accidents and incidents were recorded and appropriate action had been taken to keep people safe. There were personal evacuation plans in place. These contained information on people's abilities both physically and cognitively in an emergency along with the support and equipment they would need to get to a place of safety. This information would help the emergency services keep people safe.

People living at the home and their relatives told us that there was enough staff to keep people safe during the day but felt that at night they had to wait longer for care. One person told us, "There is one definite problem, at night time there are two seniors and one carer. The seniors have to do the medication. I have to be helped to bed and they may be part way through that when the bell rings and off they go and I have to wait." A visitor to the home told us, "I come in the evening around 7pm and there's no one on the desk. Upstairs five of the residents like staying up late. I sit there with them and in say a 30 minute slot, not one carer will walk by."

One visitor explained how this impacted on their time spent with their relative. They explained that if their relative requested support to go to the toilet, staff would then take the person to bed even though they had not asked to go to bed. This task focused care was easier for staff but did not reflect the needs of people living at the home to spend time with their loved ones.

However, staff told us there were enough staff to ensure that people received the care they needed. One member of staff told us, "We now have five minutes to spend time with people, it is better now that they have separated the home into units and staff are allocated to each unit." In addition, we saw there were enough staff around to meet people's needs during the day.

The registered manager monitored the needs of people living at the home and the numbers of staff needed

to care for people. The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

People's medicines were safely managed. One person told us, "All my worries are sorted. My medicines are delivered on time and everything is comfortable." People's medicines were safely stored and were available for people when needed. Where people needed urgent medicines such as antibiotics there were systems in place to ensure these medicines were available to people at the earliest opportunity. The medicine round had been split into three sections with it's own medicine trolley. this meant three members of staff could administer the medicines at the same time. This ensured that the medicine rounds did not last too long and that people were supported to take their medicines in a timely fashion.

Most people who had medicines prescribed to be taken as required had clear guidance in place to support staff to administer medicines consistently. However, we had particulate concerns around the administration of one person's medicine as it appeared to be being used as a restraint to prevent them from wandering into people's rooms in the night. There was no clear recording of why this medicine had been administered on certain nights when the person's daily notes recorded that they were settled and calm. We discussed our concerns with the registered manager and the head of care, who were unable to clarify when the medicine should be administered. They immediately contacted the person's doctor to request that the person's use of this medication be reviewed.

We saw some people who lacked capacity to make an informed decision about whether to take their medicines had their medicines given to them covertly by crushing them in their food. This was because they would often refuse important medicine. The registered manager had completed best interest decisions with people's doctors and family members to ensure that people's rights under the Mental Capacity Act 2005 had been supported.

People living at the home told us they felt safe. One person said, "There's always someone to help me so that's why I feel safe. They get here quickly when I press my bell." Another person said, "My health needs are looked after. I like that the building is safe so no one can get in without permission." A third person said, "There is a lovely atmosphere here which makes me feel secure. Everyone is so kind and good. It reassures me." Staff had received training in how to keep people safe from abuse and were able to tell us about the different types of abuse. Staff were clear on the steps they needed to take to keep people safe. If they had any concerns they knew how to raise concerns both internally and with external organisations.

Requires Improvement

Is the service effective?

Our findings

We saw one person's care plan noted they were nutritionally at risk of being able to maintain a healthy weight and that they should take fortified supplements. However, there was no specific risk assessments in place to monitor the person's ability to maintain a healthy weight. In addition, the person was at risk of choking when drinking and so required all their fluids to the thickened. Staff told us that the amount of thickener they should use was recorded in the person's care plan. However, records showed that there was inconsistent use of the thickener. This meant that the person was not always fully protected from the risk of choking.

We saw the recording of food and fluid intake was inconsistent and at times it was not clear to see if people had received enough to drink to stay healthy. An example of this was one person who had no fluid intake recorded for a 24 hour. We discussed this with staff, who assured us that the person would have been offered drinks throughout the day but that they had not been recorded. There was no running total of the amount of drink people had received to support staff to make decisions about the care people needed.

People told us they were happy with the food offered. One person told us, "The food is warm and tasty. There's nothing wrong with it whatsoever." Another person told us, "The food is good with nice choices. We asked for pancakes and got them. I never send my plate back empty." A third person said, "I don't like hot food and they do just what I want, maybe cheese or egg but it is always tasty, made specifically for me."

Care plans recorded people's nutritional needs and the support they needed to ensure they were able to maintain a healthy weight. An example of this was a care plan which noted that the person took a long time to eat and they would prefer soft food which was easier and quicker to eat as they could not focus too long while eating. We saw where people had diabetes their needs around food were monitored. An example of this was one care plan which noted that while the person did not like to eat proper meals they would eat any chocolate they could find within the home which could cause them to have raised blood sugar levels.

People told us that staff had the skills to provide safe care. One person living at the home told us, "The staff know what they are doing and when I need the hoist it is always two carers and they move me carefully." A relative told us, "The carers help her into the wheelchair carefully. I can see by the look on her face that everything is all right."

One member of staff told us how they had received a structured induction when they first started working at the home. This had included a period where they had shadowed a more experienced member of staff so that they could learn about people's needs and how to provide safe care. The induction ensured that staff had received the training needed to provide safe care and was in line with the care certificate. The care certificate is a national training program that provides staff with the skills needed to care for people safely.

The registered manager had a training plan in place which clearly identified the training staff needed and how often staff needed to complete refresher training. Training was provided in different formats including

face to face and computer based learning. Staff told us they had completed a number of training programs and that they had found these engaging and useful. In addition, the registered manager had identified that more training was needed in providing care for people living with a dementia. We saw that they had developed a bespoke training course in conjunction with Stirling University.

Record showed extra training was put in place for staff when they got promoted. The head of care posts had been in place for four months and as part of their on-going learning they were both completing a nationally recognised qualification.

Staff told us and records showed they received six supervisions per year. The registered manager was looking at developing supervisions to include observational supervisions and guidelines to staff on how care should been provided.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were unable to make the decision about where they lived the registered manager had completed appropriate DoLS applications. At present only one person had their DoLS authorised and there were no conditions applied to the DoLS.

Where people were not able to make decisions about treatment we saw decisions had been made in their best interests ensuring the views of staff involved in their care, health care professionals and family members were included in the decision making process. One person who was unable to make decisions for themselves had regular visits from an advocate. An advocate is an independent person who could look at the care provided and speak in the person's best interest. In addition, care plans showed where people had made legal arrangements for people to make decisions on their behalf.

People told us they were supported to access health care services when needed. One person told us, "I can see a doctor if I am unwell." A relative said, "I went to the office and told them she didn't look 100%, so they said they would put her on the list for a doctor's visit and that's what happened within days." Records showed that staff had identified when people were not very well and made sure they received appropriate medical support from Healthcare professionals. The registered manager ensured that when people went to appointments with their GP or at the hospital they were escorted by a senior member of staff who had knowledge of their care needs. This meant that health care professionals had access to all the information needed when making decisions about the person's treatment.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed.

Good

Is the service caring?

Our findings

There was a kind and caring relationship between people living at the home and the staff who looked after them. Care plans recorded people's abilities around communication. For example, one care plan recorded that although the person would talk to you they had very limited understanding of what was being said to them. Care plans also recorded people's ability to ask or call for help when needed. This meant staff knew when people needed support to make decisions about their everyday lives.

An overwhelming number of residents expressed their appreciation of the way they were treated and the 'homely' feel of the place. Carers knew people well and responded to individual needs. One person told us, "The staff are very friendly. They greet you when they see you and if I have a problem they are there. They are very caring and kind. They chat about the weather or what they've been up to." Another person told us, "They make me feel I am somebody, not just a number. The dedication and commitment I see from carers like [name] is amazing. They will do everything they can to make life comfortable. Such attitudes make me feel special." In addition, people told us that their visitors were made to feel welcome and always offered a drink.

People were offered choices through the day. This included what they wanted to eat and what clothes they wanted to wear. We saw that staff tried to accommodate people's choices. An example of this was during lunchtime one person was disappointed that there were no wafers to accompany their ice cream. A member of staff looked for wafers but could not find any so they offered the person some ice cream in a cone instead and the person thanked them with a big smile. We also saw one person did not want any of the meals offered. However, staff knew the person's likes and dislikes and offered them some cheese and biscuits the person was happy with this and ate some of the food provided for them.

At lunchtime people living with dementia were shown plates with the different options for their lunch. This supported them to make a decision about their lunch which they would not have been able to make if staff had just asked them. However, there were no menus or pictures available in the dining room to support people to make choices around their food. We discussed this with the registered manager who explained that this was an area they were aware needed improvements and they had ordered menu boards to be put in each dining area. We saw tables were not set to support people, for example, no serviettes were available. People were not given the option to personalise their meals as they were all plated up in the kitchen before being sent to each area of the home.

People told us that staff supported them to remain independent and to retain some dignity by allowing them to do as much personal care as possible. One person told us, "I do what I can for myself. I can wash myself partly and they will do what I can't manage. They are very respectful." Another person said, "They keep an eye on me but try to make me do things for myself." We saw that people were supported to maintain the standards of dress and appearance in a manner that supported their dignity. People had their names and photographs on the door so they could identify which was their room.

Good

Is the service responsive?

Our findings

The registered manager or another senior member of staff completed an assessment of people's needs before they moved into the home. They were clear about the level of care they could provide people and ensured that they only admitted people if they could manage their needs. The registered manager told us that the level of need of people living in the home had reduced. They explained that they were very clear when assessing people's needs that they were a residential and not a nursing home.

People and their relatives had mixed experiences regarding how involved they had been in planning their care. One person told us, "I don't know what a care plan is." Another person said, "I helped with my care plan when I came in, I can't remember when that was, but not since." A relative said, "No one ever asks us how we feel about [my relative's] care." However, all the people we spoke with told us that the care provided met their needs. Another relative told us, "Most staff clearly know [my relative's] needs. They address her by name and support her as I would expect."

We saw the care provided was person-centred and people were offered the opportunity to make choices. An example of this was one person who did not want a drink of squash and so the member of staff fetch them a glass of lemonade. Where people were unable to communicate their care needs staff monitored them to ensure that their needs were met. An example of this was a member of staff who fetched some socks for a person who had gone to the lounge without them. Staff were aware of people's individual care needs. For example, they explained how if one person with dementia said no to personal care they meant it and would not be persuaded. Staff told us how they would leave the person and offered care again at another time and perhaps get a different member of staff to offer the support as the person was more responsive with some staff.

Care plans were person centred and provided the information staff needed to provide safe appropriate care for people. Care plans showed an understanding of the abilities of people living with dementia. For example, one care plan recorded, "Even if fiddles with objects may be the only form of participation they can deal with."

Staff told us that they always had time to read care plans and that there was always a senior member of staff they could turn to for support or if they had any concerns about people's care. Staff were able to tell us about people's care needs and these matched the information recorded in people's care plans. To ensure that staff remained up to date regarding people's needs there was a formal handover when shifts changed which was also recorded so could be used for reference.

The activities' co-ordinator worked 35 hours each week and the registered manager was in the process of employing more staff to support people with activities. The activity co-ordinator explained how they visited people who were unable to leave their rooms and offered to put music on, read books or do hand exercises. Some of the people we spoke with told us they were happy with the level of activities offered and that they spent time watching television, listening to the radio and people watching. We also saw some good examples where staff used simple activities to help people remain calm. An example of this was the staff

encouraged a person to look through an animal book and spending time discussing each animal.

However, other people and relatives felt that it would be nice to have more activities to help people pass the day. One person told us, "I have joined in games but there's not much going on." A relative told us, There doesn't seem to be much going on to entertain the residents." In addition, we saw that there was little visual stimulation or objects for people living with dementia to engage with around the home.

We discussed activities with the registered manager. They told us as part of the development of the dementia care they had identified that the activities needed to improve. We saw that they had ordered some equipment for this and were just waiting for staff training before the equipment was made available for people. In addition, they explained how increasing the activities staff would support them to engage more with people. Plans were in place to speak with people on a monthly basis to find out what they wanted to do. The activity staff would then create an activity plan for the coming month based on people's requests.

People told us that they knew how to complain and that any complaints they had made had been appropriately dealt with. One person told us, "The seniors give a straightforward answer if you raise an issue. I like that." Another person said, "There's not a single problem as far as I am concerned, so I have not had to complain. If I did I am sure they would deal with it." Records showed that the registered manager had fully investigated complaints and responded to people in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

The provider had a suite of audits in place to ensure that the registered manager could monitor the quality of care provided to people, for example, we saw medicines audits had been done as well as infection control audits. We saw individual action had been taken where any concerns identified to improve the quality of care people received. However, these audits had not identified the concerns around supporting people to maintain healthy skin, correct administration of as required medicines and the recording of fluids that we identified during our inspection. In addition the provider and registered manager had not taken notice of our last report where we had identified that staff did not fully understand how to keep people safe from pressure sores and that staff were not supported to administer medicines prescribed to be taken as requires. They had not used the report to drive improvements in these areas.

We recommend that the provider ensures their audit systems highlight any concerns with the quality of care provided.

There had been regular residents meetings at the home to discuss the changes that would be made and to ensure people were able to comment on the care they received. However, one relative told us that they had not always been aware of these meetings. They told us, "While I accept there are meetings, I have only recently seen this on a poster near the front desk. It is not made clear that it is an opportunity for relatives to get involved. We never get told what's being offered to residents, like entertainment. There's no newsletter sent to us." People living at the home, their relatives and visiting health care professionals had been asked for their views on the care. The registered manger told us they were working on an action plan.

People living at the home told us that the registered manager was approachable and that they were able to raise any concerns they had with her. One person told us the registered manager was to be seen around the home on a daily basis. they said, "If you want to ask her something, that is so easy to do. Every day when she comes in, she hangs up her coat and then comes into the lounge to say good morning." A relative said, "The new manager is very approachable." In addition, people said that all the staff were open and approachable. One person said, "From the cleaners, maintenance team, laundry, cooks and carers to the top. They are all great, in fact they are marvellous."

The registered manager was to be seen throughout the building at various points in the day. She was welcoming and approachable throughout the visit. The management team consisted of the registered manager and two heads of care. There were also three senior team leaders each day. Staff told us that the registered manager and heads of care were supportive. One person told us, "The registered manager will sort things out and makes the home better, for example, with the decorating. The heads of care are good and I can go to them if I have got any concerns."

The registered manager had introduced more structure into the home and staff were clear on what the job roles were. One member of staff told us, "Before everyone was trying to do everybody's job. I now feel more empowered and more supported." Staff told us that the improvements in the care and the environment had also improved the staff morale in the home. They said that staff were happier and was more laughter in the

home. They told us that they felt they could be more open with the provider and that they now felt comfortable and confident having conversations with the provider. One member of staff said, "We're a team now. Things are much better." They pointed out that, "Things are getting done, like the flooring being replaced."

Staff told us and records showed that they received on-going support from the management, in the form of supervisions and staff meetings. The registered manager had ensured that the policies and procedures from the organisation were available for staff. Key policies have been identified and all staff had signed say that they understood them.

Staff told us how the registered manager had been working with the health and social care professionals to improve the relationship between them. One member of staff told us, "The registered manager is good at what they do. They get on well with the doctors and social workers. We work with the doctors more readily and also the GP practice staff rings before they come so we can have people ready for their appointments." Staff told us that the improvements had a positive effect on external agencies. One member of staff said, "It now feels like we are working together and have really nice relationships with the outside agencies."

People told us they were kept up to date about incidents. The registered manager reviewed accidents and incidents such as falls on a monthly basis to ensure there any trends were identified and action can be taken such as increasing staff in levels at times in different times of day. Where medicine errors had occurred these had been fully investigated and the member of staff who made the error was required to undergo training and have their competencies checked before they were allowed to administer any more medicines.

The provider had chosen to use a computer system to record people care needs. While we saw there were some positives to this, for example, staff sat with people while using the computer tablets to enter information and this was less intrusive to the relationship between staff and people living at the home than having a large folder of notes out. However, only the most up to date information had been transferred from the paper care plans. This meant important information on who had been involved in making decisions about the care was not always available for people to access. In addition, the computer did not keep a running total of people's fluid intake and therefore it was not always easy to see if people were receiving enough to drink.