Crown Care I LLP

Kensington 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

Overall summary

The inspection took place on 10 and 12 November 2014 and was unannounced. This means the provider did not know we were coming. We last inspected Kensington Care Home in October 2013. At that inspection we found the home was meeting all the regulations we inspected.

Kensington Care Home provides nursing and personal care for up to 49 older people. At the time of our inspection there were 38 people living at the home. The home had not had a registered manager in post since 2013. 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. The provider told us they were in the process of appointing a new manager who would apply to be registered. The deputy manager was acting as manager until a new manager was appointed.

Summary of findings

We found that people received care that protected their personal safety and welfare. Risks were assessed and measures were in place to prevent people from being harmed. Staff were trained in safe working practices and understood how to protect people during their care delivery. They had a good understanding of safeguarding people against the risk of abuse and the reporting procedure. People confirmed to us that they felt safe living at the home and with the staff who cared for them.

The home was clean and comfortable and work was being carried out to improve décor, carpets and furnishings. Appropriate equipment was provided and health and safety checks were undertaken to ensure people were cared for in a safe environment.

New staff had been properly checked and vetted before they were employed. There were sufficient numbers of staff to provide people with continuity of care and support the running of the home. The staff team were skilled and experienced. They were given training that was relevant to their roles and specific to meeting the needs of people living at the home.

People were appropriately supported to meet their health needs and to access health care services. Prescribed medicines were stored and administered safely and accurate records of medicines were kept.

Nutritional needs were monitored and specialist advice was sought when necessary. Special diets and aids were provided and staff assisted people who were unable to eat and drink independently. Meetings between care and catering staff had been introduced and changes were being made to enhance people's mealtime experience.

The management and staff had a good awareness of people's rights to make choices and decisions about their care. People and their families were encouraged to express their views and to be involved in and agree to their care. Assessments and individual care plans were reviewed monthly to ensure they reflected people's needs and the care they required.

Staff knew people well and how they wanted their care to be given. They were caring and patient when supporting people and treated them as individuals. People told us the staff respected their privacy and dignity and said they were happy with the care provided. They felt any concerns they raised would be quickly addressed.

Suitable arrangements had been made for managing the home and providing leadership to staff whilst a new manager was being recruited. There were effective systems to check and develop the quality of the service that people received.

Summary of findings

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. People living at the home were cared for safely and steps were taken to reduce and manage risks. Staff understood how to keep people safe from harm and report any concerns about their safety.

There was a safe recruitment process that ensured new staff were suitable to be employed to work with vulnerable people. The home had enough staff, with the appropriate skills, to provide consistent care.

There were robust arrangements in place for supporting people to take their medicines safely.

Is the service effective?

Good

The service was effective. People and their families were consulted about and had agreed to their planned care. Where people were unable to give consent, formal processes were followed to make decisions in their best interests.

People were protected against the risks of poor nutrition and were given support that met their eating and drinking needs.

Staff were trained to meet people's needs effectively. People were assisted to maintain good health and accessed a range of health care services.

Is the service caring?

Good

The service was caring. People were happy with the care provided and told us staff were caring, friendly and respectful.

Staff had a good understanding of people's needs and preferences. They were caring in their approach and treated people as individuals.

Is the service responsive?

Good

The service was responsive. Staff were attentive and responded promptly to people's requests. Care needs were regularly assessed and recorded in personalised care plans which were kept under review.

A range of activities were offered and people were supported to access the community to help meet their social needs.

People and their families felt able to raise any concerns they had and were confident they would be dealt with appropriately. Complaints were taken seriously and investigated in a timely way.

Is the service well-led?

Good

The service was well led. There was no registered manager at present but an acting manager was in post. The provider was directly involved in the home and supporting the staff team whilst a new manager was being appointed.

The quality of the service was regularly monitored to make sure standards were maintained. A number of improvements were being undertaken to further develop the home's systems.

Kensington 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 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.

The inspection took place on 10 and 12 November 2014 and was unannounced. The inspection team consisted of two adult social care 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.

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. We reviewed the PIR and other information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we talked with 12 people living at the home and with nine relatives and other visitors. We spoke with the provider, the registered manager of the adjoining care home (the provider's representative) who supported the inspection, two visiting professionals, and with nine nursing, care and ancillary staff. We observed how staff interacted with and supported people, including during a mealtime. We looked at five people's care records, eight people's medicine records, and the new electronic care planning system that was being introduced. We reviewed staff recruitment and training records and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

People living at the home told us they felt safe here and said the staff were good to them. One person said, "The staff treat me nice and are very polite." A relative commented, "It's nice here and the residents are safe." People and their relatives were aware of their rights to be treated fairly and protected from abuse. They told us they would feel able to speak to the staff or management if they had any concerns about the way they were treated.

The staff we spoke with understood the home's safeguarding and whistle-blowing procedures. They said they had been trained in safeguarding adults and this was evident in training records. Staff knew how to report suspected abuse or poor practice and said they were confident in raising any issues. The provider had recently introduced a 'safeguarding competency toolkit'. This was being used during supervision to check that each staff member had sound knowledge of the safeguarding process.

The provider's representative said people's safety was monitored and any concerns were acted on. They told us about an occasion at the beginning of the year when management had carried out a spot check to see how people were being cared for during the night. They had found that the actions of two care staff had put people at risk of harm and this had led to their employment being terminated.

Risks associated with the environment, equipment, and safe systems of work were assessed and managed. Audits of health and safety, infection control, the kitchen, and housekeeping were also conducted to ensure people were being cared for in a safe and hygienic environment.

People's care records showed that risks to their personal safety had been assessed. Measures were taken to reduce identified risks such as moving and handling, falls, and skin integrity. A care manager told us each of the people she visited had up to date care plans for meeting their needs and managing risks.

Staff had a good understanding of how to prevent people from being harmed. For instance, a care worker told us how staff kept regular checks on a person who was visually impaired and at risk of falling. Safety equipment was used, such as a sensor mat to alert staff if the person attempted to get up unaided.

Staff told us the home was proactive about seeking assistance from other professionals to make sure people could be cared for safely. They told us, for example, that a specialist behaviour team had provided support to people with mental health conditions. The team had given staff guidance to follow and individualised care plans were in place to ensure staff took consistent approaches to managing people's behaviour. Staff said they had also received training in safe ways to manage behaviour that challenges the service.

At the time of the inspection there were 38 people living at the home who were accommodated over two floors. The provider told us staffing levels were based on the numbers of people living at the home and the extent of care they required. A staffing model and information about dependency levels were used to calculate how many nurses and care staff were needed. The provider said that in future each care plan entered onto the new electronic care recording system would include the number of staff needed to provide care. This information would then feed into how staffing levels were determined.

The rotas showed that current staffing levels were two nurses and six care staff during the day and one nurse and four care staff at night. One person had extra staffing resources which enabled them to have one to one care for their personal safety. Separate ancillary staff were employed to support the running of the home, including catering, housekeeping and laundry staff, an activities co-ordinator, an administrator, and a maintenance person.

There were enough staff on duty and we saw they responded promptly to requests for help. Staff regularly checked on people in their bedrooms and in communal areas to see if they needed any assistance. We observed that when people used the call system to summon help, staff answered it quickly. Two people we talked with said they very occasionally had to wait for a member of staff after using the call system. They said staff always apologised for any delay, which was usually because they had been attending to other people. Four of the relatives we spoke with said at times they felt staff were "thin on the ground", and had to rush around. Staff did not express any concerns about staffing levels, though one staff member commented it was sometimes difficult to get a break during their shift. Our observations during the inspection identified no evidence of there being insufficient staff to meet people's needs safely.

Good

Is the service safe?

Existing staff, including bank nurses, covered absences and vacancies within the staff team. External agency nurses were also currently being used to maintain staffing levels and, wherever possible, the same agency nurses were requested for continuity. New staff had recently been recruited to fill vacant posts. We talked with four staff who told us references had been obtained and checks of criminal records and suitability to work with vulnerable people were completed before they had started work. This was confirmed in staff records, showing us a recruitment process was followed to ensure suitable staff were employed.

We reviewed how staff supported people with taking their prescribed medicines. Medicines were held securely and checks were recorded of the temperature of the rooms where they were stored and of medicine fridges. Records were kept of all medicines received, administered and disposed of. Staff responsible for handling medicines said they had received relevant training and this was confirmed in their training records.

We observed that staff administered and recorded medicines appropriately. They explained to people what their medicines were and waited with them until they had taken them. The staff signed the administration records to verify they had given people their medicines. No gaps were evident in the records we looked at. Where medicines were not given, for example when a person was asleep, the reason was recorded.

One person managed their own medicines and a risk assessment had been carried out. Staff regularly updated the assessment and checked medicines to make sure the person was taking them correctly. A care manager told us about a person they visited who was reluctant to take their medicines. The person had a care plan that reflected this had been problem before they came to live at the home. The care manager said they had observed staff sitting with the person and encouraging them to comply. They said this had been done in a sensitive way, with staff taking time to explain the benefits and assisting the person to feel confident in taking their medicines.

We found that people's medicines were managed safely and medicines arrangements were monitored. Monthly medicines audits were carried out and action was taken on any inaccuracies or shortfalls. For example, it was identified a person who had recently come to live at the home did not have a photograph to identify them on their medicine record. We saw following the audit this had been actioned.

Good

Is the service effective?

Our findings

Staff told us they had received all necessary training to help them understand and meet the needs of the people they cared for. They said they had received induction training when they first started work to prepare them for their roles and we saw documented evidence of this in staff files.

Records and certificates showed that staff had completed core training in safe working practices such as moving and handling and infection control and were provided with training specific to people's needs. This included topics such as pressure area care; end of life care; dementia; falls prevention; sensory impairment; continence and catheter care; wound care; and using syringe drivers.

Staff said they were provided with regular supervision and had annual appraisals of their work performance. This was confirmed in their individual records. Staff told us they felt well supported by their colleagues and senior staff and could get support from the provider when the acting manager was not available. A new staff member said, "It's a good place to work, everyone helps you when you first start and there is good job satisfaction."

We looked at how people living at the home directed their care. We observed that staff sought people's permission before carrying out any care and gave them time to make choices. Most of the staff we spoke with had worked in the home for quite some time and knew people well. They gave clear accounts of the care people needed and understood the ways they preferred to be supported. It was evident in care records that people had been asked about their routines and preferences and had consented to their care plans.

Formal processes were followed when necessary to promote people's rights and act in their best interests. Mental capacity assessments were undertaken when there were doubts around a person's ability to make important decisions about their care. For example, one person had an assessment completed to determine if they were able to manage their own personal finances. A further assessment was also planned to be carried out, at the request of the person's advocate, in relation to their health needs and treatment.

The home had policies and procedures on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. These are safeguards under the Act which are used to protect people when they lack capacity to make decisions and need to receive care and be kept safe. The provider told us they had updated their policy in line with the supreme court judgement that had extended the scope of the safeguards. They had identified five people living at the home who may need applications made to deprive them of their liberty and were working on these in conjunction with the local authority. The staff we talked with demonstrated an appropriate understanding of the implications of mental health legislation and told us they had received training in this area.

We reviewed how people were supported to have adequate nutrition and hydration. Nutritional screening was completed every month and people's weights were monitored. Where nutritional risks were identified, people were referred to dieticians and speech and language therapists for further assessment. The head chef had weekly meetings on each unit to ensure there was regular communication about people's dietary needs and the catering arrangements.

Care plans were in place for meeting people's eating and drinking needs and there was evidence that these were effective. For example, two people had gained weight following the introduction of special diets. We noted there had been a delay in another person with weight loss being seen by a dietician. The provider's representative chased up the referral, which had already been made by the person's doctor, during the inspection. We saw staff kept records of some people's food and fluid intake, but the charts were not always fully completed. The provider raised this issue with staff during the inspection to stress the importance of keeping accurate records.

At lunchtime we observed that staff gave one to one support at a relaxed pace to people who needed help with eating and drinking. Some people had aids provided, such as plate guards and spouted beakers, which helped them to manage their meals and drinks independently. Space was limited in one dining room, making it difficult for staff when they were moving around and trying to help people. A small dining area was being created in a lounge to alleviate this problem.

Care records showed that people accessed a range of health services including doctors, physiotherapists, tissue viability nurses and occupational therapists. Records were kept of all visits and appointments and any prescribed treatment. People had care plans addressing their health

Good

Is the service effective?

needs which included care and treatment as advised by health care professionals. Staff also worked closely with a nurse from a local GP practice who provided support into nursing homes and visited weekly to review patients' care.

The home and its facilities were designed to meet the needs of older people. People with physical disabilities could access all areas and appropriate aids and equipment were provided. The home was kept clean and tidy, with no unpleasant odours, and we saw domestic staff were constantly cleaning bedrooms and communal areas. Staff told us there was a system for reporting any repairs which were needed and said that these were dealt with promptly. This was confirmed in maintenance records. A programme to enhance the home was in progress. The upper floor unit was being redecorated and we saw there were plans to replace carpets and buy new furnishings.

Good

Is the service caring?

Our findings

People living at the home and their visitors said they were very happy with the care given and described good relationships with the staff. They told us, “The staff are very caring and polite”; “They are respectful and will do anything to help”; “The carers are always happy”; and, “I find carers to be pleasant and friendly. I am treated with dignity and respect”. A visiting professional also told us they were satisfied with the care people received.

During our observations we found there was an inclusive atmosphere in the home. Staff were present in and around the main communal areas, ensuring people were properly supervised. They actively engaged with people, sat and talked with them, and there was plenty of positive interaction and humour. People were offered choices such as whether to go to their bedrooms after lunch or if they wanted to take part in a music session in the afternoon.

We observed that staff spoke to people in a kind and compassionate way and were caring in their approach. For instance, a staff member noticed that a lady was not wearing a cardigan and asked her if she might be feeling cold. They went and got a cardigan for her straight away and helped her put it on. The lady also complained of a sore eye and the staff member reassured her, saying they would get one of the nurses to come and have a look.

People were asked their opinions and staff listened to them and responded appropriately. For example, we heard the activities co-ordinator talking with people about doing crafts and asking about which ones to sell at the forthcoming Christmas Fayre.

Staff took account of people’s feelings when providing their care. We saw two care workers helping a person with moving and handling, to transfer from their wheelchair into an armchair. They used a mobile hoist and discreetly explained what they were doing at each stage. The staff kept checking with the person throughout to make sure they felt safe and comfortable.

People said that staff were mindful of their privacy and dignity when carrying out personal care. One person commented to us that they felt uncomfortable if their personal care was carried out by new staff. Their relative said this was something they had discussed with the staff to resolve.

Staff demonstrated a good awareness of equality and diversity. They treated people as individuals and were knowledgeable about their needs and background. We saw staff used this to good effect and talked with people individually about their family and interests.

We carried out observations of care practices at lunchtime in two dining rooms. There was no menu on display to inform people of the day’s meals. Staff told us there was a choice of main meal at teatime and a lighter meal was served at lunch. People we talked with said they usually enjoyed the food and were asked what they would like to eat. Some people commented that sandwiches were on the menu too often. One person said, “It would be nice to be offered a pie, pasty or sausage roll for a change.”

On the ground floor we saw people waited for 15 minutes before the food arrived. The meal consisted of soup and sandwiches, followed by a jam sponge pudding and custard. Although there were four types of sandwich fillings, staff did not ask people which ones they wanted. Aprons were provided to protect people’s clothing from food spillage but no napkins were available. We noted that the home did not currently practice ‘protected mealtimes’, where other tasks, such as giving medicines, are avoided and all staff are able to focus on the mealtime.

We gave feedback on our observations to the provider and immediate action was taken. On the second day of our inspection a meeting was held with staff to ensure they were clear about how to improve people’s mealtime experience.

We found that staff made visitors very welcome and often stopped what they were doing to have a quick word with them. The relatives we talked with said staff were generally good at keeping them up to date about their family member’s well-being. Care records showed that staff completed ‘family communication’ records when they had contact with relatives about events affecting people’s welfare. Staff also noted relative’s involvement, for example, when they had taken part in a review of health and treatment with the person’s doctor.

The provider told us people and their families were consulted about care and treatment and involved in making decisions. They said people could be referred to advocacy services if they did not have family who could act in their best interests.

Good

Is the service responsive?

Our findings

People and their relatives told us the home provided social activities, entertainment and outings. One person said, "I don't take part in everything that happens. There's certain things I like to do. I really enjoy going out." Another person said, "There's usually something going on most days. I choose if I want to go or not."

The home employed an activities organiser who arranged activities and events. One to one sessions were also given to people in their bedrooms if this was their choice. The activities programme was displayed in the reception area and a copy was put in each bedroom so that people knew what was going on each day. The provider said they were looking to recruit volunteers to help with taking people out locally, to a social club and a community centre that provided lunches and tea dances.

We observed the afternoon activity of music and singing that a couple of people had specially requested. 14 people attended the session in the lounge and all were happily singing. One person, who had previously been uncommunicative, suddenly stood up and in a loud voice sang a whole song using the correct words. They were given a really good cheer and clap and then took a bow.

Relatives told us that care records were available to read if they asked staff. We looked at a sample of care records to see how people's care was assessed, planned and reviewed. The records showed that staff completed a range of assessments on a monthly basis. We saw care plans were in place for all identified needs and risks. The plans were personalised to the individual and described the care they required, their preferred routines and independent skills. Monthly evaluations were carried out to check that care plans continued to meet people's needs. We noted however that one person's care plans were not fully up to date and some reviews of care had lapsed. The provider confirmed to us that these issues were being acted on.

We were shown the home's electronic care recording system that was in the process of being introduced. The provider said the main aim of this was to enable staff to plan and implement more structured and person centred care for people. The system prompted staff to personalise care plans in line with people's likes and dislikes and the ways they preferred to be supported. It included developing a 'This is me' life story about each person's background and history and what was important to them. An emotional mapping tool was built into on going reports to build up a picture of each person's moods throughout the day. We were told us that over time this would help staff to analyse what influenced people's moods and plan their care accordingly.

The system produced reminders for staff to ensure they carried out particular care duties. For example, where a person had a care plan for wound treatment, the nurse was sent a reminder when dressings were due to be changed. If the nurse did not respond to confirm the dressings had been done, an alert was then flagged to the manager to follow up. A care summary, giving an overview of each person's planned care, was also being developed. This would give staff, including new staff and agency staff, improved information to help them get to know people's needs and wishes. The recording system was planned to be discussed at the next 'resident and relative' meeting and the provider hoped this would encourage more people to contribute to care planning.

The people we talked with had no complaints about the service and said they raised any issues with staff when they needed to. Relatives told us that any concerns they expressed were sorted out quickly. We saw two complaints had been logged over the past year. One complaint had been resolved and the other was currently being investigated by the provider. The relatives who had made this complaint told us they were confident the provider would soon be reporting back to them with their findings. The home had also received a number of cards from relatives and friends thanking staff and praising them for the care that people had been given.

Good

Is the service well-led?

Our findings

At the time of our inspection the home did not have a registered manager. The manager had recently left and the deputy manager was acting as manager until a new manager was appointed. Interviews had taken place and the provider anticipated that a manager would take up post in the near future and apply to be registered. The provider and the registered manager from the adjoining care home were currently providing management support to the home. Monthly meetings were also held with managers within the company to discuss best practice and developing services.

There were plans to make changes to the home's registration. The provider said they were proposing to reduce the number of beds, merge with the care home on the same site, and register as one home with one registered manager.

The provider was temporarily covering the home at the time of the inspection as the acting manager was on leave. They were well liked by people living at the home and by the staff. Staff told us they felt the management were approachable and supportive. For example, one staff member spoke highly of the way they had been supported during illness. They described how an adjustment to their duties was accommodated and said management continued to review their welfare during supervision.

The provider told us they were committed to communicating openly with people and their families about the running of the home. They said 'resident and relative' meetings had not been well attended to date, but further meetings were planned to take place. Surveys had also been sent to relatives the previous month to get their views about the home. They were asked about the environment; health and well-being; daily life; customer care and to rate their overall satisfaction with the service and care provided. The survey findings were planned to be collated and we were told any negative responses and comments would result in an action plan to improve the service.

We were shown evidence that suggestions previously made by relatives had been followed up. For instance, a suggestion to have more visible information about social activities and events had led to information being displayed in the entrance to the home. Relatives had also been given feedback in response to their suggestions, including explanations about why something could not be done.

Audits were conducted into the quality of the service that people received. These looked at different areas such as care planning, medicines, health and safety, kitchen and catering, housekeeping, and administration. The acting manager was responsible for making sure any remedial action was taken as a result of the audits. The provider then checked if the necessary improvements had been made when they carried out 'quality visits' to the home. They also checked a range of care and safety issues during their visits. These included monitoring accidents and incidents, any complaints and safeguarding alerts, and how they had been acted on.

The provider told us staff were made aware of the company's values which included treating people with compassion and respecting their privacy and dignity. They said staff were encouraged to express their opinions and be involved in developing the service at supervision and staff meetings. This was confirmed by the staff we talked with. Poor practice or performance was not tolerated and management took disciplinary action and terminated employment when necessary.

The provider demonstrated they were keen to develop the service and kept up to date with best practice. They were working on and had introduced a number of measures they felt would benefit the people living at the home and staff. These included electronic care recording with greater staff accountability; a review of quality assurance audits; improving the premises; introducing a safer and more efficient medicines system; and plans for leadership skills training for staff at a senior level.