Avery Homes (Wimbledon) Limited

Kingsmere Retirement Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 February 2018 and was unannounced. This was the provider's first inspection since their registration.

Kingsmere Retirement Home 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.

Kingsmere Retirement Home accommodates up to 79 people in one adapted building. At the time of our inspection 34 people were using the service. The home provides support to older people with personal care needs and those living with dementia. This was the home's first inspection since registering with CQC in September 2016.

A registered manager was in place at the time of our inspection. 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 did not always ensure that staff were supported through regular supervision. Training for staff was not always updated regularly to ensure that staff were fully trained to carry out their roles effectively. We have made a recommendation about the provider ensuring training and supervision are kept up to date.

We have also made a recommendation about the home's environment and design not being as dementia 'friendly' as it could be. Although the provider was in the process of resourcing life story memory boards we found that the environment could be improved. The colour schemes of communal areas were neutral and social spaces did not always have clear definition and pictorial signage. This lack of definition could lead to disorientation for those with dementia whose ability to see colours and contrasts may be diminished.

People and staff were not clear on the management structure and leadership of the service. We have made a recommendation about the ways in which this is communicated.

People and their relatives spoke highly of the care that they received at the home and we saw that staff approached people with a kind and caring demeanour. Interactions were friendly and reflected that staff had developed positive relationships with people. Staff treated people with dignity and respect and knew the people they supported well. People were actively supported to express their views and feedback was encouraged.

People were kept safe from the risk of harm and abuse. Staff were aware of the different types of abuse and how to report any concerns. Appropriate risk assessments were in place and reviewed regularly to support people to stay safe. Staffing levels were appropriate to meet the needs of the people living at the home and

we found the premises to be clean and well-presented throughout. Medicines were administered and managed to ensure people received them at the time that they needed them.

People's care needs were assessed and regularly reviewed to ensure that their needs were met. People were supported to have enough to eat and drink to maintain a healthy diet and were supported to access healthcare professionals when required. Staff supported people in the least restrictive way possible.

Each person had a personalised support plan in place to reflect how best to meet their needs. Staff knew the people they supported well and understood their preferences. A range of activities were on offer to encourage people to engage with leisure activities and maintain relationships with the people that mattered to them.

People were comfortable in raising any issues they had with staff and management. Complaints were managed and responded to in a timely manner. The provider completed regular audits in order to review and drive improvement across the service.

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.
Risks to people were managed and monitored and staff knew how to safeguard people from potential abuse.
Medicines were managed safely.
There were appropriate staffing levels to meet the needs of people living at the home.

Is the service effective?

Requires Improvement

The service was not always effective.
Staff were not always supported through regular supervision and some staff required updates in their training. The home's environment was not dementia friendly.
People were supported to maintain a healthy, balanced diet and see healthcare professionals when required.
Staff were clear on the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.
People were treated with kindness and their privacy and dignity were respected.
People were involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive.
People received care suited to their needs, at the time that they needed it.
People were supported to maintain relationships with people that mattered to them. People were well supported with their end of life preferences.
The provider had an appropriate complaints and compliments system in place.

Is the service well-led?

Good

The service was well-led, however people and staff were not clear on the management structure of the service.
The provider conducted regular quality audits to drive improvement across the service. People and staff were

supported to be engaged with the service and the provider worked in partnership with other agencies.

Kingsmere Retirement 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.

This inspection took place on 27 February 2018 and was unannounced. The inspection was carried out 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.

Before the inspection we reviewed the information we held about the service. This included notifications the provider is required by law to send us about events that happen within the service.

During the inspection we spoke with seven people who lived at the care home, one visiting relative and one visiting professional. We also talked with various people who worked at the care home, including the registered manager, the interim home manager, the regional support manager, five care workers, one activity coordinator and the head cook.

We also observed the way staff interacted with people living in the home and performed their duties. During lunch 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 looked at four care records, three staff files and a range of other documents that related to the overall management of the service which included quality assurance audits, medicines administration sheets, complaints records, and accident and incident reports.

Good

Is the service safe?

Our findings

People said that they felt safe living at the home. They praised the care staff and gave their care as the main reason that they felt comfortable and safe.

The provider had robust systems in place to identify, report and address any allegations of suspected abuse. Staff received safeguarding training and knew what to do to help make sure that people were protected from neglect, abuse and discrimination. One staff member told us, "I have never seen anything I have been concerned about. If I did, I would always make sure it is taken seriously. If not I would escalate it to senior managers or call CQC." Another staff member said, "I would inform the senior carer immediately."

People and staff did not always feel that there were enough staff to deliver care and spend quality time with people. One staff member told us they found it difficult when people required two staff members to support them. However, we reviewed the provider's dependency tool and observed that there were enough staff to meet people's needs on the day of our inspection and across the scheduled rotas. A minimum of five staff were available to support people overnight, and during the day there was one staff member to every three people at the home. The provider was also in the process of actively recruiting staff to ensure that people's needs were met should the home reach full capacity.

Recruitment checks were carried out prior to staff commencing employment. Disclosure and Barring Service (DBS) checks were up to date and full employment history was recorded. References were obtained prior to the start of employment and records evidenced the recruitment process.

Staff were aware of risks to people's wellbeing and how to manage them. Risk assessments were completed to help people stay safe; for example around the risk of falls, malnutrition or developing pressure sores. Staff we spoke with were able to tell us how they managed risks. For example, staff ensured people used walking aids or were monitored regularly. Where one person had suffered a recent fall we saw that the care plan had been updated accordingly to manage the presenting risk. Observation charts were also being used to help maintain people's safety. We observed staff working positively with one person to help them remain calm when they started to feel anxious.

Care plans contained information regarding people's prescribed medicines and how they needed and preferred these to be administered. One person told us "I know more or less what I take but they have to tell me as I can't see them. You have to trust them and I do especially [named staff]." Resident identification sheets used in the MAR folder included photographs and any known allergies. PRN protocols were used to identify when 'as required' medicines should be given, any side effects and the desired outcome of the administration.

We looked at medicines management on both floors of the home. People's medicines were being stored safely and securely. Temperature controlled clinical rooms were used to store medicines secured in locked trolleys and suitable Controlled Drugs (CD) cabinets.

Medicines administration records (MAR) and the CD register were appropriately maintained by senior staff who were trained and authorised to handle medicines in the home. There were no gaps or omissions on MAR sheets we looked at. The majority of medicines were supplied to the home in pharmacy supplied blister packs and our checks showed these had been administered as prescribed. Any prescribed creams or eye drops had the opening date recorded and were stored in secure refrigerators as required.

The home was very well maintained and clean throughout. Staff wore personal protective equipment (PPE) as necessary. One person told us "They are very quick to put on their gloves." One staff member talked us through the steps they would take to ensure that they were preventing infection when delivering personal care and the PPE they would use.

The provider had suitable arrangements in place to deal with foreseeable emergencies. Records we looked at showed that appropriate responses were in place should a fire occur and that fire drills had been conducted regularly. People at the home had a personal emergency evacuation plan (PEEP) on their file to provide guidance for staff should they need to be evacuated.

Risks to the premises had been managed safely and records we looked at showed that the provider had ensured electrical testing of equipment, gas safety checks and testing of the fire equipment. People were supported to stay safe in the home.

The provider kept records of any incidents and accidents that occurred, including details on any incidents that related to the safeguarding of vulnerable adults. Staff that we spoke with were aware of how to report any accidents or incidents that may occur.

Requires Improvement

Is the service effective?

Our findings

Staff were not always supported to receive training to ensure that they had the required skills and knowledge to carry out their role. Staff told us that they received mandatory training that was mainly electronic with a small number of classroom training sessions for subjects such as manual handling and fire safety. Some staff felt that the e-learning would be satisfactory for someone with previous experience in care but not for those new to the sector. One staff member commented, "I find it tricky. It's a refresher for me but not suitable for someone who has not worked in care before." Another staff member said, "If you have not done care before then it [e-learning] does not support you properly." The provider told us that staff had access to blended learning that enabled staff to enable learning in a classroom environment as well as electronic training.

Records we looked at showed that there were some gaps in the provider's mandatory training requirements. For example, records we looked at on the day of inspection showed that four members of staff had not received safeguarding training and 17 were out of date. Some staff also required refresher training in subjects such as mental capacity and moving and assisting people. Following our inspection the provider sent us an updated training matrix, however there were still some gaps in staff training.

Staff told us that they did not always receive regular supervision. The provider told us that supervisions should take place bi-monthly or more frequently if required. One staff member said "I think I've had two supervisions, I've not had an appraisal." Records that we looked at confirmed this to be accurate. One staff said, "I've had one supervision in the last five months." Another staff member said, "I did but not for a while recently." A fourth staff member commented, "That's our downfall." Two of the three staff files that we looked at did not contain any staff supervision records.

We discussed these issues with the interim home manager, the registered manager and the regional support manager. They recognised that they had some gaps in the completion of their training statistics and some training needs had been previously identified. The provider had already taken action in sending reminder letters to staff and booking in training for some of the gaps that had been identified. The interim home manager and registered manager also acknowledged that staff would benefit from more regular supervision meetings to support them to carry out their roles effectively. We were satisfied that that the competencies we observed and discussed during inspection meant that staff were skilled enough to carry out their roles.

We recommend that the service review their training and supervision records to ensure that all staff are up to date with the providers requirements.

We will check on the provider's compliance with the above at our next inspection.

We observed the home to be very well-maintained; however the home environment was not dementia friendly. The first floor corridors were difficult to differentiate and there was a lack of personalisation of the communal areas. Toilets and bathrooms were not easy to identify with only a written sign.

People's bedrooms were identified only by their name and a small current picture. We spoke with the registered manager about our findings who agreed that the home could be improved to better suit those with dementia. The registered manager told us that they had ordered memory boxes and life story boards to help people find their rooms and to support their identity. These boxes may contain pictures of people through their life and objects of significance to them.

We saw people could personalise their bedrooms with individual items such as family photographs, pictures and personal objects. Each bedroom seen was clean and comfortable with good space and seating for visitors to use and spend private time with their relative.

People were well supported to maintain a healthy balanced diet and spoke highly of the food on offer to them. One person said "I'm a poor eater and the cook is marvellous – he tries to tempt me as he wants me to eat and he doesn't want to waste things. It's easy to have an alternative to the menu – you don't go hungry."

The service provided good quality food with different options to choose from each day. The restaurant style dining environment was pleasant and the food well-presented when we visited. People ate independently but those requiring assistance from staff received it in a gentle and unhurried manner. One person was not enjoying their meal and staff presented them with an alternative which they accepted and enjoyed.

We spoke with the head chef who knew the needs of people well and was clear on people's dietary requirements and preferences. One relative told us "The staff and kitchen have been excellent in supporting [my relative] with the pre op diet that the hospital require and they are supporting [my relative] emotionally as I'm not here all day."

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 make 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. At the time of our inspection seven Deprivation of Liberty Safeguards (DoLS) were in place. Records confirmed that the appropriate paperwork had been submitted and the provider had a tracker in place to ensure that authorisations were kept current. Where appropriate, records showed that best interests meetings had been held with relevant partners.

People were supported to access healthcare professionals. One person said "I see a physio here privately and then I have exercises to do." Another told us "When the lady comes to do my feet we go into a corner in the library where it's quiet." People told us that staff would accompany them to any external appointments if a relative was unable to do so.

Care plans addressed healthy living and any support required for more specialist health conditions. Records showed people had good access to the doctor, optician, dentist and chiropodist. Professional visitor's notes were kept on people's files and recorded details of any appointments they had attended.

Good

Is the service caring?

Our findings

People felt that the home was caring and were happy with the nature of the staff. One person said "Wonderfully caring and they have got to know me." A relative said "Staff are consistently good, genuine manner."

Staff were also positive about the quality of care provided. They said the team worked well together to ensure this. One staff member said, "They get good care here. All the care staff try their best." Another staff member told us, "My residents are amazing. We get on well." A third staff member commented, "I would recommend it. They have freedom of choice. It's their home."

People were supported by staff who knew them well. Staff demonstrated a good understanding of people's needs and supported them with what they wanted. They were able to tell us about people's health, important relationships and their background. Life histories were documented to help staff to relate and engage with people positively.

An allocated 'resident of the day' process was used to focus staff on one person's care needs and make the day special for them. For example, having their favourite meal cooked, being supported to a favourite activity and having their room deep cleaned.

Staff said that people were always treated with dignity and respect. Staff gave us examples of how they made sure people's dignity was upheld. For example, making sure people's doors were closed for privacy when supporting them with personal care. One staff member said "I always keep people updated with what I'm doing." We observed staff treated people with dignity and addressed people using their preferred names. They knocked on bedroom doors and greeted people when they went in. One staff member said, "People are definitely treated with respect. I work with all the staff – they listen to people."

People were supported to remain as independent as they were able to, for example we saw that some people had the keys to their patio in order to have direct access to the outside space.

People were encouraged and supported to express their views. Care plans included details of any cultural or spiritual needs, for example their religious preferences and people told us that a chaplain attended the service on a Friday.

Good

Is the service responsive?

Our findings

Care plans were comprehensive and were reviewed regularly. Care plans addressed people's social needs and communication. Each care plan section addressed the person's likes, dislikes, what they could do for themselves and areas they required support with. Each record was kept up to date to help make sure they met people's individual needs. Each person's plan addressed their activities of daily living such as their mobility, nutrition, continence, personal care needs and any risks to their health and wellbeing. Where necessary, people and their relatives were involved in their care planning. People's preferred interests and activities were reflected in their care plan. For example, one person's care plan talked about their love of classical music and walks in the outdoors.

People were supported to maintain relationships with people that mattered to them and visitors were permitted any time of the day. Relatives were invited to dine with their loved ones and the home provided a private dining area should people wish to utilise it.

The wellbeing staff that delivered activities were held in high regard by people at the home. One person said "There's plenty to do and quite a variety. Outings – sometimes with a picnic lunch and if more want to go they just book more taxis. Richmond Park and a coffee stop or the pub lunches – a particular favourite of mine." Another person told us "I'm no longer interested in going out but there's plenty to do for the fitter folk and I go to some of the things indoors. Nobody pesters you but there are plenty of programmes around."

A relative told us "I arranged with the maintenance man to have one of the raised beds put on [my relative's] patio and we have planted it up together. I have also put a bird feeder which [my relative] loves." Where one person had expressed an interest in flowers they told us that the florist that tends to the home brought them extra, and we saw these evident in the person's room.

A full schedule of activities was in place aiming to address people's social, psychological and physical needs. For example, amongst others the service held Tai Chi sessions, visits from a pet therapy service, fruity Friday food tasting, interactive music sessions and ballroom dancing. A speaker was giving a talk on the day we visited and this appeared to be well attended.

People's preferences in relation to their end of life care were recorded on their files. Appropriate guidance was in place to support staff to care for people in line with their preferences. A visiting relative told us "Staff attend the funerals of residents – it helps the families and the staff as they have done a lot with those people."

People were clear on who they could report to if they had any concerns or complaints. One person said "Any concerns can be raised with anyone or brought up at the residents meetings". Staff told us that they would attempt to address any concerns themselves or would direct them to their senior. Records showed that the provider had a complaints system in place and that any actions and investigations were logged. Investigations into any verbal complaints were also kept and learning shared with staff when necessary.

Good

Is the service well-led?

Our findings

A registered manager was in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was compliant in their responsibilities to the Care Quality Commission.

The provider had an interim manager in post and were in the process of recruiting a new permanent home manager. Staff spoken with were unclear as to who was in day to day charge of the home and all said that the home would benefit from a sustained period under consistent leadership. One staff said, "There have been lots of changes in management. It's a bit confusing." Another staff member commented, "I am not 100% sure. I think we have an acting manager but the business manager seems to be in charge." Most people knew who the managers were but they were unaware that someone was in overall charge of the home.

The home manager was interim whilst the post was being filled. The registered manager had been the home manager but was currently in the role of business manager. We were informed that an application to deregister would be submitted once the permanent role of home manager had been successfully recruited.

We recommend that the service seek appropriate support, for the management team, to ensure the leadership structure is clear to people and staff. Following our inspection the provider presented us with evidence to show that letters had previously been sent to staff, people and their relatives to inform them of the management changes.

The managers that we spoke with were passionate about the care they delivered to people and interactions we observed were positive and supportive. The provider had quality assurance systems in place to identify trends and drive improvement across the service. Monthly quality audits covered topics such as care plans reviews, pressure ulcers and resident appointments. Environmental standards were routinely checked and maintenance records were kept up to date.

People at the home were supported to be engaged with how the home was run and share their views. Residents and relatives meetings were held quarterly covering topics such as food choices, wellbeing and activities and any maintenance issues. One person said "Food is talked about a lot – just menu ideas and the chef likes us talking about his food." Feedback cards were also made available to visitors upon entry to the home. We also looked at a comprehensive monthly newsletter that was made available to people that included details of any upcoming activities and photographs from recent events.

The provider told us of relationships they had built with local community groups. Local schools attended the service regularly for befriending and people were supported to attend events at the local community hall. People were also supported to attend services at the local church where requested.