Crown Care IV Limited

Balmoral Court

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

Summary of findings

Overall summary

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

Balmoral Court provides nursing and personal care for up to 58 mainly older people with dementia-related conditions and other mental illnesses. The home is set out over two floors, one designated for accommodating females and the other for males. At the time of our inspection there were 46 people living at the home.

The service was last inspected in August 2016 and rated as 'Requires Improvement'. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective and well-led to at least good. At this inspection we found the necessary improvements had been made in the management of medicines, upholding people's rights under mental capacity law, and to the governance of the service. The service had improved to good and met each of the fundamental standards we inspected.

A new manager was in post who had applied to be registered. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Systems were in place to safeguard people against the risks of harm and abuse. The home had been enhanced and the environment was clean, comfortable and equipped to meet people's needs.

There were enough skilled and experienced staff who provided continuity of care. The staff received training and support that enabled them to care for people effectively. People were appropriately supported in maintaining their health and nutritional needs.

Staff were caring in their approach and had formed supportive relationships with people and their families. They respected privacy and dignity and encouraged people to make choices about their care. Formal decision-making processes were undertaken with the involvement of advocates, when necessary.

People's needs were assessed and care planned, guiding staff about the care and support the individual required. A range of activities and access to the community was provided to support people in meeting their social needs. Good arrangements were made when people were cared for at the end of their lives.

The manager promoted an inclusive culture and provided leadership to the staff team. Feedback was sought and any complaints received were taken seriously and responded to. The quality of the service was continuously monitored to check that standards were maintained and improved.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service had improved to good.	**Good**
Is the service effective? The service had improved to good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service had improved to good.	**Good**

Balmoral Court

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 was 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 was unannounced and took place on 1 and 4 December 2017. It was carried out by an adult social care 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 service including the notifications we had received from the provider. Notifications are reports of changes, events or incidents the provider is legally obliged to send us within required timescales. Due to technical problems, we had not asked the provider to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We contacted commissioners, the local authority safeguarding team and Healthwatch, the local consumer champion for health and social care services. Comments received were used in our inspection planning.

During the inspection we talked with 10 people living at the home, four relatives, and spent time observing people's care experiences. We spoke with the manager, regional manager, deputy manager, clinical lead, two unit managers, three care staff including seniors, an activities co-ordinator, a domestic, the chef and the administrator. We reviewed five people's care records, staff training and recruitment records, and other records related to the management and quality of the service.

Good

Our findings

At our last inspection we found a breach of regulations regarding the management of medicines. There were shortfalls in checking stocks, monitoring storage temperatures, and in the directions and recording of medicines administration. During this inspection we judged the necessary improvements had been made and people's medicines were safely managed. Sufficient stocks of medicines were maintained, stored securely and administered by the nursing staff, who were trained and had their competency assessed. Care plans and information held with administration records explained people's medicines regimes and preferred methods. Protocols were in place for giving medicines prescribed on an 'as required' basis. A separate file was now kept with guidance for staff and specific care plans detailing the requirements of people who had their medicines given covertly (disguised in food or drinks). Administration records, with one exception, were accurately completed and supported that medicines were given safely. Thorough monthly audits were conducted to check that standards of managing medicines were met.

The people we talked with felt safe at the home and with the staff who supported them. Their comments included, "I feel very safe because I know I will always get the help I need" and "I like it here, I'm not on my own and that makes me feel much safer." A relative told us, "They really make sure (family member) is safe. The manager and the staff are great." Posters explaining types of abuse and how to report any concerns were displayed in the home to help promote the understanding of people and their representatives.

Staff were informed about the provider's safeguarding and whistleblowing (exposing poor practice) procedures and had received training in how to recognise, prevent and report abuse. A safeguarding flowchart had been devised that instructed staff on the steps they must take, including informing relatives. The manager and staff we spoke with understood their safeguarding responsibilities. Allegations had been notified to us, the local authority safeguarding team and a log was kept that evidenced the action taken in response. This had included performance managing staff, internal investigations, and working with a specialist behaviour team when untoward incidents occurred between people living at the home. The service had systems to account for and audit money held for safekeeping on people's behalf.

Records demonstrated that new staff were checked and vetted to ensure their suitability before they started work. Dependency tools were used each month to calculate the staffing levels required to safely care for people. The manager told us, and rosters confirmed that staffing had been increased in line with occupancy and the complexity of people's needs. Cover for absence was provided by the existing care staff and nurses, supplemented by nurses from an external agency until two vacant nurses' posts were filled. Staff were employed who were responsible for activities, catering, housekeeping, laundry, administration and

maintenance to support the running of the service. The manager, deputy and clinical lead operated an on-call system that enabled staff to get advice or support out of hours.

During our visits we observed no instances of unsafe or inappropriate care. People were suitably supervised without unduly restricting their freedom or privacy. Where people's actions might present risks to themselves or others, we saw staff carried out and recorded 'close observations' to monitor their safety. Care was taken to mitigate risks before new people were admitted to the home. For instance, we heard the manager assuring a relative about what needed be in place in readiness for their family member's admission.

The service had policies for staff to follow on data protection, confidentiality and sharing of personal information. Clear expectations were set about care recording responsibilities and paper-based and electronic records were readily accessible to staff. Records were mostly up to date and care plans provided staff with sufficient details about how to provide safe care. Risks associated with people's care had been assessed and measures were taken to maintain personal safety.

Any accidents and incidents were reported on and analysed. This led to updating people's risk management, provision of aids/equipment including door alarms and sensor mats, and referrals to other professionals. Small double size beds were also being filtered into the home to help reduce the risks of falls from bed. Lessons were learned when things went wrong in the service and were used to make improvements. Learning points from safeguarding issues, complaints and untoward incidents were reinforced with staff to heighten their awareness and make changes to practice.

We observed all areas of the home were clean and odour-free. People told us, "They (domestics) come in every day and tidy up, clean the bathroom and the floors" and "My room is kept spotless." Staff were guided by policies and procedures about the prevention and control of infection and had received relevant training, including food hygiene. Any chest, urine or other infections that people experienced were documented along with the courses of treatment prescribed. Personal protective equipment such as disposable gloves and aprons was supplied for staff use. A unit manager, who took the lead role for infection control, told us some areas had needed to be improved, resulting in the provision of practical, face-to-face training with staff. They showed us they did regular infection control audits that included observing practice, such as hand washing. An audit had also identified the lack of an available kit for efficient cleaning and disposal of spillages, which had now been rectified.

A range of internal checks were made to ensure the environment and facilities were safe and suitably maintained. Records and certificates verified servicing by contractors of gas and electrical safety, fire equipment, the passenger lift, nurse call system, hoists and testing of portable electric appliances. Fire safety checks were carried out and the home had taken remedial action following a visit from the fire brigade. Personal plans were devised to support people in the event of needing to be evacuated from the home. A business continuity plan and arrangements for escalating emergencies to the provider's senior management team were in place.

Good

Our findings

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.

At our last inspection we had found a breach of regulations regarding consent to care. At this inspection we judged the service was applying the MCA to uphold the rights of people who did not have mental capacity to make decisions about their care. The manager had established where people had an appointed power of attorney and a more proactive approach was taken to assessing capacity and making decisions in people's best interests. It was evident from records that decisions had now been made on people's behalf, involving relatives and professionals, about specific areas of care. These included the use of safety aids and following formal processes to authorise medicines being given covertly. A 'best interest assessor' and an interpreter had recently visited to support a person, whose first language was not English, with decision-making. The manager told us they were committed to working in people's best interests and had, for example, requested GP's to review the extent of anti-psychotic and sedative medicines prescribed.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The majority of people living at the home had DoLS in place to ensure they were provided with the care and treatment they required.

New staff were provided with induction training to prepare them for their roles. This included undertaking the 'Care Certificate', a standardised approach to training for new staff working in health and social care. Thereafter, staff received training updates in safe working practices and other topics in line with the needs of people living at the home. The manager reported they worked with the provider's other care homes in sharing training, particularly in aspects of clinical skills. Eighteen of the care staff had achieved nationally recognised vocational qualifications in care and a further four were studying for these qualifications.

A delegated system and planner was in place for providing staff with individual supervision and appraisals to support their personal development. Staff we talked with felt they received a good level of training and were well-supported. They told us, "The manager is supportive and is guiding me through my career", "I'm

growing in confidence" and "It's much better since the manager started. We've got good nurses and more staff."

People and relatives confirmed that staff had the skills and experience to provide the support required. One relative said, "Nine months ago I refused to let my (family member) come here, but I came back a few months ago when the new manager came and it is so much better. I can't fault it. There's been so many changes to how the place looks. They look after (family member) well and they look after us too."

A rolling programme was in place to continue to enhance the building. Some bedrooms had been redecorated and new furnishings provided. Communal spaces and corridors were now themed with pictures, memorabilia and other items of interest which helped people interact with their surroundings. A relative told us, "The place is kept nice and fresh. The walls have recently been painted and the flooring has been changed as well."

Staff had completed training in good nutrition and hydration for older people. People's nutritional needs and risks were assessed, care planned and dietetic advice was sought when necessary. Weights and food and fluid intake were monitored. Special diets were catered for and the menus had been revised. Menus with choices of meals and photographs were displayed. We observed people were appropriately supported by staff and encouraged with eating and drinking. Snacks and drinks were served between meals and were also laid out in lounges and at a 'snack station' for people to help themselves.

A staff member told us they felt the food provided had much improved in recent months. We saw meals looked appetizing, were of good portion size, and there was little waste. People confirmed they could have alternatives to the menu and said they enjoyed the food. Their comments included, "The food is good, I like it", "You don't go hungry here", "I like a jacket potato and you can have beans, cheese or tuna or the lot if you want" and "I have a cooked breakfast and there's a choice of meals. The café is very good."

Staff worked with other professionals to co-ordinate care when people were referred to the service. New admissions were phased and, if necessary, there was a series of pre-admission assessments to determine whether the person's needs could be met. Staff confirmed that information about the person was relayed to them in advance of admission. Where a person was being cared for in hospital, the manager aimed to arrange 'formulation meetings' prior to them coming to the home. These meetings were held between the home's staff and ward staff, including the consultant where possible, to discuss and help plan the person's care and treatment. People were allocated named nurses and key workers with particular responsibilities for their support. We observed there was a real sense of teamwork, with staff working well together and being given direction by the management and senior staff.

The manager told us the service worked to best practice guidance to deliver effective outcomes for people. This included following guidelines from The National Institute for Health and Care Excellence on medicines practice and techniques in preventing and managing violent and aggressive behaviours. Lead roles were allocated to the management and senior staff who were suitably skilled and had undertaken advanced training. These included mental health, dementia, medicines, end of life care, infection control, fire warden and two staff identified to become moving and handling facilitators. Unit managers and a senior carer were working towards becoming qualified as Care Home Assistant Practitioners. This role extends the responsibilities and clinical skills of care staff with supervisory experience, enabling them to further support the nurses in meeting people's needs.

People accessed a range of health care services to support their physical and psychological wellbeing. Good working relationships had been established with NHS mental health services, the local challenging

behaviour team and a nurse specialist continued to visit the home at least weekly. Medical history information had been obtained, care plans addressed health needs and all contact with other professionals was recorded and passed onto staff. The service was implementing NEWS, an early warning score developed by the Royal College of Physicians, that monitors vital signs with the aim of detecting changes in people's health. Relatives told us health care professionals were contacted when required and felt they were kept informed about their family member's health and welfare.

Good

Our findings

People living at the home spoke positively about their care and the staff who supported them. Their comments included, "It's great here. The staff are excellent", "They're fantastic, oh yes marvellous. They will give you whatever help you need", "The care is great, second to none", "The staff are really, really good. They're really helpful and cheerful and we always have a good chat", "There's plenty of staff and plenty of help and they're all very, very good" and "It's hard to describe how good the staff are. They are all nice people."

There was a relaxed and welcoming atmosphere in the home. Relatives we talked with told us, "This is a brilliant place. It's made a massive difference to (family member). He is much more calm and settled" and "The staff are great because they care. The whole character of the place has changed with music in the background, newly painted walls and I know there's more planned. It's like 'home from home' for (name)." Another relative said, "Staff have a good understanding of (family member's) needs."

There had been changes in the staff team, however those staff we talked with knew people well. They were able to give accounts of people's backgrounds, their lifestyles and the support they needed. Where individuals were resistant to being supported, staff recognised the best approaches to take to gain their co-operation. For example, a unit manager explained how a new person responded better to female staff and had updated their behavioural care plan accordingly.

During our visits we saw the staff and management were visible on both floors of the home and spent time engaging with people. They were polite and friendly, and used humour appropriately and to good effect. We observed instances of staff intervening and showing compassion when people were anxious or distressed. They were very patient, listened to and acknowledged how the person was feeling, and stayed with them until they were reassured and calmer.

The manager told us they instilled in staff the importance of flexible routines and encouraging people to make day to day choices. This was reflected in our observations where we saw people were offered choices, given time to make decisions and supported at their preferred pace. People told us that they chose where they spent their time and could get up and go to bed and have a bath or shower when they wanted. One person commented, "We've just started up the residents meetings again and I'm the Chair."

The service aimed to employ staff of the right calibre, with caring qualities and checked their values during interviews. The manager said they often worked alongside staff, observing their care practices and would

not tolerate uncaring attitudes. The clinical lead told us, "We've got good relationships with residents and their families and have very caring staff." Dignity training had been provided and a member of staff was designated as the 'dignity champion' to promote best practice. People we talked with confirmed that they were treated with dignity and respect.

Information was made available to keep people and their visitors informed of what to expect from the service and about what was happening in the home. A dementia-friendly' version of the guide to the service had been introduced. Photographs and information about staff, the 'residents committee', social events and survey results were displayed. Relatives told us they felt involved in their family member's care and represented their views. Some people had also been supported by Independent Mental Capacity Advocates, who safeguard the rights of people unable to make important decisions about their care and treatment.

Good

Our findings

We observed that staff were attentive towards people and responded to their needs and requests in a timely way. They quickly identified any potential conflict and defused tense situations between people by diverting their attention or conversations. People living at the home felt that support from staff was readily available. Their comments included, "Someone's always nearby if you need anything" and "They're quick to come if you need help."

The service used an electronic form of care recording that prompted if any records were overdue to be completed. Reviews of care were being added into the system and reports were run to keep a check on different aspects of people's care and welfare. The manager was keen to use and was looking into technological and therapeutic aids which would benefit people living with dementia.

Care records showed that people's needs were assessed before admission and assessments were updated on a monthly basis to confirm current needs and the level of dependency. This information had been used to develop individualised care plans. The plans set out the care and support staff needed to provide, the person's routines and any risk factors. There was evidence the effectiveness of care plans was regularly reviewed and that plans were adapted if the person's needs had changed. Staff recorded day and night reports accounting for the care given to each person and commenting on their wellbeing. Additional records were made, either in paper form or electronically, which helped monitor specific areas of people's care. Profiles had also been drawn up to give staff information about individuals, their backgrounds, interests and how they liked to be supported.

A full time co-ordinator was employed who organised a flexible monthly programme of social activities, including one-to-one sessions with people, outings and events. They had good stocks of activities materials and told us they were supported by other staff and that relatives got involved with activities. Records were kept of each person's participation in activities, though not always by staff when the co-ordinator was off duty. We were given assurance this would be addressed.

During our visits we saw people enjoyed activities, such as arts and crafts, and using the 'Balmoral Bar'. This was a room on the upper floor which was set out as a traditional style bar with drinks and a social area where people met to talk, read newspapers, play snooker or watch television. Christmas activities and events were planned, including a party for people, their visitors and staff. Links with the community had been made and people continued to go out to a social club for meals and entertainment. Individuals were also accompanied by a staff member to go shopping or use other amenities in the local community. Primary

school pupils, college students, police cadets, a local church choir and pet therapy visited the home. Hairdressing services had been secured and a beautician was being sourced.

The deputy manager used their expertise as a trained palliative care nurse in making the necessary arrangements for people to have a dignified and pain-free death. We noted they liaised with a person's GP and heard them being insistent with the pharmacy on the telephone about promptly supplying anticipatory medicines (for timely symptom relief) which had been prescribed. Detailed care plans were in place which addressed all areas of comfort and safety for the person who was being cared for at the end of their life. We saw they looked very comfortable in bed and well cared for. The manager had purchased a special pillow, in the shape of a body that hugged the person. The person's relatives felt this was a very good idea and comforting. They told us, "We can't praise the staff enough, or fault the care (family member) has received." The relatives said staff were supportive, provided refreshments and were pleased their family member, who had lived at the home for a number of years, could continue to be cared for here. The manager confirmed that staff were arranged to sit with the person, so they would not be left alone, when their relatives were not able to be there.

The home's complaints procedure was displayed and an easy read version was provided in the guide to the service. People and their relatives said they would speak to the staff or manager if they had any concerns. A relative told us, "The manager said to me that if I've got any problems just to talk to her, and I would." No-one we talked with had any complaints about the care or the service in general. Complaints made over the past year had been investigated and responded to.

Good

Our findings

A new manager had been appointed four months ago who had applied to the Care Quality Commission to become registered. The manager was supported by the regional manager, managing director and had established a supportive senior team with a range of nursing and care qualifications, skills and experience. The manager's hours and a proportion of the deputy manager and clinical lead's hours were supernumerary to staffing levels to enable them to effectively fulfil their managerial responsibilities.

At our last inspection we had recommended the provider ensure standards of care and communication were more closely monitored. At this inspection we judged that the governance arrangements had been strengthened and there was improved oversight of the service. Engagement with staff and people's families had progressed and quality assurance of the service was more robust.

The manager acknowledged they had faced challenges when they started, including the need to replace nursing staff who had left and build a cohesive team. They had held meetings with all grades of staff and heads of department who were accountable for different areas of the service. Minutes from meetings showed the manager praised the team for embracing the changes to practice that were being implemented and reinforced standards. Staff surveys had been carried out to look at morale, confidence and any further support needed. The provider's benefits for staff included a pension scheme, an employee assistance programme, discounts and free influenza vaccinations.

Staff told us they worked collaboratively, had good leadership and were committed to their roles. Their comments included, "Everyone is passionate about making a difference", "We're seeing the impact of effective care" and "We get positive feedback from relatives and staff are motivated by the changes being made."

Letters had been sent to relatives introducing the manager and profiles of staff were displayed in the reception area. The manager hoped that future meetings for relatives would be better attended and the first resident committee meeting had been held. Relatives had completed satisfaction surveys and people had completed surveys about the food, which had influenced improvements.

The manager told us that 'duty of candour' was part of everyday practice, ensuring families were kept informed about any safeguarding concerns or other matters affecting their family members. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

People and their relatives were very complimentary about the manager and staff and felt they had significantly improved the home in a short period of time. They told us they had seen improvements to the atmosphere in the home, the environment, the care, teamwork and staffing. One person said, "Balmoral Court is a good place to live." All described the manager as being approachable, having an 'open door', and a visible presence in the home.

The manager worked in partnership with their peers and other health and social care professionals. They were keen to develop further links with the community and raise the profile of the home. For example, invitations were being extended to older people living alone in the local area, to come to the home on Christmas day.

The provider's quality and compliance manager completed in-depth bi-monthly quality audits, resulting in an action plan that the regional manager monitored. The manager reported to the regional manager on a weekly basis about occupancy, any safeguarding concerns, complaints, staff issues and updates on the action plan. This in turn was formulated into a report to the provider's senior management to keep them appraised. The regional manager had regular contact and prepared detailed monthly reports on the service, including feedback from people, visitors and staff. Internal audits checked quality in areas such as medicines management, care recording, housekeeping, the environment, and safety. The manager and regional manager then audited the audits to confirm they had been conducted correctly and review the findings.

The manager had worked night duty and visited the home unannounced during the night to check the standards of people's care. Observational audits of people's care experiences were also planned to be introduced. The manager told us they were currently consolidating standards of person-centred care and working to a business plan in developing the service. The plan included more activities co-ordinators hours as occupancy increased and purchasing further equipment and themed items to support people living with dementia. A minibus to be shared by the provider's group of care homes was also being sourced.