Laudcare Limited

Kingsmead 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

This was an unannounced inspection which took place on 26 January 2015.

Kingsmead Care Home is registered to provide care with nursing for up to 43 people. There were 38 people in residence on the day of the inspection. The home does not use the double bedrooms for two people. People have their own bedrooms and all but one bedroom have en-suite facilities. The home is purpose built over two floors. There are spacious shared areas within the home and gardens.

There is a registered manager running the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe in the home. The registered manager and staff team were trained in and understood how to protect people in their care from all types of harm or abuse. People said: ''nothing unpleasant happens here''. A relative said: ''I am 100% happy my mum is safe''

Summary of findings

General risks and those specific to the individual were identified and managed appropriately. The service looked at any accidents and incidents and learnt from them. They tried to ensure they did not happen again, if possible. The staff and registered manager took all health and safety issues seriously to ensure people were kept as safe as possible.

The service had enough staff to keep people safe and meet their needs. The minimum numbers of staff, as identified by the registered manager, were always on duty. The way staff members were recruited meant that the provider was as sure as they could be that staff were suitable and safe to work there.

People were given their medicines in the right amounts at the right times. Medicines were stored safely. People and their families told us they received: ''very good healthcare''. People were supported to make GP appointments and make contact with other healthcare specialists as necessary.

The service understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. They had taken any necessary action to ensure they were working in a way which recognised and maintained people's rights. The service liaised with the local authority with regard to people's mental capacity and made appropriate DoLS referrals.

People's capacity was identified on their care plans. Plans clearly described which decisions people were able to make, about what and when they could make them. Staff knew what action to take if people did not consent to care.

People told us the: ''food is very good, you can't fault the food''. Menus included fresh healthy food and people were helped to eat their meals, as necessary. People's nutritional needs were assessed regularly and any action needed to meet changing needs was taken.

Staff had built strong relationships with people who lived in the home and their families. Staff members knew people well and were able to describe and meet their needs. Staff interacted very positively with people throughout the inspection. They used humour and appropriate physical contact to relate to and comfort people.

The home provided a variety of activities which people could participate in if they chose to. People were treated as individuals and their choices and wishes were respected. Treating people with dignity and respect was an important part of the way care was given. Those people who were able were encouraged to maintain their independence for as long as possible.

People who used the service, families and staff told us the service had a good manager and they had every confidence in her. Staff told us that the home had a very open and positive culture and they felt valued and respected. The registered manager was well known to the people who lived in the home and was very involved with their care.

The service checked the quality of care they were providing by using a variety of methods. These included the registered manager regularly looking at all aspects of the running of the home. Improvements and developments were made as a result of the quality checks.

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.

Staff knew how to protect people from abuse and people felt safe living there.

Any health and safety or individual risks were identified and action was taken to keep people as safe as possible.

People's medicines were given to them at the right times and in the right quantities to keep them as healthy as possible.

Is the service effective?

Good

The service was effective.

Staff understood consent, mental capacity and deprivation of liberty issues. People were helped to make as many decisions and choices as they could.

People were helped to see G.P s and other health professionals to make sure they kept as healthy as possible.

Staff were properly trained to ensure they could meet people's needs.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and dignity at all times.

Staff built strong relationships with people.

The service worked with other specialists to provide the best and most appropriate care for people at the end of their life.

Is the service responsive?

Good

The service was responsive.

People were listened to and care was delivered in the way that people chose and preferred.

People were offered daily activities which helped them to enjoy their life.

People knew how to complain. Their concerns and complaints were listened to and action was taken, as necessary.

Is the service well-led?

Good

The service was well-led.

The registered manager knew people well and was involved in their care.

Summary of findings

The home had an open and positive culture and people and staff felt they were listened to and respected.

The home regularly checked that the home was giving good care. Changes to make things better for people who lived in the home had been made.

Kingsmead 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.

This unannounced inspection was completed by one inspector and took place on 26 January 2015.

Before the inspection we looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law. After the inspection we looked at the Provider Information Return (PIR) which the provider sent to us. 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 looked at the quality assurance report provided by Swindon Borough Council, which was completed on 4 December 2014. A care manger and health professionals provided us with information about the service after the inspection.

We looked at six care plans, daily notes and other documentation relating to people who use the service such as medication records. In addition we looked at auditing tools and reports, health and safety documentation and a sample of staff records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with four people who live in the home, four relatives of people who live in the home, seven staff members, the area manager and the registered manager. We looked at all the information held about six people who lived in the home and observed the care they were offered during our visit.

Good

Is the service safe?

Our findings

People told us that they felt very safe in the home. One person said: ''nothing unpleasant happens here''. A relative said: ''I am happy she is in safe hands'' another said: ''I am 100% happy my mum is safe''. Staff members told us that the home was: ''safe and comfortable for residents and staff''. People, relatives and staff told us they had never seen anything they were not comfortable with.. A relative said : ''I am confident that the manager protects people in her care''.

Training records showed that 56 of the 57 care and ancillary staff had received safeguarding training, which had been up-dated in 2014.One staff member was in the process of completing the training. Staff had an in-depth understanding of their responsibilities with regard to protecting the people in their care. They were knowledgeable about the signs of abuse and what would constitute a safeguarding concern. They described, in detail, how they would deal with a safeguarding issue. This included whistleblowing and reporting concerns outside of the organisation, if necessary. One staff member told us: ''we stay alert for any poor practice or poor care, that's our job''. The registered manager had made appropriate safeguarding referrals to other agencies. She had taken all the necessary steps to keep people safe.

People's care plans included any necessary risk assessments. The identified areas of risk depended on the individual and included areas such as choking, bed rails, behaviour that may cause distress to the individual or others and mobility. Care plans instructed staff how to minimise the risk to individuals as far as possible. The service used recognised assessment tools for looking at areas such as nutrition and skin health.

The service ensured the safety of the people who lived there, staff and visitors. The registered manager and staff team completed detailed generic health and safety risk assessments and conducted regular health and safety checks. We looked at a sample of the checks and assessments. Health and safety checks included weekly, monthly and three monthly fire equipment, monthly call bell and monthly water valves. The last monthly checks had been completed at the end of December 2014. Health and safety risk assessments included trips/slips and falls, office working, young persons in the home and dogs visiting the home.

Detailed incident and accident records were kept. Incident reports included unexplained bruising. A full description of the incident or accident, the investigation, if any and the actions taken were recorded. Action plans were cross referenced to care plans and risk assessments and any necessary actions added to those documents. All accidents and incidents were added to the provider's computer recording system called 'datix'. Managers at various levels of the organisation were able to access the records. The computer programme alerted the home and the organisation if records were not completed or if there were any areas of concern identified. We saw an example of an incident that had been thoroughly investigated and a series of actions had been taken to minimise the risk of any recurrence. Staff knew about the incident and what preventative actions they needed to take.

People were supported by staff who had been recruited safely. There was a robust recruitment procedure which included the taking up of references, police checks and checking people's identity prior to appointment. Application forms were completed and interviews held. Records of interview questions and responses were kept.

People said: ''staff always have time for you''. People agreed and we observed that if they rang their bell staff would arrive quickly. One staff member told us that there were: ''plenty of staff to keep people safe''. Others said: ''there are enough staff to offer safe care but more would be nice''. Minimum staffing levels and skills required to meet the needs of people in the home were calculated from a CHESS (Care Home Equation for Safe Staffing) dependency tool. The registered manager told us they staffed above the number recommended by the tool. There were a minimum of nine care staff on duty during the daytime hours and five during the night. Direct care staff were supported by a team of ancillary staff. We looked at rotas for the preceding 12 weeks and saw that staffing levels did not drop below those described. The registered manager had the authority to provide additional staff, as necessary to ensure the safety and comfort of the people who lived in the home.

People received the correct amount of medicine at the right times. The service used a monitored dosage system (MDS) to assist them to administer medicines safely. This

Good

Is the service safe?

meant that the pharmacy prepared each dose of medicine and sealed it into packs. Medication records included people's photographs and the name they preferred to be called by.

The medication administration records (MAR) were accurate. Qualified nursing staff administered medicines on the first floor and care staff trained in giving medicines administered medicine on the ground floor. The Registered nurse showed us the processes they followed to administer medicines. They explained that the medicine round, on the first floor, sometimes took two hours. We saw that the time medicine was given was written on the MAR sheet. This meant that medicines could be given at the right intervals to ensure they worked as they should. Medicines were stored safely and the trolley was locked when not in sight of the staff member.

There were guidelines in place for people who had medicines prescribed to be taken as and when required (PRN). Staff were able to describe clearly when PRN medicine would be given for pain and to help people to manage their behaviours. However, the detailed guidelines were kept in care plans rather than being easily accessible in the medication files. Body maps were used to instruct staff where to apply creams and lotions.

Good

Is the service effective?

Our findings

People told us that they: ''really like the home''. One person said: ''we get very good care''. A relative told us: ''the home gives excellent care it cannot be faulted''. Another said that their family member was very happy in the home.

People and their families told us they received: ''very good healthcare''. People were supported to make healthcare appointments when necessary. Records noted appointments with healthcare professionals and any necessary follow up actions. Specialist healthcare support, such as continence advisors, Parkinson's consultants and end of life care advisors, was sought as required. We saw examples of the service's staff team working closely with a local hospice to ensure they offered the best end of life care they could. Visits by other professionals such as G.Ps, tissue viability nurses and social workers were recorded. People's health needs were reviewed every month, by staff allocated to have oversight of an individual's needs (key workers). People had received their flu injections and other routine healthcare and well-being check-ups and procedures, as appropriate. A relative told us that their family member was now bed bound. They said that the care plan reflected their current needs, staff checked on them frequently and answered all their needs. Other professionals told us that staff were approachable and had a shared interest in meeting people's clinical needs.

One person told us: ''we make all our own decisions, while we can ''. People's capacity was identified on their care plans in each area of care such as finances and personal care. The specific decisions people were able to make and when about these areas was included. Plans noted clearly if people were able to make small or large decisions about their life and described people's possible variable capacity. They described how staff should assist people to make as many decisions as they could. There were clear guidelines to inform staff what action to take if people did not or could not consent. Staff described how they constantly assessed people's ability to make choices.

The registered manager and other staff demonstrated their understanding of consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted DoLS applications to the local authority, as appropriate. These were mainly for people who were unable to leave the home unaccompanied. Door code pads were used as the least restrictive method of keeping people safe. Records showed that 49 of 57 care and ancillary staff had received DoLS training. Ten senior staff had received full Mental Capacity Act 2005 training and other staff were clear about who to approach and what action to take if they had any concerns about people's ability to consent.

People who lacked capacity to make significant decisions were provided with a formal advocate called an IMCA (independent mental capacity advocate). Some people had a valid power of attorney. A power of attorney is someone who is able to legally make specific decisions on another person's behalf. These people help to make sure that all decisions were made in people's best interests.

During the inspection staff were interacting positively with people and their families and visitors. Staff were laughing and joking with people who were responsive and animated. People were given time to join in with conversations and constantly asked their views and feelings about what was going on. When offering assistance staff described what they were doing and people were asked for their permission before care staff undertook any care or other activities.

People told us the: ''food is very good, you can't fault the food''. A relative told us: ''the home is very accommodating. They try hard to tempt her with food she really likes''. The menus were well balanced, included healthy fresh food and reflected people's tastes and choice. People chose where to eat their meals. Many chose to eat in lounges or their private space. Staff members used humour and gentle persuasion to encourage people to eat. There was laughter and positive interaction between staff and people in the dining areas. Staff asked colleagues, who had a more developed relationship with an individual for advice and assistance about how to support someone to eat.

Records showed that two people had lost weight and two people had gained weight in the previous month. The service provided people with additional or alternative foods and staff support to ensure they were eating their meals, if issues were identified. Referrals were made to health care specialists if people's weight control became a health issue. The registered manager completed a monthly audit of weight records and recorded the reasons for fluctuations. Staff were instructed whether to increase the frequency of weight checks and any other changes to the care plan that may be necessary. Nutritional assessments, weight, food and fluid charts were accurately completed for individuals, as necessary.

Good

Is the service effective?

Staff were trained in areas relevant to the care of the individuals who lived in the home. Training was delivered by a variety of methods which included e– learning and face to face training. Examples included dementia care and palliative care. Thirty-four care staff had achieved an NVQ or diploma level 2 (or equivalent) or above and six further staff were completing a qualification course. Staff told us they had good opportunities for training

Staff told us they received formal supervision approximately every three months. They could request supervision from senior staff at any time. Records showed and staff confirmed they had an annual appraisal. Staff said the service had good staff morale and good team work because they were well supported, at all times.

Good

Is the service caring?

Our findings

People who lived in the home told us: ‘‘staff treat everybody with respect’’. People said: ‘‘staff are very careful to help people with dementia or Alzheimer's keep their dignity’’. Relatives and people told us that the staff and manager were very caring. One relative told us the staff team: ‘‘do the little caring things, nothing is too much trouble’’. Throughout the inspection we saw that staff treated people with compassion and care. Examples included offering appropriate physical re-assurance and comfort to someone who was upset and making sure a person’s personal possession which gave them comfort was in easy reach.

Staff were trained in how to offer privacy and dignity and in equality and diversity. They gave us examples of how they ensured they respected people’s dignity. These included knocking on doors, ensuring curtains were closed and offering people the alternative of same gender staff members. Staff also explained how the use of appropriate body language and acceptance of people’s differences showed respect and preserved dignity. Relatives told us that staff members never forgot to close curtains or knock on doors and that they were very re-assured by the staff’s caring attitude towards their family member. Staff described some ‘experiential training’ they received which had made a big impact on their understanding of people’s feelings and vulnerability. This involved staff members being a resident for the day and having a simulated sensory loss or disability.

Care plans noted people’s spiritual and cultural views and wishes. People were assisted to worship as they chose to. Staff explained how diversity in the staff team had a positive impact on people who lived in the home. They understood the importance of people’s culture. Staff members gave us an example of one person who chose to eat a special diet and converse in their first language. Some of the staff had a thorough knowledge of the chosen diet and were able to talk to the person as they preferred.

People were encouraged to be as independent as they were able. Care plans noted how much people could do for themselves and were clear about the level of encouragement or support they needed in specific areas of care. One person told us: ‘‘they respect my independence and work hard to make sure I can stay as independent as possible’’.

People were helped to maintain relationships with people who were important to them. Relatives and friends were welcomed to the home and there were no restrictions on times or lengths of visits. Relatives told us: ‘‘everyone is made to feel very welcome and made to feel part of the family’’. Staff were very knowledgeable about the needs of individuals and had developed good relationships with them and their families. Staff responded quickly to people if they asked for or showed that they needed assistance.

People told us that they attended their review meetings and were involved in their care planning, if they chose to be. Care plans were looked at every month. People’s views on their care, if they were able to express them, were noted on the reviews. The registered manager recorded how they involved people and obtained their views if they were unable to express them verbally.

Care plans included end of life care wishes and funeral plans. Staff had received training in end of life care and were supported by the local hospice service to provide as comfortable and pain free end of life as possible. Do not resuscitate forms were completed appropriately. They noted the discussions the G.P had with individuals, families and any other relevant parties. Advance decisions were recorded where relevant. G.Ps completed verification of expected death forms. These were put in place so that registered nurses could take the necessary actions when someone died, rather than having to wait for a doctor to attend. Records showed that when people were at the end of their lives, staff completed hourly reports, as a minimum, and people were not left alone.

Good

Is the service responsive?

Our findings

People had a full assessment of their needs prior to moving into the home. The assessments were completed by the registered manager or a senior staff member. A care plan was written, with the individuals, from the information included in the assessment. Care plans were reviewed monthly.

Each person had individualised plans which described their tastes, preferences and choices about how they wished to be supported. Staff were trained in person centred care and demonstrated their understanding of what this meant. They told us that the care plans and their knowledge of people meant that each person was treated in the way they wanted and according to their needs. Staff members discussed and described the varying needs of people, from those who needed encouragement to stay as independent as possible to those who needed end of life care. One staff member told us that there had been a big improvement in the last few years and person centred care was now: ''at the heart of what we do''.

Staff were responsive to requests by people who lived in the home. For example one person asked for a cup of tea during a medicine round. The staff member immediately asked another staff member to supply the tea, which they did in a very short time. We saw this type of response throughout the inspection.

People were able to choose from range of activities what they would like to participate in, on a daily basis. People told us there was: ''enough to keep you happy if you want to join in''. One person said: ''there's always something going on but I generally choose to do my own thing''. The activity programme included activities such as visits to the local school, dog visits and lunch clubs. The garden had raised flower beds so that people could get involved in the gardening, weather permitting. Activities staff included specialist activities such as visiting a steam museum and organising a D-day memorial. We saw that people were encouraged to participate in the everyday activities and routines of the home. This included laying tables and helping to tidy their rooms.

People told us they knew how to make a complaint and wouldn't hesitate to do so, if necessary. They said they would go to the manager, if they needed to, but were confident that any staff member would listen to them and take action. The home had a comprehensive complaints procedure available to people and their families. Staff were provided with written instructions of how to respond to any complaints received. Complaints, the investigation and resolution were recorded in detail. All complaints and concerns were entered on the computer system used by the service and could be accessed by senior managers throughout the organisation. All complaints had been dealt with effectively and had been resolved to the satisfaction of the complainant.

The home had recorded eight complaints and 13 compliments since the last inspection.

Good

Is the service well-led?

Our findings

People who live in the home told us that they had a good manager who: ''expects high standards''. They said they had every confidence in her. People and staff told us the manager: '' is very approachable, she listens to and helps everyone''. Staff told us that the home had a very open and positive culture and they felt safe to: ''admit mistakes because they are used for learning rather than blame''. All team members told us they felt valued and respected. They said they were listened to and made contributions to the quality care the service provided. People and their relatives told us that the manager had a good rapport with everyone in the home. We saw the registered manager communicating with a person explaining what was happening about a request the person had made. The registered manager was well known to the people who lived in the home. Staff told us she was very involved with people, always available and often worked with staff 'on the floor'.

The home held regular meetings for staff, people who lived in the home and relatives. Minutes for the staff meeting held on 15 January 2015 included the discussion of issues such as DoLS, safeguarding, infection control and reviewing wound and illness care plans daily.

People who used the service, their friends and family, staff and other professionals were sent quality questionnaires each year. Results from the questionnaires were analysed by the provider and an action plan was developed, as necessary. Action was taken to rectify any shortfalls identified. Changes made as a result of the quality assurance and monitoring and reviewing systems included replacing flooring and the provision of an additional cleaner.

People received good quality care. The service had a variety of internal reviewing and monitoring systems to ensure the quality of care they offered people was maintained and improved. Care quality indicators were reviewed monthly. They included pressure ulcers, nutrition, infections, and bed rail use and staff supervision. The records of the monthly reviews contained explanations of what was being done about any areas of concern. Five care plans per month were audited and action plans written, if necessary. The key worker was responsible for ensuring any improvements were made.

The registered manager, staff and people who lived in the home knew what roles staff held and understood what responsibilities this entailed. The registered manager told us she was given the authority to make decisions to ensure the safety and comfort of the people who live in the home. Examples included being able to have additional staff and ordering emergency repairs, as necessary.

People were supported by staff who were aware of some of the latest relevant developments and guidance. The service had been registered by the PEARL (positively enhancing and enriching resident's lives) scheme. This is a training initiative accredited by Bradford University and is based on dementia mapping. Staff were completing this face to face training provided by the organisation's learning team.

People's needs were accurately reflected in detailed plans of care. Records related to the care of individuals were complex and information was repeated in a number of places. However, staff completed them accurately. They cross-referenced information to make it easier to find and 'track' any actions taken. The registered manager had developed a system to enable staff to locate information quickly. Staff members were able to find any information we asked to look at promptly.

Records relating to other aspects of the running of the home such as audit records and health and safety maintenance records were accurate and up-to-date. The Provider Information Return (PIR) which the provider sent to us accurately assessed what they do well and what needs improving. It reflected the service positively whilst noting future development to maintain and improve the quality of care offered.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

Enforcement actions

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