Blanchworth Care Limited

Kington Court Community Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Kington Court Community Care Centre is a residential care home which provides personal and nursing care to people either permanently or temporarily. People living at Kington Court Community Care Centre are older people, who may live with physical disabilities, sensory impairment or dementia. There were 30 people living at the home at the time of the inspection. The service can support up to 48 people. The building is purpose built with all the accommodation and communal space located on the first floor.

People's experience of using this service and what we found
People did not always have risks to their safety managed effectively. Risks within the environment were either not clearly identified or suitable action was not always taken to keep people safe. These risks included window safety, water temperatures, call bells and use of wheelchairs.

Peoples' medicines were not always managed safely. Staff were not always managing and recording people's pain relief patches effectively and in line with the manufacturer's instructions to ensure people fully benefited from these. Clear action was not always taken when potential errors were made by staff members.

People's care needs were not always met in a timely way by staff members. Observations made were fed back to the management team.

Management systems and audits had not always identified or actioned areas whereby improvement was required in order to keep people safe. Where improvements had been acknowledged these were not always sustained by staff consistently.

Feedback from people's family members were positive in relation to staff and the care provided.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 08 November 2019).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been sustained and the provider was still in breach of regulations. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to the management of medicines, staffing and management follow up. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. In addition, this inspection was based on the previous rating of requires improvement.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

The overall rating for the service has remained as requires improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kington Court Community Care Centre on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people's safety, medicines and good governance at this inspection.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Kington Court Community Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Kington Court Community Care Centre 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first day. We announced our return so as to ensure a member of the management was able to be present at the location.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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 used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and one relative about their experience of the care provided. We spoke with fourteen members of staff including the registered manager, the operations manager, the clinical lead, an agency nurse, two residential coordinators, five care staff, one activities coordinator, one receptionist and one maintenance person. We carried out an observation during a mealtime to help us understand people's experience.

We reviewed a range of records. This included three people's care plans plus a small number of others which were viewed for specific information and multiple medicine records. We looked at two staff files in relation to recruitment. In addition, we looked at records relating to the management of the service. We viewed the environment where people were living.

After the inspection
We continued to seek clarification from the operations manager and registered manager including a meeting using electronic technology. We sought and reviewed additional information. We also spoke with three relatives of people for their experience of the service provided.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection we found shortfalls with the safe management of medicines and a potential risk within the environment. This was a breach of regulation 12 (Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were at risk of harm due to insufficiently managed or recognised environmental risks. The providers own policies were not always followed.
- The registered manager was aware a first-floor window had been identified as at risk of falling out. Although the registered manager believed the window to be bolted this was not in line with our findings. The window was unsecured and therefore at risk of falling to the ground and potentially causing injury. In addition, people and staff were at potential risk of falling from a height and sustaining significant injury.
- The provider's own policy regarding hot water temperature checks were not always carried out at all points of delivery at the frequency stated within the policy. This meant the provider could not be regularly assured water temperatures were not too hot which could potentially result in scalding incidents.
- People were at additional risk of injury by staff who assisted people in their wheelchair while failing to ensure their feet were on the footrest. This presented a risk of entrapment.
- People did not always have access to a call bell while in their bedroom. Risk assessments were not in place when staff told us people were at risk of injury in the event of them having a call bell lead at hand. Not having a call bell meant people were not able to call for assistance from staff.
- Management had identified some people to be at risk of dehydration and therefore staff needed to keep a record of their fluid intake in order to monitor people's fluid taken. Staff were either not always recording people's fluid intake or not ensuring people had enough fluids. This placed people at risk of not having their individual needs met.
- Some people were receiving thickener in their drinks to assist with swallowing difficulties. The date the thickener was opened was not indicated on individual containers. These items have a limited time when opened before the manufacturer recommends the disposal of any remaining thickener. There was a risk the thickener could be used beyond this time frame.
- Nursing staff were not always ensuring people had their pain-relieving patches applied in line with the manufacturer's instructions. Records introduced following concerns identified at the previous inspection were not always completed accurately.
- Gaps in medicine records where not followed up in a timely way to improve practice and ensure people received their medicines as prescribed. Medicine counts and medicines carry forward from a previous month were not always accurate.

● Topical creams were not always applied in line with the frequency prescribed by a medical professional. It was not always clear where creams were to be applied. These shortfalls meant people may not have received the care and support they needed in line with the prescriber's instructions.

Systems were either not in place or robust enough to ensure people were safe and their wellbeing managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The window at risk of falling out was boarded up following us bringing the concern regarding people's safety to the attention of the operations manager.
● We were further reassured documents were reintroduced regarding body maps for creams to ensure staff had information required to inform them of where these items were to be applied.
● Additional reassurance was given regarding an investigation to be carried out to establish the reasons behind a medicine recording error and actions put in place to prevent this happening again.
● The provider was aware of the need to refurbish a kitchenette area within the home where staff were preparing drinks and meals such as breakfast. Work surfaces were seen to be damaged while the drink trolley and trays were stained. We were informed of the actions in hand for the refurbishment of this area.
● Where people had prescribed medicines on an "as required" basis there were protocols for nurses and other staff to follow.

Systems and processes to safeguard people from the risk of abuse
● Staff we spoke with informed us of the actions they would take in the event of them having concerns about potential abuse of people living at the home. However, staff did not put this knowledge into practice to inform the registered manager when people could have come to harm through medicine errors.
● The registered manager and the operations manager were aware of their responsibility regarding the reporting of incidents. Records were maintained in relation to concerns investigated by the management team following information received by the Care Quality Commission.

Staffing and recruitment
● Staff we spoke with raised concerns about the staffing level on the residential side of the home. At the time of the inspection twelve people were living in this area with two members of staff. One of these staff members needed to carry out additional duties such as administer medicines. The management team believed staffing levels met the needs of people living at the home.
● Our observation on the first day of the inspection around lunch time evidenced people were not always having their individual needs acknowledged and met in a timely way due to staff deployment. One person did not receive suitable support to ensure they were encouraged or assisted with their meal in a timely way. Staff did not recognise the person needed assistance. Another person requested assistance to go to the toilet and staff were not present or available to assist this person at the time they were needed.
● The registered manager informed us of a recent increase in night staff to ensure the needs of people were able to be met.
● Family members spoke highly of the staff team. One relative described the care as, "Brilliant" and told us staff were, "Worth their weight in gold" and go "Out of their way to be caring."
● The provider's recruitment procedures included checks prior to new members of staff commencing their employment. These included reference checks to ensure they were of good character and checks through the Disclosure and Barring Service (DBS).

Preventing and controlling infection
● We were somewhat assured that the provider was using personal protective equipment (PPE) effectively

and safely. Staff were seen at times to have their face mask below their nose. Some staff had lowered their mask while for others their mask had slipped. This posed a risk of avoidable infection transfer between staff and to people living at the home.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. Family members confirmed they undertook a test for COVID-19 prior to seeing their loved ones and needed to wear PPE including gloves, aprons and a mask.

Learning lessons when things go wrong

- The registered manager reviewed accident and incident records and fully analysed these to identify any trends or patterns. We saw incidents such as skin tears were recorded, and short-term care plans implemented.
- The provider had ensured concerns raised by people to the Care Quality Commission and shared with the local authority were investigated and where necessary action taken to make improvements.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The governance and oversight of the service were not sufficient to ensure the safe care and treatment of people living at the home. Quality checks and audits failed to identify areas of concern including areas of risk in relation to people's health and safety.
- Environmental checks had failed to identify risks including an unsafe window. The risk associated had not been brought to the attention of the provider to ensure prompt action was taken to keep people safe and not at risk of serious injury.
- Staff meetings earlier in the year had highlighted some concerns similar to those found as part of this inspection regarding medicines. The provider had assured us improvements had taken place following a previous inspection. However, we found shortfalls as part of this inspection. Staff practices regarding the applying of pain relive patches received we not compliant with instructions and guidance available to the staff team which placed people at risk of harm.
- Audits had not identified the providers own policies were not followed in relation to environmental checks. For example, we found conflicting information regarding the frequency of checks. The most recent record for checks for the safety of windows restrictors was in June 2020. The operations manager confirmed this should be done monthly.
- Although there was evidence the registered manager had identified some similar concerns to those, we highlighted regarding face masks and calls bells, these concerns remained. We found call bells leads for example were not only unplugged but the lead put away within the person's draw.

The provider's governance systems were not fully effective in areas including quality assurance and auditing systems. These shortfalls placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured by the operations manager new systems were introduced without delay following our findings in relation to the checking of window restrictors and hot water temperatures. We will review these as part of the action plan requested from the provider.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The majority of staff felt supported by the registered manager and operations manager. Some staff did feel additional support was needed. This comment was fed back to the operations manager at the time of the inspection.
● Relatives told us they believed the service to be well managed. One relative told us they had received support from the management and staff team in relation to their loved one's care. Another relative told us they found the registered manager to be, "Easy to talk with."
● Relatives felt engaged as far as possible during the pandemic in the care and support of their family member.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● The registered manager and operations manager acknowledged the findings of this inspection and where necessary took immediate action to keep people safe. It was acknowledged areas should have been identified and acted upon sooner. Assurances were given to make additional improvements.
● The provider worked with other agencies such as the local authority in addressing any concerns received by them. The provider was transparent in their finding when areas were recognised as needing improvement.
● Relatives told us they had confidence in the management team and believed they could raise any concerns they had.
● The registered manager was aware of the requirement to inform the Care Quality Commission of certain events through statutory notifications.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to ensure people were safe and their wellbeing managed. Regulation 12 (1) (2) (a), (b), (d), (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were not fully effective in areas including quality assurance and auditing systems. Regulation 17 (1), (2), (a), (b), (c)