Alliance Care (Dales Homes) Limited

Kingston 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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection on 8 March 2018. Since the previous inspection of this service Kingston Care Home has had a change of ownership from Four Seasons (No. 10) Limited to Alliance Care (Dales Homes) Limited. As a result this is the service's first inspection under its new ownership.

Kingston Care Home 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.

Kingston Care Home provides nursing and residential care for sixty-seven older people. The home is located opposite Kingston Hospital with good access to public transport. Accommodation is provided over three floors that are served by a passenger lift. At the time of inspection 53 people were using the service.

The registered manager had recently resigned and the service was actively recruiting for a replacement.

People told us they felt safe at Kingston Care Home. There were appropriate safeguarding policies and procedures in place, staff had received training in safeguarding adults and had a good knowledge and understanding of how to identify if people were at risk of abuse and knew what action to take in these circumstances.

Risks were identified and plans were in place to monitor and reduce risks to help keep people safe.

There were systems in place for the safe storage, administration and recording of medicines. Each person's medicine was stored securely and only trained and competent staff were authorised to administer medicines. During the inspection all medicine records we observed had been filled out correctly and medicine audits were completed to ensure medicine procedures were robust.

Staff had been recruited safely with appropriate checks on their backgrounds completed. Staff had completed an induction programme and on-going training was provided to ensure skills and knowledge were kept up to date.

We observed positive and appropriate interactions between the staff and people who used the service. Staff were caring and treated people with kindness, dignity and respect. People and their relatives were complimentary about the quality of care they received.

There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. People were encouraged and supported to eat and drink well and their nutrition and hydration were monitored regularly.

Staff had received training which gave them the knowledge and skills to support people effectively. Staff had

received training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). People were asked for their consent to the care and support they received. Where people were unable to give informed consent staff acted in people's best interests.

People and their relatives were encouraged to express their views and opinions. They knew how to complain and make suggestions, and were confident their views would be acted upon. The provider had a complaints procedure to support this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were protected against unsafe care by robust safeguarding policies and procedures.

Risks to people's safety and welfare were assessed and measures were in place to reduce risks.

The management of medicines was safe and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective. People's needs and choices were met by staff who knew and understood their needs. Staff had the knowledge and skills required to carry out their roles.

The manager and staff understood the main principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS).

People's health was regularly monitored and they had access to a variety of external healthcare professionals and services. People were supported to have sufficient amounts to eat and drink and to maintain a balanced diet

Is the service caring?

Good

The service was caring.

Staff treated people with kindness, dignity and respect.

Their privacy was respected and promoted.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes.

Is the service responsive?

Good

The service was responsive. People's treatment, care and support was reviewed regularly.

There were a range of activities available within the service to ensure people did not experience social isolation.

People were encouraged to voice their concerns or complaints and they were confident any concerns would be acted upon.

Is the service well-led?

Good

The service was well-led.
There were systems in place to assess, monitor and improve the quality of the service people received.

There was a positive culture within the home that was focussed on people as individuals. People were enabled to make decisions and share their views.

Staff were supported by a management team which ensured staff had opportunities for support, learning and supervision.

Kingston 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 inspection took place on 8 March 2018, and was unannounced. The inspection team included two inspectors, a specialist advisor with expertise in people's medicines and an expert-by experience, whose expertise included caring for older people and dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law. We reviewed safeguarding alerts and information received from a local authority.

We spoke with 11 people using the service and four relatives who were visiting. We spoke with the regional manager, deputy manager and catering manager as well as seven care staff including nurses and care staff.

We reviewed the care records for 12 people residing in the home and looked at how medicines were managed and the records relating to this. We looked at eight staff files and the records kept for staff training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

Good

Is the service safe?

Our findings

People and their relatives told us they felt they received care that was safe. One person told us, "Oh yes. I feel safe here." Another person said, "Once I fell just outside the front entrance and they helped me immediately."

During this inspection we looked at staffing levels for day and night shifts and found there was an adequate number of staff to keep people safe. On each floor there was an average of four care assistants supported by one registered nurse throughout the day and night. Domestic staff were on hand throughout our inspection.

Staff we spoke with had a good understanding of how they kept people safe within the service, would recognise signs of abuse and report any concerns they had. For example, one member of staff said they would "report and record it, tell the senior who reports to the manager who will report to the local authority safeguarding team." Another member of staff gave an example of what they would do if they found someone had fallen to the floor and told us they would "call the Senior, not move the resident because you might cause more damage, stay by the person's side, and you must remain calm."

Staff had received training in safeguarding vulnerable adults as part of their induction programme with on-going refreshers as part of their mandatory yearly training.

Recruitment checks were carried out before people could work at the service. Each staff file had a checklist to show that the necessary identity and recruitment checks had been completed. These included proof of identification, references, qualifications, employment history and checks with the Disclosure and Barring Service (DBS). Nurses' personal identification numbers (PIN) were updated as required. In line with best practice the provider asked staff to complete criminal record declarations every three years. Recruitment files included photo identification, proof of residence and professional references. This meant that people were protected against unsuitable staff.

Risk assessments were completed to help keep people safe. Each file contained a 'care alert' at the front detailing key areas of risk including areas such as falls, medicines or lack of mental capacity. Risk assessments were comprehensive and covered areas such as mobility, falls, skin integrity and nutrition. The home used a number of standardised evidence-based tools to assess people's needs, such as the Malnutrition Universal Screening Tool (MUST) to monitor people's nutrition and the Waterlow assessment tool to monitor people's skin integrity. We saw evidence that people's risk assessments were reviewed monthly or when required.

People received their medicines in a safe manner. 'As required' (PRN) medicines and 'homely remedies' (medicines which can be purchased over the counter) were administered safely following clear protocols. There was clear guidance on the administration of covert medicines which included the requirement that there had to be the involvement of the multidisciplinary team and with the family. At the time of inspection there was no one who had medicines administered covertly.

Medicines records showed that there were appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were receiving their medicines as prescribed and any reasons for not giving people their medicines were recorded. Where medicines were prescribed to be given 'only when needed' or where they were to be used only under specific circumstances, individual 'when required' protocols were in place. The protocols gave administration guidance to inform staff about when these medicines should and should not be given. This ensured people were given their medicines when required and in a safe and consistent way.

Controlled drugs were stored appropriately and were signed by two staff when administered. There were appropriate arrangements for the receipt and disposal of medicines.

The premises were clean and well maintained. Staff had completed mandatory infection control training and we observed domestic staff taking pride in their work. Staff followed the service's uniform policy and used protective clothing such as gloves, which decreased the risk of transmitting a healthcare associated infection. We observed good hand hygiene practice when we were present. Wall mounted Hand sanitizers were filled with gel and were available throughout the home, and in the individual rooms used by people with high dependency.

Good

Is the service effective?

Our findings

People felt supported by staff who knew them and who had sufficient skills and experience to carry out their roles. One person said, "They are very good. No complaints at all." Another told us, "They vary a great deal but most of them are excellent. About 90% of them are good. They often do extra duties such as accompanying residents to the hospital."

A relative commented, "They're very good. I asked them to help me to turn [my relative] and I've been reading his care plan and they are turning [my relative] every 2 hours."

People's care and support needs had been assessed and discussed with them prior to their admission to the service. A full assessment of their needs was completed which involved the person and their relatives or friends where appropriate. This covered people's health and mobility needs their likes, dislikes, daily routines and communications needs.

Staff told us there were good opportunities for training and confirmed they had received training and refreshers. The service maintained records of staff training which identified when staff needed to be updated. One staff member told us, "We have had training in mental capacity and safeguarding and we have that every year. We have to be able to demonstrate knowledge and awareness following the training and we are encouraged to ask questions."

All new staff received an induction that introduced them to the home, taught them the basics they needed to know, the policies and procedures and mandatory e-learning. Care staff went through a period of shadowing other, more experienced staff before being allowed to work unsupervised.

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.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager had a good understanding and awareness of their role and responsibilities in respect of the MCA and DoLS and knew when an application should be made and how to submit one. Applications made to deprive people of their liberty had been properly made and authorised by the appropriate body. Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and DoLS.

Staff continually checked that people were happy with what they were doing and activities they had chosen throughout our visit. People's capacity to make decisions and consent to treatment was regularly monitored by the service and recorded in their care plans.

People were supported to eat and drink enough to maintain a balanced diet. People told us they were offered a choice of food and drink at meal times and most people were happy with the quality of food. Comments included, "It's very good" and "They write down every night what we want the next day." Relatives we spoke with also told us they were happy with the choice and quality of the food provided.

We observed lunch on the day of inspection and saw that the atmosphere was relaxed and friendly. Where people required supported with feeding this was completed in an unhurried manner with staff giving people positive encouragement and support. People were informed of their meal choice as it was presented to them and were offered beverages throughout. Some people received their meals in a puréed form depending on their individual needs. Puréed meals were presented in an appetizing manner.

The chef spoke knowledgeably and passionately about the service's philosophy regarding meals for people and was able to demonstrate how people's individual preferences, cultural needs and health needs were accommodated when planning and preparing meals.

People had access to healthcare services and received on-going healthcare support. Care records showed input from health and social care professionals including optician, audiologist, mental health team, occupational therapist and palliative care nurse. We saw the GP visited the home for a regular session each week. People also had access to an in house dietician and speech and language therapist.

Good

Is the service caring?

Our findings

People spoke positively about the caring attitude of the permanent staff. One person told us, "Oh it's very good. All the staff get on well with the residents and likewise. I've not seen or heard any confrontation." Another person said, "They're very good, very patient. I have difficulty walking and I need to be on this chair that needs to be wheeled from my room to the lounge. I just tell the staff I want to go and they take me."

A relative told us, "They're very good. The communication between the staff is great. They help me to call the family and stuff like that."

People and their relatives were involved in the planning of their care and support. Records contained information on people's life histories including family relationships, work and social history. Details of people's preferences and likes and dislikes were also recorded. People's rooms were personalised with keepsakes and photographs. Where one person had a like for flowers recorded in their care plan we saw flowers and pictures in their room. Care plans were regularly reviewed to reflect any changes in people's needs.

Care records included specific details of how staff should support people with any assessed need. For example, one care record contained instructions on how to make sure a person was sitting upright whilst eating in order to minimise the risk of choking.

Relatives were kept informed of the care people received. Care records included details of discussions with people's significant others and these covered a range of issues such as updates on health issues and wellbeing.
The deputy manager told us that staff were encouraged to ask themselves what they could do to create a special moment for people at the home. An example of this was where a resident wanted to watch a movie in a cinema and this trip was arranged for them.

People had their dignity and privacy respected. Staff were observed knocking on people's doors before entering rooms. Staff told us they felt it was important to be sure of the likes and dislikes of people in order to provide a service that was caring. One member of staff said the best way to do this was to "get to know the resident and their families. It is also important to learn how to deal with difficult situations so I don't make things worse for the person."

Staff had a good understanding of person-centred care and what it meant. One member of staff said person-centred care was when you "think about how you would like to be treated, and think about the other person's needs, wants and choices." Another member of staff explained that people "have different care needs and you give care the way the person wants it."

People could choose where to spend their time, where to have their meals and when to get up or go to bed. We observed people moving freely around the home and visitors were able to visit at times that suited them.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. For example, one person had stated their preference for being assisted by care staff of the same gender which was respected. Another person required the support of staff to choose appropriate clothing for the day. Staff responded to this in a way that ensured the person was able to maintain their dignity whilst exercising choice and autonomy.

The service had an activities team which produced a range of in-house activities as well as opportunities for trips out. Examples included music, religious services, arts and crafts and fitness sessions. Occasional "Friendship Days" invited friends and family to visit for tea and cake.

Staff told us that activities were based on people's interests and what they told them. One person told us, "I usually find something to do. If I don't want to participate in anything here I can go to my room and watch my television or read the paper."

Activity recommendations along with likes and dislikes were in people's care records, including potential activities that they could engage in if they preferred to stay in their own room. For example, we saw one example where therapeutic hand massage was documented.

People knew how to give feedback about their experiences of care and support. The provider had a complaints system to ensure that matters were investigated effectively. One of the provider's values was 'sort it' and staff were encouraged to problem solve in their day to day work. At the time of our inspection the provider had managed one complaint and this had been resolved satisfactorily. Records of compliments were also kept including thank you cards following people's departure from the home and gratitude to the chef following arrangement of a birthday party.

People's communication needs and preferences were also recorded and staff were able to communicate with people who were not able to read or understand conventional notices or records. For example, someone for whom English was not their first language had arranged with a relative to supply information to care staff as to what was the most effective way to communicate. This included phrases and words in the person's mother tongue and staff felt it was an effective tool which they could use to respond to the person's needs.

People told us they knew who to complain to if they needed to. One person told us, "I once made a complaint about the food and about another resident at the home. I was able to tell them what was wrong and my points were listened to and registered."

Another person told us, "I haven't had to make a complaint. It would depend on what the complaint was but generally I would speak to the home manager."

People's wishes in respect of care towards the end of their life were documented in care records. These were completed with the person, their family and, where appropriate, with any other person such as health

professionals.

Good

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager in post. 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 registered manager had recently resigned and the service was actively recruiting a replacement. The deputy manager was managing the service supported by the regional manager.

The deputy manager said "We have an open door policy for all" and "If someone asks to speak with a manager I'll go and see them in their room, I always look to remain visible."

People and their relatives were encouraged to express their views through quarterly residents and relatives meetings. Monthly meetings were also held for residents to discuss activities, trips, entertainment and any one to one activities they wanted to partake in. A staff survey had been completed and the provider was in the process of collating the responses.

The deputy manager was passionate and clear on the values of the organisation and told us how these core values were established across staff training. The workforce across the home were referred to as a 'team' regardless of their roles and this supported the provider's aims of developing an inclusive and positive culture.

The provider had implemented a range of audit systems to quality assure and monitor performance whilst driving improvement across the service. Each month the home was responsible for auditing a range of topics under care, support, environment, staffing and leadership to monitor quality compliance. A recent training audit had identified the need for staff to complete fire safety training and records showed that this had been booked. Audits included responses from both people and the staff team to ensure that stakeholders were engaged and involved. Part of the deputy manager duties was to complete daily walkarounds to check on people's welfare, environment and observe care giving.

The home worked in partnership with other agencies including a health "Impact" team which provided support and extra care in situations not requiring emergency services. Good links had been built with regular attendance from the Princess Alice Hospice and working alongside the continuing care assessment team in relation to DoLS. A local nursery also attended the home to undertake activities with people such as storytelling and arts and crafts.

People spoke positively about their ability to communicate and raise things with the management team and their overall satisfaction with the home. One person told us, "Oh gosh, yes. Very easy to speak to people and I would recommend the home to others." Another person said "it's a nine out of ten." Relatives were also complimentary about the care provided and the atmosphere in the home.

The management team understood their responsibilities in line with the requirements of the provider's registration. They were aware of the need to notify CQC of certain changes, events or incidents that affect a person's care and welfare. Records and information was stored securely and confidentially.