Kincaid House
Care Home Service

Kincaid House
Oakfield Terrace
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PA15 2AH

Telephone: 01475553920

Type of inspection:
Unannounced

Completed on:
28 June 2024

Service provided by:
Kincaid Care Limited

Service provider number:
SP2021000161

Service no:
CS2021000264

About the service

Kincaid House is a care home service registered to provide support to a maximum of 90 older people. The maximum number includes four named people under the age of 65. The service is located in a residential area of Greenock. It is close to local amenities, including shops and transport links. The provider is Kincaid Care Limited operated by the Meallmore Group.

The care home is a purpose built property with accommodation over three floors, divided into three units - Arran, Bute and Waverly. All 90 bedrooms have ensuite facilities that include a wet floor shower room. People also have access to communal bathrooms on all floors. There are lounges and dining facilities, satellite kitchen areas and adapted bathrooms on each level. The garden area is landscaped.

There were 89 residents living in Kincaid House when we visited.

About the inspection

This was an unannounced inspection which took place on 25, 26 and 27 June 2024 between the hours of 07:30 to 19:30. The inspection was carried out by three inspectors from the Care Inspectorate and supported by a Care Inspectorate volunteer. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection. In making our evaluations of the service we spoke with:

- 13 people supported
- 25 family members
- 20 staff and managers
- two visiting professionals.

In addition to this, we took account of feedback from Care Inspectorate surveys from 21 staff, 11 people using the service, 25 family members and five external professionals. We also observed practice and daily life and reviewed documents.

Key messages

- Staff engaged with people and their families in a meaningful, friendly and sensitive manner.
- People's health and wellbeing had improved since moving to the service.
- Development is needed to support people with their medication correctly.
- Effective quality assurance systems benefitted people's health and wellbeing.
- People were supported by skilled and knowledgeable staff who knew them well.
- Partnership working with other professionals enhanced people's outcomes and experiences.
- Some care plans need further development to ensure monitoring of people's health is clearly set out.
- The service is supported by a strong and supportive management team.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	5 - Very Good
How good is our staff team?	5 - Very Good
How good is our setting?	5 - Very Good
How well is our care and support planned?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

We evaluated this key question as good, where several strengths had a positive outcome for people and clearly outweighed areas for improvement.

People living in the service had positive experiences and were treated with compassion, dignity and respect. Staff engaged with people in a meaningful, friendly and sensitive manner. People told us "Staff are magic, I am happy and love it here". People's families spoke positively about their relationships with the service and how well their relative was cared for. "Staff don't just care for my mum; they care about her". This demonstrated that the service had built meaningful relationships with people and their families.

People and their families were at the forefront of planning care. The service had a good system to carry out initial assessments for people moving to the home. People using the service, their families and other professionals were involved in the assessment process. The service worked alongside other professionals to ensure they were prepared to meet people's needs. This ensured planned care and support was right for each person.

Legal documentation was in place to support the involvement of others in care planning where people did not have capacity to make decisions about their care. Positive risk-taking was supported by families who acted as advocates for their relatives. For example, where people had been identified as a falls risk. Risk assessments were used to safeguard people whilst also enabling independence. This meant that people's social and emotional needs were valued as well as their physical wellbeing.

Where people were known to experience stress and distress, person centred plans were in place to offer guidance to help maintain people's emotional wellbeing. We observed staff adopting a calm and sensitive approach to prevent and avoid escalation of distressed reactions. This evidenced that staff had a good awareness of how to support people with signs of stress and distress in a personalised manner. Some people required medication to help reduce distressed reactions. Some medications were prescribed to be taken as and when required, known as PRN medication. Where PRN medication is prescribed, a clear protocol should be in place to offer guidance on when this should be given, the desired effect and when further action should be taken. PRN protocols sampled didn't always clearly set this out. Records of administration of PRN medication were inconsistent. This means there is potential that people may not receive their medication correctly which could impact their emotional and physical wellbeing. **See area for improvement 1.**

The service had a good overview to monitor people's support with their nutritional needs. Where people were at risk of malnutrition, regular assessment was taking place. Support measures included weight monitoring, providing food supplements and referrals to dieticians. Screening tools used to monitor people's weight highlighted where people had gained weight. This meant that the service was proactively supporting people with their nutritional needs.

Observations of mealtimes were well organised to ensure people had the right level of support with their meals. People told us the food on offer was plentiful and they had access to regular drinks and snacks through the day. 'Strictly come dining' events had taken place over the year which enabled people to have tasters of the various meals on offer. People were asked for their views which had influenced the development of menus. This promoted people's choice, inclusion and control.

Monitoring of people's care and support was not always carried out consistently, such as records of people's fluid intake and bowel management. While there was no evidence of people's health and wellbeing being adversely impacted by our findings during the visit, the service's ability to make informed decisions to ensure support is responsive to changing need may be limited. For example, where monitoring of recordings may highlight further interventions to support people to remain hydrated or promotion of healthy bowel function. We have discussed this further in the report under section 'what the service has done since the last inspection'. **See area for improvement 2.**

Areas for improvement

1. To ensure people receive their medication in line with their assessed support, the service should review the content of PRN (as and when required) protocols. This includes clearly setting out guidance on when medication should be given, the desired effect and when further action should be taken. Recording of administration of PRN medication must be in line with the agreed protocol.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state: "Any treatment or intervention that I experience is safe and effective' (HSCS 1.24).

2. To ensure responsive decision making is taken around people's health and wellbeing, the service should improve recording and monitoring that relate to hydration and bowel management.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15) and 'Any treatment or intervention that I experience is safe and effective' (HSCS 1.24).

How good is our leadership? 5 - Very Good

We found significant strengths in aspects of the care provided and how these supported positive outcomes for people, therefore we evaluated this key question as very good.

Effective quality assurance systems were used which had enabled the service to have clear visions for continuous improvement. The service completed regular audits that related to people's health and wellbeing, infection control, medication and care planning. Where areas for improvement were identified, these had led to actions with timescales for completion. Clear links were made between the service improvement plan and the actions identified from audits. This demonstrated the service had a good overview of areas for development and were prioritising these in accordance with risk.

The manager carried out a monthly service review. Senior managers used this information to evaluate the overall performance of the service. We viewed this as an effective and responsive tool to support the service to make improvements.

The service evaluated people's experiences to further drive continuous improvement. This ensured that feedback led to improvement. People and their families shared their views and opinions about the service by completing surveys and attending meetings. Staff told us that they felt listened to, respected and included. People we spoke with told us that managers were very visible and supportive. This meant that there was a collaborative approach to improving the service.

During our visit we looked at how the service takes learning from any concerns raised to improve the service. Systems to record complaints were robust and we were satisfied that the complaints process followed the organisation's complaints policy. Families told us that any concerns they had raised had led to a satisfactory outcome. This assured people and their families that their views and opinions mattered.

The management team worked collaboratively with external stakeholders to strengthen service delivery. During our visit we heard about the ongoing partnership working with the local authority to engage with improvement projects such palliative care and positive behaviour support. This demonstrated the investment and commitment of the service to improve the quality of life and outcomes for people.

How good is our staff team? 5 - Very Good

We found several strengths in the support provided that led to people having positive outcomes and experiences. Therefore, we have evaluated this key question as very good.

Staff had a good understanding of people supported and positive relationships had established which extended to people's families. During our visit to the service, we saw people's families and visitors made welcome by staff. We observed genuine and familiar interactions between staff, people and their families. People's families told us "I know most of the staff by their first name" and "They know me, and I know them". This highlighted the service's strengths to develop meaningful connections with people and their families.

People should be supported safely by the right number of people with the right knowledge and skills to meet their needs. The service carried out regular assessments of people's needs to ensure that changing needs were recognised and influenced staffing levels. There had been an increase in staffing levels in some areas of the home due to a rise in falls. A review of falls over the following months noted a reduction. This indicated that the service adopted a proactive approach to ensure staffing arrangements were right to keep people safe. Sampling of the staff rota assured us that senior staff and nurses were available throughout the day and night to offer leadership and guidance to care staff when needed. Staff arrangements ensured a good skill mix of staff, experience and knowledge. This meant that staff were responsive to the needs of people supported

The service promoted staff's continuous learning and development in line with the Scottish Social Services Council (SSSC). A robust training plan was in place setting out requirements for all staff to complete mandatory and essential training. This included adult support and protection, manual handling training, medication training, dementia awareness and infection prevention and control. Compliance levels for the completion of training were high. This demonstrated that staff had the right knowledge and skills to support people safely. Staff told us about recent training delivered by the clinical psychologist and how this helped them to have a better understanding of people living with a cognitive impairment. Staff were encouraged to reflect on their learning through one-to-one supervision, this enabled staff to apply their learning into practice. This meant that staff had a greater understanding of how to support people to meet their needs. We suggested learning which we felt could further enhance staff skills when supporting people with de-escalation of behaviours that may challenge. We also discussed the importance of debriefs with staff to offer support following any incidents. The service has agreed to explore this further.

There was a good sense of wellbeing and positivity amongst the staff team. Overseas staff working in the service were encouraged to hold cooking nights to share cultural knowledge and offer each other peer support. This demonstrated good practice to promote and develop team work. A range of wellbeing supports for staff was taking place such as staff recognition and employee of the month schemes.

Staff we spoke with told us they felt valued, and management were approachable and supportive. This demonstrated that the service recognised the importance of staff wellbeing which contributed to a positive environment for people supported.

How good is our setting? 5 - Very Good

We evaluated this key question as very good, as people benefitted from a safe and well-maintained environment that enabled people to have many positive outcomes.

The service was bright, fresh and clean throughout and maintained to a good standard in line with legislation and health and safety standards. The service improvement plan included plans for refurbishment and re-decoration. People and their families were involved in decisions about the refurbishments of communal areas. This meant that people were included in decisions about their home. An assessment of the planned activities in the home had taken place which involved feedback from people supported. Communal spaces had recently been re-purposed to be better utilised to meet specific people's interests. This is hoped to promote people having opportunities to make additional connections with like-minded people.

The service benefits from a large secure garden that is accessible to people using the service. There were planned improvements for the garden area and some of these works were under way during our visit. The garden was used well in recent months to benefit people's well-being. Intergenerational days had taken place and we heard about a local school sports day held in the garden area. People and their families spoke very positively about their enjoyment of the day and having this celebrated in the local newspaper. This benefitted people's physical, social and emotional needs and provided opportunities for people to meet.

People were encouraged to have freedom to explore and move around the home independently as far as possible. We observed groups of people choosing to sit together in communal areas and at the front reception. This contributed to a positive and welcoming atmosphere for people living in the home and visitors.

How well is our care and support planned? 4 - Good

We have evaluated this key question as good, as several strengths taken together outweighed any areas for improvement.

The service had a strength-based approach to personal planning, which included the involvement of people and their families as well as relevant professionals. Families told us that they had met with management and were asked about their family members' preferences and life history. Care plans detailed people's preferences, likes and dislikes and routines. Examples viewed stated people's choices in relation to how they wanted to dress, what activities they liked to be involved with and recognised people's abilities. People told us "Staff can't do enough for you; you can't get any better than this". This evidences good practice around person-centred planning.

There was a strong focus on enablement and independence in the service. People's families told us that their relatives care had improved since moving to the service. Where people's independence, choice and control were restricted, the service managed this in a person-centred way considering risk and outcomes. Risk assessments were completed for people identified as a falls risk. Where risk reduction measures included restrictive practice, people and/or their families were involved, and relevant consents were in place. One family told us that their mother's mobility had improved "Mum has a new lease of life."

This meant the service supported people to maintain skills where possible.

A multi-disciplinary approach was taken to personal planning. Care plans sampled included evidence of support from health professionals such as district nursing, GPs, speech and language and mental health teams. This meant the service was seeking support from external professionals outwith their expertise to meet people's needs.

Good communication was used to share information when people's needs had changed. During our visit we observed essential information being shared with staff at shift handovers. This included changes to people's assessed support in areas such as diet and nutrition and medication. Staff were made aware of people who required additional monitoring due to ill health daily. This ensured that people had safe and effective care that met their individual needs.

People and their families where at the heart of discussion around planning care. Families we spoke with all told us they had attended care reviews and were able to advocate for their relative where they were unable to do so for themselves. People and their families were asked to contribute to care plans. Some families we spoke with had not seen their relative's care plan, but were confident that care was provided in line with their relatives needs. This gave families reassurance and confidence that their relative's care was right for them.

People's care plans should set out their views and wishes for their future care and toward end-of-life. Care plans sampled varied in detail about people's future care needs. The service is currently part of a palliative care programme which involves enhanced training for staff. On discussion with the management team, we were confident that this was a recognised area for development and plans were in place to enhance the content of people's future care plans.

The content of some people's care plans was not always set out consistently to clearly establish support and monitoring of their health needs. We have discussed this further under area for improvement 5 in the section "what the service has done since the last inspection".

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

Personalised programmes of activities in place for each resident living in the home should continue to develop and take account of the abilities and preferences of everyone experiencing care. The service should include people's views around increased access to technology and the repurposing of underused communal spaces.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS), which state: 'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day' (HSCS 1.25).

This area for improvement was made on 6 June 2023.

Action taken since then

The service benefitted from dedicated activity workers who were enthusiastic, skilled and knowledgeable.

A wide range of planned activities were taking place regularly and planned monthly. Feedback from people supported, as well as their families had been sought to enhance the range of activities that had occurred. The service shared and maintained a record of the activities that had taken place throughout the month. Information and photographs were shared with families via the monthly electronic newsletter. Activities included D-Day celebrations, singers, International family day and visits from petting zoos. The service had made good community connections. People had visited their local community gardens, sports centres and intergenerational visits were arranged between the local schools and nurseries. People were also supported with their religious and cultural beliefs from arranged church services. People and their families spoke highly about the range of social activities on offer and how this had enhanced their emotional wellbeing.

People were also supported on a one-to-one basis where they did not wish to be involved with group activities. The activities team is working to develop one-to-one sessions designed around individual interests and abilities. We learned about the re-purposing of some communal areas, including the introduction of a namaste relaxation area. Development of activities is ongoing to ensure this is adaptive to include people with a range of needs and abilities. **This area for improvement has been met.**

Previous area for improvement 2

The service should continue to ensure people's health, safety, and social care needs are appropriately assessed, documented, and effectively communicated between all relevant staff, including accurate assessments of people's;

a) health
b) physical and mental health needs
c) falls risk and management
d) nutritional needs
e) dementia care, and stress and distress and
f) continue to provide training to develop staff skills.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15) and 'Any treatment or intervention that I experience is safe and effective' (HSCS 1.24).

This area for improvement was made on 6 June 2023.

Action taken since then

The service had good systems in place to review people's ongoing and changing needs. This included support with people's physical, emotional and mental health needs. Care plan reviews were carried out monthly to ensure the content of plans was current and up to date. There was evidence of monthly assessment of people's support with their nutritional needs, stress and distress and regular analysis of falls. Where changes had been identified to people's support, this had been documented and shared amongst staff.

We observed daily flash meetings and handover meetings with senior staff, clinical staff and care staff. Flash meetings were well organised and informative to ensure that all staff were made aware to any changes to people's support on a daily basis. **This area for improvement has been met.**

Previous area for improvement 3

Where organisation adopts practices which differ from those stated in the Care Home Infection Prevention and Control Manual, (CH IPCM) you should ensure safe systems of work including the completion of risk assessments approved through local governance procedures.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state: 'I experience high quality care and support based on relevant evidence, guidance, and best practice' (HSCS 4.11).

This area for improvement was made on 6 June 2023.

Action taken since then

The service had robust cleaning regimes in place which linked directly to the Care Home Infection Prevention and Control Manual (CH IPCM). Housekeeping staff we spoke with were very knowledgeable about their role and maintaining the cleanliness of the home in line with good infection prevention and control practice.

The service had adopted a cleaning system which included the use of single use mops. Safe systems of work had been developed to support the decisions taken around cleaning systems outwith the (CH IPCM). These systems aligned with local governance procedures . **This area for improvement has been met.**

Previous area for improvement 4

The provider should ensure an oversight of all staff training to provide good outcomes for people experiencing care. Regular one-to-one supervisions and competency observations should be completed for all areas of staff practice. These should inform and link to a robust training analysis and training development plan.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS), which state: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14).

This area for improvement was made on 6 June 2023.

Action taken since then

The service had an up to date robust training matrix which evidenced mandatory and specific training completed for all staff in line with their job roles. Training included adult protection, medication, moving and handling, dementia awareness, fire safety and infection prevention and control. Compliance levels for staff training across the service was high. The service had sought further training to enhance staff's skills and knowledge from the Care Home Collaborative and Mental Health teams on stress and distress and palliative care. This is an ongoing process, with further plans to develop the training programme.

Where staff were responsible for administering medication, the relevant competency assessments had been carried out. All staff had been supported with competency reviews in relation to health and safety and infection prevention and control. This ensured that staff were working safely and following best practice guidance and legislation.

Staff we spoke with told us they had received regular one-to-one supervision which they found supportive and helped them to reflect on their practice for self development. We discussed the frequency of staff supervision in line with organisational policy. The service had a plan in place to increase staff supervisions across the year. **This area for improvement has been met.**

Previous area for improvement 5

People should benefit from dynamic and aspirational care and support planning which informs all aspects of the care and support experienced. This may include a range of approaches to ensure people are able to contribute to, and review their personal plans in a meaningful way. People and those important to them should be supported to be as involved as they want to in the development of their personal plans.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am fully involved in assessing my emotional, psychological, social and physical needs at an early stage, regularly and when my needs change' (HSCS 1.12). 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15).

This area for improvement was made on 6 June 2023.

Action taken since then

People using the service and their families were central to support planning. People and their families told us they had attended reviews and felt their views and opinions had influenced care needs. Sampling of six monthly reviews carried out included people, families and other professionals.

Care plans did not always set out clearly the monitoring required to support people with their health needs. For example, where people required support to remain hydrated, fluid recordings were carried out inconsistently. Some people did not meet targets for their daily fluid intake and we were unable to identify actions that were taken to ensure people were not at risk of dehydration.

Continence management sections of care plans were not always well detailed, in particular to give information on required monitoring with bowel management. This included maintaining records of bowel movements that may influence decision making where people had PRN (as and when required) medication in place to reduce the risk of constipation. Records and care plans pertaining to some people's bowel monitoring was not always clear to enable responsive decision making to keep people safe. Although we did not feel that people were at significant risk around their health and wellbeing, we felt there was further development needed to care plans in these area. **This area for improvement has not been met.**

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good

How good is our leadership?	5 - Very Good
2.2 Quality assurance and improvement is led well	5 - Very Good

How good is our staff team?	5 - Very Good
3.3 Staffing arrangements are right and staff work well together	5 - Very Good

How good is our setting?	5 - Very Good
4.1 People experience high quality facilities	5 - Very Good

How well is our care and support planned?	4 - Good
5.1 Assessment and personal planning reflects people's outcomes and wishes	4 - Good

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