Beech Meadows Homes Limited

Kingsthorpe View Care Home

Inspection report

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18 November 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Kingsthorpe View is a purpose-built residential care home, providing personal and nursing care to people living with a mental health diagnoses, dementia, physical disability or sensory impairment. The service can support up to 46 people. At the time of our inspection there were 29 people living at the service.

People's experience of using this service and what we found
We found significant concerns around how the service was managed, medicines management, care plans and records, health and safety and risk management.

People living at the service were not always receiving their medicines safely and as prescribed for them. Systems and processes in place to manage medicines safely were inadequate.

Health and safety and infection prevention and control were not always well managed. We found the environment and furniture to be in a poor state of repair in some areas. Whilst we saw the provider had an improvement plan in place for the service, there were inadequate systems in place to identify this prior to the inspection.

There was a lack of robust managerial oversight of the home. There were no effective audits of some aspects of care delivery. Care and support plans for people were not person centred or reflective of people's current level of needs.

We observed people to be happy living at Kingsthorpe View, supported by kind and caring staff. People and their relatives did not express any significant concerns regarding the service.

Staff understood safeguarding and how to keep people safe from abuse. Staff told us, and we saw that they received training to support them in their role.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 September 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 made and the provider was still in breach of the regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

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 coronavirus 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.

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

We carried out an unannounced inspection of this service on 10 November 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the breach in Regulation 17 Good Governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kingsthorpe View Care Home 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 four breaches of regulation around person centred care, medicines management, infection control, premises and equipment, safe care and treatment, staffing and good governance. The failings found are detailed in the main body of the report.
Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Kingsthorpe View Care Home

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
The first day of inspection was undertaken by an inspector and a Specialist Advisor Nurse. The second day of inspection was undertaken by an inspection manager and an inspector. Telephone calls to relatives and staff were made by an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Kingsthorpe View 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 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.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection. We contacted Healthwatch for information they held on the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection
We spoke with five people who used the service and 11 relatives about their experience of the care provided. We spoke with 10 members of staff including the provider, registered manager, clinical lead, nurse, senior care staff, care staff, domestic staff and the chef. 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 reviewed a range of records. This included people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, staffing rota's, policies and quality assurance records. We spoke with one professional who regularly visits the service.

Inadequate

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 now deteriorated to Inadequate

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- We found poor care plan, risk assessments and oversight for people who lived with epilepsy. There were no clear seizure rescue medication plans attached to the medication administration (MARS) records of people we reviewed. One member of clinical staff we spoke with showed an incorrect knowledge of the medication to be given to one person in the event of a seizure occurring.
- Risks associated with people's health, medical and care needs were not always clearly assessed so that staff were aware of how to minimise known risks to people or identify incidents which placed people at risk of harm. For example, we saw that one person had been given biscuits during an episode of prolonged seizure activity, which increased the risk of them choking.
- Risk assessments and care plans we viewed for people were not always comprehensive or regularly reviewed and some were generic. This meant that people may not be receiving care that was appropriate to their specific needs.
- Where concerns had been raised by external professionals about people's care, these issues had not been always been addressed in a timely manner and subsequent concerns were found on our inspection. For example, a health professional had expressed concerns regarding missed appointments for one person, which could leave them at risk of not receiving appropriate treatment for their clinical condition.
- In light of the current pandemic and the risks presented to vulnerable people with specific health conditions, the provider had not always assessed the impact of Covid-19 on people. We did not find evidence of impact plans in people's care and support records detailing what should happen if people required isolation.
- In two communal bathrooms, we observed open, dirty pipework. Placing people at risk of potential scalding.

Using medicines safely

- Medications were not always administered in a safe way.
- We found significant errors in the way some people's medicines were recorded.
- Some of the medicine administration records (MARS) we viewed were incomplete. For example, one person had a medication patch which needed to be removed and rotated after seven days. We saw that staff had not accurately recorded the removal and reapplication sites in the MAR chart. This potentially placed the person at risk of skin damage from the patch being applied in the incorrect place. This meant the provider could not evidence medicines were administered as prescribed.
- Some people took 'as required' (PRN) medicines and there was no clear information in some people's

records for staff on the protocols for administering these. For example, how many doses could be given within 24 hours. We discussed that these needed to be more robust for each person, as this could lead to people being given too much medication.
● We saw from records that some people were receiving their medication covertly. We saw people had covert protocols in place with evidence that best interests' meetings had taken place involving their GP, next of kin and an assessment of their capacity. We found a pharmacist had not been consulted on the appropriate and safe method for administration following this.

The provider took immediate actions to rectify this following inspection, we were assured by this.

● Provider medicines audits had failed to pick up the medicines issues that were found at this inspection. This is discussed further in the well-led section of this report.

Preventing and controlling infection
● People were not protected from the risk of infection. On both inspection dates we found significant areas of concern in relation to poor infection control practice at the service.
● We were not assured that the provider was preventing visitors from catching and spreading infections, due to the lack of robust implementation of infection control practices at the service.
● We were not assured that the provider was meeting shielding and social distancing rules. We did not observe any appropriate shielding or distancing measures in place in the service.
● We were not assured that the provider was using PPE effectively and safely. We observed some staff not wearing PPE correctly during the inspection period. There was no designated PPE donning and doffing area for staff.

The provider took measures to ensure these areas of concern were rectified following the inspection, we were assured by their actions.

● We found that although the provider's infection prevention and control policy was up to date the registered manager was not ensuring this was being implemented robustly .
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed, due to the lack of robust implementation of their infection control process and procedures.
● People may not have always been protected and kept safe from the possible spread of infection.
● We found the home to be visibly unclean and there were malodours noted during both days of the inspection.
● We were provided with evidence of additional cleaning schedules which had been implemented as a direct result of the Covid-19 pandemic. On day one of the inspection we did not observe any extra cleaning on high-touch points taking place around the home.

The providers failure to provide safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care staff that we spoke with were able to tell us the correct order in which Personal Protective Equipment (PPE) should be put on and taken off.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was admitting people safely to the service.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of

the premises.
● During the inspection, we found the home was in a general state of disrepair and required modernisation. This meant that people may not have always been kept safe and could be placed at risk because of health and safety issues around the home. We observed;
● Flooring throughout the service was noted to be in a poor state of repair and visibly unclean in parts.
● Doorways to bathrooms were noted to have threshold strips missing, leaving gaps in the flooring, causing a potential trip hazard and a crevice for dirt.
● Some items of furniture in the bathrooms were noted to be damaged, unclean and in a poor state of repair.
● We observed ingrained dirt in a cupboard in the dining room, used for the storage of crockery.
● We identified several radiator covers that were broken and dirty placing people at the risk of harm.

The poor condition of parts of the home and the failure to identify and address these issues was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Safe recruitment practices were not always followed. A member of senior clinical staff had been recruited without appropriate risk assessments being in place for their suitability to work in their specific role prior to their appointment. This was despite previous concerns being identified at interview. This meant that the registered manager could not be assured that people were protected from the risk of potential abuse from unsafe staff.

Failure to ensure fit and proper persons were employed was a breach of Regulation 19 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Throughout the inspection we saw that there were sufficient staff available to ensure people's safety.
● Required recruitment checks and assurances had been obtained which included criminal record checks, evidence of conduct in previous employment and identity verification.

Systems and processes to safeguard people from the risk of abuse
● People were protected from potential abuse and staff understood their roles in protecting people in their care. We saw from records that staff had received safeguarding training at the service.
● The majority of people we spoke to told us they were treated with respect and kindness by staff. One relative told us, "We're very pleased our family member is looked after really well. They are safe and very well cared for."
● One staff member told us, "If I did have concerns, I would raise it with my management. I would feel confident they would support me and deal with the issues raised."

Inadequate

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 deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found the provider had failed to implement robust quality monitoring processes, and this was the third inspection where the provider had been rated as requires improvement, which led to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of this regulation.

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

- Quality management systems were not effective and the provider oversight of the service was poor. We saw a lack of evidence that the provider had identified these shortfalls and were not assured that the provider had made and sustained improvements at the service.
- Provider audits were carried out to identify issues, however there were no action plans following these to show who, how or when these issues would be addressed or followed up to ensure they had been completed. Therefore, we could not be assured the provider had oversight about the overall quality of care people received.
- Although quality monitoring systems were now in place to monitor the standards of care received by people in the areas previously identified by the CQC as a concern, other areas lacked oversight, for example, infection control processes.
- We found the registered manager had failed to identify medicines management issues through medication audits.
- Systems used for monitoring and auditing had failed to identify gaps in staff knowledge in relation to some of the specific needs of people using the service. Such as, epilepsy management, PRN protocols, and seizure medication protocols.
- The provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety in relation to the risk of infection. The Registered Manager was not ensuring that staff were following current guidance in the wearing of PPE.
- There were no robust management audits or checks in place, to ensure people were in receipt of good

quality care and to ensure good managerial oversight.
● We saw a lack of review dates on care and support plans, which stated they were due for review on a monthly basis. This meant that the service did not fully consider people's risks had changed or that people were at additional risk due to changes in their health or circumstance such as Covid-19.
● Where concerns had been raised by external professionals about people's care, these issues had not been promptly addressed. For example, a health professional had expressed concerns regarding one person's seizure management. We saw from records they were not responded to in a timely manner and the service had missed external appointments for this person. The health professional had made several attempts to gain accurate information from the service. This left the person at risk of not receiving care and treatment for their condition.
● We found evidence of a lack of formal engagement with people and their relatives regarding the way the service was run. One relative told us, "I would like to see a regular newsletter or an email." Another relative told us, "I feel like I've not been kept up to date with Covid-19 changes."
● Whilst people we spoke to were mainly positive regarding the contact staff maintained with them via the telephone about their relatives, we did not see evidence of alternative approaches to obtaining people's views.
● The provider had failed to attain compliance with the fundamental standards over a period of three consecutive inspections.

Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found there was an improvement in the monitoring and recording of falls for people, as we saw that the provider now had a method for analysis of trends to reduce risks for people. We saw people's weights were now being monitored and audited through regular electronic monitoring.
● We saw that accidents and incidents were now always documented, appropriately acted upon, investigated and follow up actions were recorded where required.
● The registered manager had met their registration regulatory requirements of notifying CQC of certain information through statutory notifications.

● The majority of relatives we spoke with felt they had been kept informed by letter or email throughout the current pandemic by the provider and felt that they had not yet formed an opinion on the new registered manager. They were largely positive in their feedback on the staff but commented that they felt in the evenings and at night it could be difficult to contact the service.
● There were staff meetings and the minutes we viewed showed information and learning was shared with staff. One staff member told us, "We carry out reflections and learning from incidents with the registered manager."

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
● The registered manager and provider worked in an open and transparent manner and understood their responsibilities in relation to the duty of candour.
● One relative told us they had made a complaint and the registered manager had not addressed this to their satisfaction. Staff we spoke with understood their responsibilities in relation to managing complaints raised by people or relatives.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments failed to document people's known risks. Where risks were documented these often failed to provide staff with adequate guidance to minimise the risks. The environment overall presented an infection control risk to people using the service. Some fixtures and furniture were in a state of disrepair. There were ineffective systems in place to manage medicines. Regulation 12 (1) (2)

The enforcement action we took:

We imposed conditions upon the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The poor condition of parts of the home and the failure to identify and address these issues placed people at risk.

The enforcement action we took:

We imposed conditions upon the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service.

The enforcement action we took:

We imposed conditions upon the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care

proper persons employed

The registered manager had failed to ensure through their recruitment processes that people were protected from the risk of potential abuse from unsafe staff.

The enforcement action we took:

We imposed conditions upon the provider