Mrs Virginia Evelyn Mary Taylor

Kingsgate Residential Home

Inspection report

25-29 North Street
Sheringham
Norfolk
NR26 8LW

Tel: 01263823114
Website: www.kingsgateresidentialhome.com

Date of inspection visit:
23 January 2020
24 January 2020
28 January 2020

Date of publication:
28 February 2020

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Kingsgate Residential Home is a residential care home providing personal care and support for 24 people aged 65 and over at the time of the inspection. The service can support up to 33 people.

People's experience of using this service and what we found
At this inspection we found the provider had still not taken sufficient action to achieve compliance with the regulations. At our last inspection we found the provider was in breach of five of the regulations. Whilst some improvements had been made, the provider remained in breach of four of the regulations.

There was still a lack of effective quality assurance systems in place to monitor and assess all areas of the service. Some audits had been implemented, but these were still ineffective.

People's care records did not contain enough detail and the needs of some people had not been assessed and planned for. Risks relating to people's health and wellbeing were not managed robustly.

Reports of accidents and incidents were not detailed, and notifiable incidents had not been reported in line with the regulatory requirements.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were cared for in a respectful way and felt involved in the planning of their care and treatment, along with their relatives. There was a lack of provision for people to take part in activities, but work was being undertaken to improve this.

There were opportunities for people and their relatives to provide feedback about the service and action plans were in place to address any concerns raised.

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 inadequate (published 8 July 2019) and there were five breaches of the regulations. 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 four of regulations.

Following the last inspection we placed conditions on the provider's registration. This meant the provider was required to send us monthly action plans to show what action they were taking in response to the

concerns we found. These conditions will remain in place as the provider has not made enough improvement.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kingsgate Residential Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, need for consent, good governance and notification of other incidents at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Special Measures:
The overall rating for this service is 'Requires improvement'. However, the service will remain in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Kingsgate Residential 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.

Inspection team
The inspection team consisted of one inspector, a medicines inspector and an assistant inspector.

Service and service type
Kingsgate Residential Home 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. The registered manager was also the provider, there was also a manager in post who oversaw the day to day running of the service. For the purposes of this report we refer to the registered manager as the provider.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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. We also reviewed the action plans the provider had sent us. This information helps support our inspections. In addition to this we sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection

We spoke with four people who lived in the service and five relatives about their experience of the care provided. We also spoke with the provider, manager, office manager, two members of care staff, maintenance staff and a member of kitchen staff.

We looked at three people's care records in detail and records relating to a further four people in part. We reviewed the medicine management arrangements at the home and medicine administration charts and associated records for 13 people. During the inspection we reviewed three staff recruitment files and a range of documents relating to the day to day running of the service.

After the inspection
We continued to seek clarification from the management team to validate evidence found and spoke with staff over the telephone.

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 inadequate. At this inspection this key question has now improved to requires improvement. We found that the service had made some improvements, however, further improvements are still required to achieve compliance with the regulations. 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; Learning lessons when things go wrong;

At our last inspection we found the provider failed to notify the CQC and safeguarding of incidents in line with the regulations. These findings constituted a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 18.

● We reviewed accidents and incidents and found that the CQC and the local safeguarding authority were still not notified of reportable events in line with the regulatory requirements. We saw two incidents of unexplained bruising which had not been reported to safeguarding.

Further improvements are required in relation to identifying and reporting notifiable events. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection we found individual risk to people and within the environment had not been identified or planned for. These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 12.

● Some people who lived in the service showed behaviour that challenged. There were no risk assessments in place to detail the level of risk or what support was required from staff to mitigate the risk.
● The risk assessments relating to people's moving and handling needs were poor. Whilst there was a brief mention of the risks in people's care records, there were no detailed and individualised risk assessments in place.
● One person had a pressure ulcer, their repositioning records showed they were not repositioned at the frequency detailed in their care plan.
● There were a number of people who were at high risk of falling. One person had a sensor mat in place which alerted staff when they were mobilising. We saw two other people were also at risk of falling and their

care records identified sensor mats would mitigate this risk but had not been put in place. We raised this with the manager who put the sensor mats in place.
● We found one uncovered radiator in a communal lounge which was hot to touch. We reported our concerns and the office manager immediately turned the radiator off and we were assured a cover would be purchased.
● Reports and corresponding information relating to accidents and incidents were not kept in the same place. Accounts of accidents and incidents were also not consistent. For example, the report in one person's care file differed from the report logged in the accidents and incidents folder.
● There was a lack of information on the accidents and incident forms to show these had been thoroughly investigated and lessons had been learnt in order to minimise the risk of future occurrences.

Systems and processes to safeguard people from the risk of abuse
● Staff had received training in safeguarding. However, potential safeguarding incidents were not always identified and reported to the local authority safeguarding team for further investigation.

We found no evidence to show people had been harmed. However, there was a lack of robust systems in place to demonstrate safety was managed consistently and effectively. 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.

● All of the people we spoke with told us they felt safe living in the home.
● A healthcare professional we spoke with told us there had previously been issues with staffs' practice around moving and handling, but this had now improved.
● We found improvements had been made within the environment; a majority of radiators had been covered and large furniture items had been tethered to the wall.

Staffing and recruitment

At our last inspection we found there were insufficient staffing levels to maintain people's safety. These findings constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of this regulation.

● We discussed our concerns about staffing levels at night with both the provider and manager. A number of people required two staff to support them with moving and handling needs, and there were only two staff working at night. The manager agreed an extra member of staff should be employed. After our inspection the manager confirmed staffing levels had been increased.
● Pre-employment checks were carried out before staff commenced their employment. These included seeking references and information from the Disclosure and Barring Service to ensure staff were of suitable character.

Using medicines safely
● There was a system in place for ordering and giving people their medicines as prescribed. Medicines were being kept safely and at correct temperatures. Records showed people received their medicines as prescribed.
● Staff were trained and assessed for their competency to handle and give people their medicines safely,

however, not all staff giving people insulin by injection to manage their diabetes had recently had their competence re-assessed to ensure they did so safely.

● People were encouraged to manage some of their own medicines to maintain their independence. The home had assessed the risks around this but for some people had not clarified how often the assessments should be reviewed.

● Written guidance was available to help staff give people their medicines prescribed on a when required basis, however, records confirming the reasons the medicines were used were not always completed.

● Records of people's allergies to medicines were not consistently recorded to ensure these medicines would not be given to them. The manager confirmed immediate action would be taken to resolve this.

● People's blood sugar monitoring was not always being completed as set out by their care notes, however, the manager informed us the frequency of testing was currently under review for each person monitored.

Preventing and controlling infection

● The service was clean throughout and we observed staff wore gloves and aprons when necessary.

● There were a number of handwashing facilities with plenty of soap and disposable hand towels.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Ensuring consent to care and treatment in line with law and guidance

At our last inspection we found people's capacity in relation to making decisions about their care and treatment had not been assessed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 11.

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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- There was a lack of assessment of people's choices. For example, one person who had capacity, refused care and treatment sometimes. There was nothing in their care records to document this or signed consent to show they understood the possible implications of refusing care and treatment.
- Applications to deprive people of their liberty did not fully detail what restrictions were placed on people to maintain their safety or what decisions had to be made in people's best interests. For example, one person had a pressure mat in place to alert staff when they were mobilising, this had not been mentioned in their DoLS application.
- Whilst some people's capacity had been assessed, these assessments were not always clear what care and treatment should be provided in a person's best interest. For example, one person's capacity

assessment stated they required staff support with personal hygiene in their best interest. However, this failed to detail the person could attend to some aspects of their own personal hygiene as stated in their care plan regarding this. This did not show best interest decisions considered the least restrictive option.
● The need to provide personal care in this person's best interest was also stated on their DoLS application, there was nothing further to show why this decision was restrictive and it also failed to document they were independent with some aspects of their personal hygiene.

These findings constituted a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People and their relatives we spoke with told us staff supported them to make appointments with their GP or other healthcare professionals. One person commented, "[The staff] will help me sort out appointments, and they are quick at it too." One person's relative explained, "[The staff] are very good at noticing if something is not right, [family member] had a bit of a bad spell last year and they got [family member] the care [they] needed."
● One healthcare professional told us staff worked well with them and were able to tell them about people's care needs, they also said staff followed professional advice.

Staff support: induction, training, skills and experience
● We reviewed staff training records and noted staff were out of date with some mandatory training set by the provider. After our inspection, the manager confirmed refresher training had been booked.
● People we spoke with told us they thought staff were well-trained. One person commented, "They are well-trained, and they know what they are doing." A second person explained, "I would say they are all well-trained, and if they did not know anything, they would find someone who does know or can help."
● New staff completed an induction where they shadowed a more experienced member of staff. Staff also attended regular supervisions with the manager, these were regular meetings where staff could discuss their role and any support they required. Staff also had annual appraisals.

Supporting people to eat and drink enough to maintain a balanced diet
● People we spoke with were complimentary about the food. One person told us, "[The food] is very good, good variety, well-cooked hot food." A second person commented, "It is really wonderful, it is tasty. The cook is wonderful."
● We spoke with a member of kitchen staff who understood people's dietary requirements and told us staff kept them informed if there were any changes. Our observations showed people's food was prepared according to their dietary needs.
● Our observations showed people were offered drinks regularly and jugs of squash were available throughout the home. During the afternoon, people were offered a choice of hot drinks, home-made cake and biscuits.
● The office manager told us a member of kitchen staff had been enrolled on a course where they would develop their awareness of nutritional issues experienced by people who lived in a care setting.

Adapting service, design, decoration to meet people's needs
● There was signage throughout the home to identify the bathrooms. People's bedrooms also had numbers on the door. This assisted people to navigate around the service independently.
● People were able to access a courtyard style garden where there was seating.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their relatives we spoke with told us staff were caring. One person explained, "I would say they are kind and caring, I have never seen a bad [member of staff]." A second person said, "Yes, [the staff] do [have a caring attitude], even if they are busy, they will make time for you, you do not feel rushed and I feel settled here." One person's relative told us, "With [family member's] dementia, [they] can refuse [care and treatment] a lot, but they work with [family member] so well, [they are] well cared for here."
- People told us they felt staff knew their needs and preferences. One person said, "I do a lot for myself, but they know how I like my tea and what I like to eat." A second person explained, "I would say they know me well. We sit and chat, mainly at lunch, but it is nice to talk to them."
- Our observations showed staff spoke with people in a kind and empathic manner. One member of staff comforted one person who was distressed. The member of staff knelt beside the person and spoke softly to them. Another member of staff supported a person at breakfast, they were conversing with the person and did not rush them with their meal.
- Staff we spoke with understood people's care needs changed daily, and some days people sometimes required more support.

Supporting people to express their views and be involved in making decisions about their care

- Staff supported people to make choices about their care and day to day activities. One person told us, "I choose when I want to go downstairs or if I want to come and sit in my room. I choose when I want to go to bed. I mean, we do not do much, and I cannot do as much now I am getting older, but I can choose what I do daily." A second person commented, "I come down[stairs] when I like, we can have drinks when we like. I have no issues here."
- People and their relatives were involved in the planning of their care. One person told us, "I have seen my care plan. I have only seen it once as I am not bothered what is in it. I have had a review; we had a meeting with my relatives to see if I am happy here or if I need more help, but I am okay."

Respecting and promoting people's privacy, dignity and independence

- People told us they were treated in a respectful way which upheld their dignity. One person told us, "[The staff] are always patient with me. They are polite, and I have not heard them use bad language." A second person explained, "I would say [the staff] are kind and polite to all. I feel they are all wonderful."
- People's relatives told us their family member's dignity was upheld. One relative said, "[Family member] is always presentable, [they are] always well dressed. [Family member's] hair is done weekly. Toe nails done every six weeks and [their] nails are clean."

● People were supported to maintain their independence. One person told us, "When I came [here], I could not walk far, but with their care and the frame, I can now walk to the bathroom and walk outside, so their care has improved me. They also push me to do more, not in a bad way, but in an encouraging way."
● Our observations showed staff respected people's privacy. We saw staff drawing curtains and close people's doors when providing personal care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- Whilst people and their relatives were involved in the planning of their care, people's care records still required further improvement. For example, some people were living with dementia and there were no care plans to show how staff should support people with this.
- People's care records failed to document their emotional needs and what support people required when they showed behaviour that challenged.
- We saw from people's care records staff understood how to offer people choice. For example, one person's care records detailed one person was able to choose what to wear and what they would like to eat if they were presented with two visual choices.
- Not everyone had an end of life care plan in place. The end of life care plans we looked at lacked detail. For example, there was nothing to show whether they wanted family present or how they wanted their care to be delivered. However, staff we spoke with told us how they would provide person-centred care for people at the end of their lives.
- The manager told us they were working with senior care staff to update people's care records to make them more detailed and person-centred.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information was not available to people in accessible formats such as pictorial or easy-read format.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There was a lack of daily activity provision. An activities coordinator visited once a week and provided both group activities and one to one activities. The manager recognised activity provision was poor and told us they had contacted a number of community groups to improve activities within the home.
- People were able to have visitors without restriction and visitors were able to stay and have a meal with those they were visiting. We saw that staff welcomed visitors and made time to speak with them.

Improving care quality in response to complaints or concerns

- There was a complaints procedure in place and people knew who they would go to if they wished to raise a concern. The service had not received any complaints since our last inspection.

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 inadequate. At this inspection this key question has remained the same. 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.

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

At our last inspection we found the provider had failed to make enough improvement to achieve compliance with the Regulations and implement robust governance systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider remains in breach of regulation 17.

● A number of ongoing concerns were found during this inspection and the provider remained non-compliant with the regulations.
● There were no robust systems to monitor and assess the quality of service being delivered. Audits that were in place were not comprehensive enough to identify shortfalls within the service. Some areas of the service had not been audited at all, for example, accidents and incidents.
● The provider did not carry out any audits to gain an overview of the day to day running of the service.
● The provider continued to not report notifiable incidents to the CQC or safeguarding.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
● People's care records still required further detail and some people's needs had not been assessed and planned for. Risks relating to people's care had not been adequately assessed.
● It had been identified at our last inspection that staffing at night needed to be reviewed and staffing levels had not been revised until after this inspection in January 2020.
● Lessons were not learnt from accidents and incidents and there was a failure to mitigate known risks in a timely way.

These findings constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● A new manager had been in post since October 2019. They told us they wanted to train senior staff to take on more responsibilities. They also planned to appoint a head of each area of the service who would take

responsibility for the day to day management of their given area.

● The manager was a visible presence and we saw them speaking with people and their relatives. People and their relatives spoke positively about the manager and the changes they were implementing, as did the staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Regular meetings took place for people who lived in the home and there were also monthly relative's meetings.

● People and their relatives were able to provide feedback via a questionnaire about the service. We saw that actions plans were in place to address concerns raised.

● Management and staff were working with the local authority quality assurance team regarding their ongoing improvement plan.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of reportable incidents. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the mental capacity to make a specific decision the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

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 The provider had failed to ensure accurate and effective assessments of risks to the health and safety of people using the service. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:

Conditions were imposed on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess and monitor the service. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Conditions were imposed on the provider's registration