Caring Homes Healthcare Group Limited

Kingsclear

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Kingsclear is a care home with nursing and accommodates up to 97 people in a new adapted building. The first floor provides care and support to people who are living with dementia. At the time of our inspection there were 54 people living at Kingsclear.

People's experience of using this service and what we found
There was a lack of managerial oversight of the service. The provider's quality assurance systems had failed to identify concerns found during the inspection. Safeguarding concerns had not always been identified and reported to the local authority and CQC in line with requirements. Risks to people's safety and well-being such as fluid monitoring, mouth care and catheter care were not always effectively assessed and monitored. Records in relation to people's care lacked detail. Information shared in handover between staff was not recorded in order to ensure any concerns could be tracked. Medicines administration records in one area of the service were disorganised and contained gaps in recording. Other aspects of medicines administration were managed well.

There was a lack of social interaction with some people who spent time in their rooms. We have made a recommendation regarding staff deployment in relation to this.

People and their relatives were involved in the care planning process. Care plans were detailed and contained personalised information for staff to refer to. Robust infection prevention and control measures were followed by staff. Staff told us they felt supported and valued by the management team. Safe recruitment processes were in place to ensure staff were suitable for their roles.

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 25 Oct 2019). Breaches of regulations were identified in relation to person centred care, safe care and treatment, staffing and the governance of the service. We completed a further targeted inspection on 17 September 2020 (published 3 November 2020). A continued breach of regulation regarding personalised care was identified. Improvements were found in all other areas. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. The provider completed an action plan following both of these inspections to show what they would do and by when to improve. At this inspection we found previous improvements had not been sustained and the provider was in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding processes and risks to people's safety and welfare. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this

full report.

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

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

We have identified breaches in relation to risks to people's safety and well-being, medicines recording and safeguarding processes. We identified a lack of management oversight in identifying these concerns.

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
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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Kingsclear

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 inspection was carried out by two inspectors

Service and service type
Kingsclear is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before 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 information gathered from the service during monitoring calls. This included information provided by the registered manager, discussions with the leadership team and feedback from four relatives and three staff members. 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.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with eight members of staff including the registered manager, regional manager, deputy and dementia care managers, nursing and care staff.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and a variety of records relating to the management of the service, including accidents and incidents, safeguarding information and meeting minutes.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed feedback from two further relatives and continued to speak with professionals involved in the service.

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 inspection in July 2019 this key question was rated as Requires Improvement. At the targeted inspection in September 2020 we found the provider had made improvements in relation to staff deployment and the management of risks to people's safety. At this inspection we found these improvements had not always been sustained. The rating for this key question remains Requires Improvement. 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

- Risks to people's safety and well-being were not always effectively monitored. Records did not demonstrate how fluid intake for people at risk of dehydration or infections was monitored. Staff told us one person's fluid intake was being monitored due to an infection. Records stated they had received under 200mls of fluids each day during that week. Whilst staff told us these levels were incorrect, there was no evidence this had been identified and acted upon. This meant staff were unable to demonstrate if the person had received sufficient hydration.
- Prompt action was not always taken where concerns were raised. This included ensuring mouthcare was completed and recorded for one person where specific concerns had been raised, that catheter care was monitored and information regarding oxygen adjustments clearly displayed for staff. This meant people were at an increased risk of becoming unwell.
- Risk assessments were not always comprehensively reviewed following incidents. One person's care plan reflected they were fully independent in areas of their care. However, risks had not been reviewed following an incident which suggested they may require additional support to maintain their independence whilst remaining safe.
- In other areas we found risks had been managed well. Where people had experienced falls their care plans had been reviewed and action such as putting sensor mats in place had been implemented.
- Where people's anxiety and behaviour impacted on others, care plans were in place to guide staff on how to support them. Information included potential triggers and guidance on what helped the person feel calmer.

Using medicines safely

- Medicines administration records (MARs) were not always organised and accurately maintained. We identified gaps in the recording of medicines administration for seven people which meant the provider could not be assured people had received their medicines in line with their prescriptions. In addition, gaps in the monitoring of where skin patches were placed were also identified. The regional manager told us they had identified this concern and planned to implement additional handover checks of medicines to address these issues.

The failure to ensure risks to people's safety were consistently managed and that MAR charts were accurately maintained was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

● In other areas, we found that medicines were managed well. MAR charts contained information in relation to the person including an up to date photograph, name, DOB and information of any allergies. Where entries of prescribed medicines were handwritten these had been double signed to ensure the information was correct.
● Protocols were in place for medicines which were prescribed for 'as and when required use' (PRN). Information included the reason for the medicines being prescribed, support to be offered to the person and the frequency the medicine could be taken.
● The service was working closely with a pharmacist to ensure people were prescribed the most suitable medicines for their specific needs. This had led to a reduction in some people's medicines. Where people wished to manage their own medicines, risk assessments were completed. This process determined if people required any specific support whilst enabling them to maintain their independence.

Systems and processes to safeguard people from the risk of abuse
● We received mixed responses from relatives about the safety of their loved ones living at Kingsclear. One relative gave feedback they felt their loved one's needs had been neglected by the management and staff at the service as they had not followed up on concerns raised by the person and their family. A second relative told us, "I do feel he's safe because staff understand him now. He's formed a nice bond with the staff there now."
● Potential safeguarding concerns had not always been reported to the local authority in line with requirements. This included unwitnessed falls and incidents between people living at Kingsclear. This meant the local authority safeguarding team were unable to monitor the service and ensure appropriate systems were in place to keep them safe.
● Where the local authority had requested additional information in relation to safeguarding concerns, this was not always comprehensively responded to. We reviewed two responses provided in relation to people's care and found the concerns had not been robustly investigated to ensure lessons were learnt going forward.
● The registered manager and regional manager acknowledged that some potential safeguarding concerns had not been reported as required. They told us that despite all staff being trained in reporting safeguarding concerns, they had not always recognised some incidents and accidents required reporting to the local authority. They told us they had implemented additional measures to ensure all incidents were reviewed promptly by senior staff members to minimise the risk of this happening again.
● Following the inspection, the registered manager and regional manager assured us they had provided all the information required by the local authority and were working alongside them to address outstanding concerns. The local authority confirmed this was the case.

The failure to ensure effective processes were in place to identify and investigate, immediately upon becoming aware of it, any allegation or evidence of abuse requirements was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We received mixed responses from people and their relatives regarding staffing at Kingsclear. On person told us, "There are plenty of staff, they are very, very good." One relative said, "I think during the day things are okay but it's the evenings and weekends when it can be hard to find staff and they seem rushed." A second relative told us, "Very much so (have sufficient staff). I see who else they have living there, and they are well cared for."
● Staff members told us staffing had been difficult but was now improving. One staff member told us,

"Things are picking up now as more staff have been recruited. When we're up to numbers we have enough to manage everything. I would like to be able to spend more time with residents though, to have time to chat with them more."

● A dependency tool was used to calculate the number of staff required to support people's needs. Staff rotas showed staffing levels were above the number determined by the dependency tool. However, we found staff were not always effectively deployed to minimise the risk of people becoming socially isolated, particularly where people spent time in their own rooms. One person's care plan stated they enjoyed one to one interaction. We observed that although staff regularly checked the person was safe and attended to their care needs, they did not spend social time with them.

● The registered manager told us there had been difficulties with staffing for a few months. Cover had been arranged through the use of regular agency and the management team covering shifts. In addition, auxiliary staff had been trained to provide additional support such as supporting people at mealtimes. This gave increased flexibility and enabled care staff to concentrate on other tasks. The registered manager told us that following a successful recruitment drive, pressures had begun to ease with the majority of newly recruited staff having started or completed their training and induction.

● Robust recruitment checks were completed which included all potential staff completing an application form and undergoing an interview. Disclosure and barring service checks (DBS) were completed prior to staff starting their employment. A DBS check is a record of a prospective employee's criminal convictions and cautions. Where necessary, evidence of up to date registration with the Nursing and Midwifery Council (NMC) was included."

We recommend systems are reviewed to ensure staff have time to spend with people socially.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 inspection in July 2019 this key question was rated as Requires Improvement. At the targeted inspection in September 2020 we found the provider had made improvements in relation to the management and governance of the service. At this inspection we found these improvements had not been sustained. The rating for this key question is now 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- We received mixed responses regarding the management of the service. One relative gave feedback they felt there was a lack of follow-up from the management team resulting in their loved one having a negative experience. Other comments included, "It's not perfect because they don't always do what they say they will do so leadership is lacking in that way.", "They seem nice, I think they do their best." And, "I know I can phone (management team) anytime and ask what's happening and they will feedback any information. We have a good understanding of (family member) and of each other."
- Management systems had not been effective in ensuring robust oversight of the service. Concerns found during our inspection including the monitoring of fluid levels, catheter care, mouth care and staff deployment had not been identified through the quality assurance process in place.
- The provider had failed to learn from previous concerns. The service had not achieved a rating of Good since its first inspection in 2018. Breaches of regulations had been identified at four of the previous five inspections. Whilst significant improvements were noted at the last inspection, these had not been sustained and embedded into practice.
- Following our inspection, the service forwarded an action plan for Kingsclear. This reflected actions required which had been identified between December 2020 and February 2021. The dates for actions to be completed was set to April 2021. The last review of the actions was completed in September 2021 and reflected they were 90 percent complete in most areas. It was not clear what further audits had been completed since this date to ensure these systems had been fully completed, embedded into practice and to check for any additional concerns. The provider assured us regular audits were completed of all systems although evidence of this was not provided.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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 provider had failed to implement robust systems to ensure safeguarding concerns were consistently identified and reported. We spoke with the registered manager and regional manager about these concerns

prior to the inspection. They provided assurances that systems had been implemented to minimise the risk of this happening again. However, during our inspection we found there had been further instances of potential safeguarding concerns such as unexplained falls not being reported.

● Records of the care people received were not always comprehensively completed. Some records lacked detail and language used was not always clear. This meant there was a risk staff may not always be fully aware of changes to people's care and any action taken or required. This also presented difficulties when investigating concerns following incidents.

● Information discussed during handovers between staff was not recorded. We asked to see handover records in relation to an incident where concerns had been raised. The deputy manager told us staff may keep their own notes, but handover records were not kept in the service. This meant there was a risk information relating to people's needs could be missed. We observed one staff handover and found people's individual needs and well-being were not discussed to ensure staff coming on duty were aware how people were or of any concerns.

● The regional manager told us they were in the process of reviewing the handover process to ensure additional checks were implemented to include areas discussed during the inspection. This included medicines management, fluid balances and mouth care provided. We will review the effectiveness of these systems during our next inspection.

The lack of effective management oversight and good governance was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other areas we found improvements had been made in how people were involved in their care planning. New care plans had been implemented which contained detailed personalised information regarding people's preferences and life histories. As many of the staff team were relatively new to the service the registered manager assured us they would be given time to read this information and get to know people.

● Staff told us they felt supported by the management team and involved in decisions about the service. One staff member said, "I'm quite happy to go to managers. They are positive and approachable. I can get advice from them."

● The provider had failed to ensure the CQC were notified of significant events within the service in line with their statutory responsibilities. This included incidents between people living at Kingsclear, an incident where a person was supported to return to the service by the police and safeguarding concerns being reviewed by the local authority. This meant we were unable to effectively monitor risk and the actions taken. Following the inspection, the regional manager confirmed there would be a senior staff member on each shift who would be responsible for reviewing incidents and notifying CQC where required.

Failing to submit statutory notifications was a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.