Mr D & Mrs J Barnacle

Kingswood Lodge Residential Care Home

Inspection report

Kingswood Lodge
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Tel: 01162812582

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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
Kingswood Lodge Residential Care Home is a residential care home providing personal care for up to 21 older people living with dementia, the accommodation is set over two floors. There were 15 people living at the service at the time of the inspection.

People's experience of using this service and what we found
The provider and registered manager failed to have systems or processes in place to assess the quality and safety of the service. The lack of oversight in infection prevention and control, health and safety, fire safety, food safety, care plans or medicine records placed people at risk of harm.

Staff did not have current or accurate information about people's needs as care plans and risk assessments were not up to date or reflective of people's needs.

People were at risk of not being able to summon help if required as call bells were not within people's reach.

People did not always receive their medicines in a safe way, systems and oversight measures for medicines were not effective. This placed people at the risk of harm.

There were not enough staff deployed to meet people's needs. The provider had failed to ensure sufficient staff were deployed to carry out cleaning or support people with activities.

Infection control risks were not assessed, and government guidance was not being followed to minimise the risk of infection to people using the service.

The provider failed to respond appropriately to concerns raised by relatives.

The provider failed to act in a timely way to safety concerns raised at our inspection visit or complete action plans set by other agencies.

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

Rating at last inspection
The last rating for this service was good last report (published 08 June 2018)

Why we inspected
We received concerns in relation to the safety and wellbeing of people using the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. 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 Kingswood Lodge Residential 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 monitor the service.

We have identified breaches in relation to the safe care and treatment, premises and equipment, staffing and governance at this inspection. 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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 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

This service was not safe

Details are in our safe findings below

Is the service well-led?

Inadequate

This service was not well-led.

Details are in our well-led findings below.

Kingswood Lodge Residential 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 inspection was carried out by two inspectors.

Service and service type
Kingswood Lodge residential care 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.

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 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 three people who used the service and six relatives about their experience of the care provided. We spoke with nine members of staff including the provider, registered manager, senior care assistants, care assistants, cleaner and the chef.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two 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 and a variety of policies.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- People did not always receive their medicines in a safe way. The systems and management oversight for medicines were not effective which could place people at the risk of harm.
- Medicines were not always stored safely. We found prescribed flammable topical creams in people's bedrooms, there were no assessments in place to show it was safe to store medicines in people's rooms.
- Dispensing errors from the pharmacy had been identified by staff, but they had not been actioned appropriately. We found some tablets had been incorrectly dispensed by the pharmacy and continued to be administered to people. Some of the medicines had had been taken out of the dosset box and left in the medicine trolley to administer at a later time. Poor practise and lack of action taken by the registered manager meant people were placed at risk of receiving medicines not prescribed for them.
- Staff had not received the specialist training required for two medicines that had been prescribed for people. however, their administration had continued. We raised this with the registered manager and provider who took action after our inspection visit to ensure the medicine was administered by the district nursing team going forward.

Preventing and controlling infection;

- PPE was not always used safely and effectively. During the inspection we observed some staff were observed as not wearing their face masks correctly causing them to be ineffective and some not wearing a face mask at all. We raised this immediately with the registered manager and provider who told us the action they would take.
- We found the premises to be visibly unclean and found no evidence that high touch cleaning was regularly being completed.
- The registered a manager was not following current government guidance by asking visitors if they were experiencing any symptoms of COVID-19 or if they had been in contact with any persons infected with COVID-19.
- Risks were not assessed, and government guidance was not being followed to minimise the risk of infection to people using the service, staff were not checking people's temperature on a regular basis and required risk assessments for staff were not in place.
- The provider did not have an adequate policy or plan in place to manage an outbreak of COVID -19.

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

- Care plans and risk assessments were not up to date or reflective of people's needs. We identified conflicting information in one person's care plan about their wishes at the end of their life. Another person's plan did not have clear instructions which sling staff should use to support the person with their moving and

handling needs. This meant staff did not have the correct information to support people safely or in line with their wishes.
● People were at risk of not being able to summon help if required. We found call bells propped on handrails in corridors outside of people's reach in ten bedrooms. Care plans stated people needed access to a call bell to call for assistance if required.
● We found black mould and damp in one person's bedroom which had not been identified by the provider, placing them at risk from illness.
● Not all people living in the service had a personal emergency evacuation plan (PEEP's) in place which would support people should they need to evacuated from the home.

The provider failed to assess and mitigate risks, manage medicines safely or have systems in place to prevent or manage infection outbreaks. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We highlighted our concerns with the registered manager who following the inspection provided evidence of action taken to mitigate risk.

● People were at risk from fire. The fire risk assessment for the service had not been reviewed as required, we found hazards in the service that increased the risks, for example the cooker was found to have thick deposits of fat and we found a hoist blocking a fire door which was labelled keep clear.
●Health and safety checks had not been completed as required, we found gaps in records relating to water temperature testing and legionella.
● Hazards to people had not been identified or actioned. We found exposed wiring and multiple brackets and fixings with sharp edges in people's bedrooms and bathrooms that could present as a risk to people and cause them injury.

The provider failed to ensure the premises and equipment were clean and properly maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We highlighted our concerns with the registered manager who following the inspection provided evidence of action taken to mitigate risk.

Staffing and recruitment
● Staff were not always safely recruited. We reviewed the recruitment records for staff and found that the provider could not evidence that background checks for a staff member had been fully completed.
● There were not enough domestic staff deployed to keep the environment clean, staff told us of nine occasions where the home had not been cleaned, cleaning records evidenced that cleaning had not been recorded as carried out on these dates.
● Relatives and staff told us they felt at times there was not enough staff to meet people's needs. Staff told us "We could do with an extra person on shift" and a relative told us "I think they need more staff, I have seen it when there is no staff around in the lounge." During our inspection, we observed staff were not always available to people when they needed support. This placed people at risk of falls from not being supervised when mobilising.
●People did not have opportunities to take part in their chosen activities as activities staff had not been replaced when they left the service. Care staff did not have the time allocated to provide supervision for activities.

The provider failed to have enough staff deployed to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Staff had received training in how to safeguard people from abuse. Staff understood how to report any concerns they had to relevant professionals, however as the issues we found during this inspection had not been reported we could not see this training was put into practice
- The provider did not have an effective system in place to monitor accidents and incidents. Not all accidents or incidents had been reviewed by the registered manager and appropriate actions had not always been taken to reduce the risk of re-occurrence.

- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- 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 last inspection this key question was rated as good. At this inspection this key question has now 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.

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

- People were at risk from the lack of provider oversight of the service and systems in place to make improvements in a timely manner. We found there was no auditing system in place to identify risks and failings in infection prevention and control, health and safety, fire safety, food safety, care plans, call bells or medicine management.
- The registered manager failed to ensure staff had the information they needed. Staff handovers did not contain important information relating to two people's medicines and the specialist care required for its administration.
- There was no system in place to monitor the information that was required for the safe recruitment of staff to the service.
- There was no system to ensure there were enough staff to meet people's needs. The provider had failed to ensure sufficient staff were deployed to carry out cleaning or support people with activities.

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; Continuous learning and improving care

- The provider and registered manager were not responsive to the feedback we gave during the inspection, we asked for immediate actions to be taken to mitigate the risks we found in relation to the management of medicines. We found at the end of our inspection visit that these actions had not been carried out. We have since received assurance that the provider and registered manager have now taken appropriate action.
- The registered manager failed to respond appropriately to concerns raised by relatives. Relatives told us when they had raised concerns with the registered manager these had been fully addressed or resolved.
- The registered manager was working to an action plan set by the local authority which identified improvements that needed to be made. We reviewed the plan and found the actions set had not been met in the imposed timescales. The lack of action from the provider and registered manager placed people at risk of harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider and registered manger did not seek the views of people or stakeholders about the service.
- Communication systems between the staff and relatives required improvement. Relatives told us they were not kept up to date with changes or incidents. A relative told us "We hear about things by chance" and another relative told us "If we didn't visit, I don't think we would get to find anything out."

● Staff feedback was not obtained, and staff performance was not evaluated. A staff member told us "I have not had a supervision for years, I want one it makes me think about leaving."

The provider failed to have systems and processes to assess, monitor and mitigate risks relating to the quality, health, safety and welfare of people or to identify where actions were required to improve the service. This was a breach of regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We observed that staff did not have time to engage in activities with people. The service had a board on display which listed various activities on offer. We found no evidence that these activities took place. A relative told us "[Staff], who did the activities left at the start of the pandemic, they have not replaced them".

● We observed staff to be kind and caring throughout the inspection and relatives consistently told us staff knew their relatives well. One relative told us "Staff are lovely" and another relative told us "Staff are very good, they are utterly kind."

Working in partnership with others

● The service worked in partnership with other professionals such as GP's and the In-Reach team to support people to access healthcare. However, the relatives we spoke with told us they were not kept update to date with their relatives changing needs.

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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 HSCA RA Regulations 2014 Staffing The provider failed to have enough staff deployed to meet people's needs.

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 not done all that was reasonably practicable to mitigate the risks to people's safety and welfare. This placed people at risk of harm.

The enforcement action we took:

Imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not done all that was reasonably practicable to mitigate the risks to identified in the premises. This placed people at risk of harm.

The enforcement action we took:

Imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate an effective system to assess and monitor the service.

The enforcement action we took:

Imposed conditions on the providers registration.