Achieve Together Limited

Kingsdown House

Inspection report

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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?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Kingsdown House provides accommodation and personal care for up to nine people aged between 18 and 65 years, who have a learning disability and autism. At the time of our inspection, there were nine people living at the service. The service was a large home, bigger than most domestic style properties. This is larger than current best practice guidance. However, the negative impact of the size of the service on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size nearby.

People's experience of using this service and what we found

Right Support
Although staff knew people well and we saw good interaction between them, there were shortfalls in the running of the service. This meant people could not be assured they would always receive the right support which would help them to reach the best possible outcomes. Medicines were stored and managed safely within the service, however there were some issues with the prescribing of medicines which resulted in one person receiving an out of date medicine on multiple occasions.

Right Care
Staff were caring, knew people well, and were able to describe how they supported people to maintain their independence. We saw this in practice. However, the provider's processes to learn lessons and continuously improve did not ensure that people would always receive the right care.

Right Culture
People told us they were happy living at Kingsdown House, and we saw from our time inspecting that people appeared happy and content. However, the provider did not promote a culture of person-centred support that focused on clear outcomes and putting people first. There were maintenance and furniture replacement concerns that had not been addressed in a timely manner.

There were insufficient staff, so people did not always get the support they needed, and staff told us they were tired. A process was not in place to monitor incidents and check for trends so improvements could be made to benefit people.

People were not always protected against risks associated with their care and support. The provider did not

ensure there was robust auditing to review and improve the quality of care.

People received the right support to follow a healthy diet and to choose their meals and when they ate. Staff supported people to access the health care they needed to maintain and improve their health and well-being.

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

Why we inspected
This is the first inspection for this newly registered service. We undertook this inspection to assess that the service is applying the principles of Right support, right care, right culture.

The last rating for the service under the previous provider was good, published on 16 November 2018.

Follow up
We will request an action plan from 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 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?

Requires Improvement

The service not always well-led.

Details are in our well-Led findings below.

Kingsdown House

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
Three inspectors, including a member of the CQC medicines team carried out the inspection.

Service and service type
Kingsdown House 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. When we visited on the first day of inspection 25 January 2022, we found the service had an outbreak of COVID-19. We inspected the area of infection prevention and control on the second day, 26 January 2022. A manager from one of the provider's other services was present during this. We then paused the inspection until the COVID-19 outbreak had ended and we returned on 8 February 2022 to continue the inspection, ending on 10 February 2022. The registered manager was present for the rest of the inspection.

What we did before inspection

We asked for feedback about the service from local authority commissioners and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed the information the provider had sent us, such as notifications of significant events the provider is obliged to send without delay. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke/communicated with three people who used the service and two relatives about their experience of the care provided. We spent time with all the people living at Kingsdown House in the communal areas on each day of the inspection, observing their day and how they communicated and interacted with staff. This helped us to understand their body language and limited verbal/nonverbal communication when seeking feedback.

We spoke with seven members of staff including the registered manager, senior support staff and support workers.

We reviewed a range of records. This included six people's care records. We reviewed nine medicine administration records. We looked at three 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 quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated 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

- People could not be assured they were supported to stay safe as individual management plans to support people to live their lives safely were not always in place.
- Risk management plans did not take into account people's individuality, so plans were the same for different people. Some people needed support with their continence needs. Guidance for staff to make sure people were supported with this in the way that suited them and to maintain the integrity of their skin was not in place. Some people were at risk of choking and their food needed to be cut into small bite sized pieces. A choking risk assessment was not in place to provide staff with detailed guidance to manage the risk and what action to take if they had concerns.
- Positive behaviour support plans were in place for people who became anxious and sometimes reacted in a way that was challenging. These were not kept up to date. One person's positive behaviour support plan referred to interventions that were no longer used by the provider and staff were no longer trained to carry out those interventions. The plan was written in November 2020 and six monthly reviews had been carried out. However, no changes had been made to the plan to take into account this significant change. Although staff had not been using the techniques, this could place the person at risk of receiving inappropriate support at times of acute anxiety.
- Staff had received online learning training to use a de choker appliance if a person was choking. The guidance around the use of these appliances states they should be used by skilled professionals or individuals with advanced life support training. The guidance is clear they must be used in specific and limited circumstances and only when currently recognised basic life support protocols have failed. Some people were at risk of choking, however, no training had been provided to staff to prevent choking or what action to take immediately, before the decision to use a de choker device. Risk assessments in place did not include the guidance to ensure best practice was used and understood by staff. Only one member of staff had received training in dysphagia (swallowing difficulties).
- The dining chairs people used to eat their meals were in a very poor state of repair. They were cracked and torn which posed an infection control risk. Staff told us the chairs were a second-hand gift from a closing down centre. However, they were not fit for the purpose. Labels were not evident to show they were fire safe. We asked the registered manager if they knew if the chairs were fire retardant and they said they did not know. A risk assessment had not been considered to mitigate the risk of fire. The registered manager told us they had ordered some new dining room chairs and were awaiting a delivery date.
- The plans in place to support people to evacuate the building in an emergency such as a fire (PEEP) were not adequate to ensure safe evacuation. The information about the specific support individuals needed to leave the building safely were not detailed. The PEEP for each person recorded similar information even though people's needs were different. The registered manager contacted the provider's health and safety

department in March 2021 requesting advice about how to support the evacuation of one person who refused to leave during fire drills. Some advice was given. However, this was not used to review the person's PEEP and the concerns remained unresolved. The registered manager said they would review and update all PEEP's straight away.

● One person fell over on the second day of the inspection. The person did not appear to be injured. However, when we checked the accident and incident records the next day, staff had not recorded the incident and the registered manager was not aware of it. This meant an injury may go unnoticed and the registered manager could not be assured incidents were accurately recorded so lessons could be learnt.

The failure to manage individual risks in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● The service did not always evidence effective infection, prevention and control measures to keep people safe. The service looked clean. However, cleaning schedules did not evidence increased cleaning in relation to the COVID-19 pandemic. A record to document when staff had cleaned frequently high touched areas, such as light switches and door handles, had been introduced a week before the inspection. Staff completed the record by ticking once in the morning and once in the afternoon. An outbreak of COVID-19 was in progress at this time, the cleaning of high touch areas had not been introduced earlier as a preventative measure. Staff told us they cleaned high touch about every two hours but there was no record of this.

● Staff did not always use personal protective equipment (PPE) effectively and safely. On the first day of our inspection, when we were told by staff there was an outbreak of COVID-19 infection in the service, staff were not wearing the appropriate PPE for those circumstances. When we returned the second day, staff were following current guidance and were wearing the correct PPE. Bins used for the disposal of soiled PPE were not suitable as staff needed to touch the bin to open and dispose of their equipment. The manager ordered some new bins during the inspection.

● Staff told us testing for infection in people using the service and staff followed current guidance. However, there was little evidence of this as records had not been consistently kept.

● The service did not make sure that infection outbreaks could be effectively prevented or managed. Staff had not contacted the local United Kingdom Health Security Agency (UKHSA) to alert them to the outbreak and to receive professional advice how to manage the COVID-19 infection outbreak effectively and safely.

● The service's infection prevention and control policy was not up to date. There were different versions of the policy which would make it confusing for people and staff. The most up to date government guidance was not included in the policy available in the service.

The failure to safely manage infection prevention and control was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The service prevented visitors from catching and spreading infections.

● The service followed shielding and social distancing rules as far as they were able to. Some people were able to socially distance during an outbreak of COVID-19 infection in the service. However, due to their level of understanding, some people were not able to isolate in their room and were walking around the service.

● The service had not admitted any new people to the service during the pandemic and no one had been admitted to hospital.

● The service promoted safety through the layout of the premises and staff's hygiene practices.

● All relevant staff had completed food hygiene training and followed correct procedures for preparing and

storing food.

Visiting in care homes
● The provider was supporting visiting in accordance with current guidance. Visitors had access to personal protective equipment (PPE) for use during their visit and arrangements were made to make sure they were tested for COVID-19 before entering the service. Visits were booked to make sure the service could maintain safe visiting.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency.

● The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

We have also signposted the provider to resources to develop their approach.

Using medicines safely
● People' medicines were not always administered and managed safely. One person's antibiotic suspension had expired and was still being administered up to a week past its expiry date. The records confirmed that this had been happening for many months and staff were giving the medicine over two weeks past the expiry each month. This had been raised by the service with the person's GP in September 2021. The GP had told staff to continue to administer the medicine and continued to only prescribe one bottle per month. The issue had not been escalated by staff to make sure the person received safe medicine, and staff continued to administer out of date medicine. Staff contacted the GP immediately during the inspection, who prescribed the correct amount of medicine to last the month and said they would continue to do so.
● Allergies were recorded for people living in the service. However, the information for one person was not consistent across their different records which created a potential risk to their health.
● Protocols to help staff know when to give 'as required' medicines were in place although on two occasions the protocol did not match the information on the medicines administration records (MAR). The dose of one person's medicine to be given prior to a blood test was unclear.

The failure to safely manage people's prescribed medicines was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Processes were in place for the timely ordering, supply and storage of medicines. Medicines were administered in a timely manner and in a way that respected people's preferences. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.
● Audits of administration were being conducted and regular checks up to three times a day of the medicines were in place to ensure people received their medicines as prescribed. All staff had undergone medicines training and their competency was checked regularly.

Staffing and recruitment
● People did not always get the support they had been assessed as needing as the assessed staffing levels were not maintained. Some staff were working a day shift then a waking night shift, and the same the next day. Some staff had worked a full week without a rest break.
● Staff told us there were not enough staff. They said they covered shifts that were outstanding and were

happy to do so to make sure people got consistent support. However, staff told us they were tired. One member of staff said, "We are short staffed and that is impacting on everyone. I myself feel very tired".

● Staff told us that people were assessed as needing one to one support at times through the day, and they received funding for this. However, they did not receive this as often as they were assessed as needing it, as there were not enough staff to provide the level of support. People were not getting the support they should to enable positive outcomes. One person's care record documented they were assessed as needing seven hours 1:1 support each day. The person needed the hours to maintain and increase their independence and to access community resources. We spoke to more than one member of staff who said the person did not receive this level of support to achieve the outcomes. Staff were not added to the rota to provide seven hours individual support as there were not enough staff to do this.

● The registered manager told us some staff had left and they had been unable to recruit to the positions, although an ongoing recruitment campaign was in place. Agency staff had not been used to relieve the pressure. The registered manager told us after the inspection they had started to use agency staff.

The failure to ensure sufficient skilled staff were deployed to provide people's care and support was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● One member of staff missed 20 years of employment history off their employment application form. This was not picked up either by the provider's head office staff who collected this information from applicants, or by the registered manager during the recruitment process. This is an area to improve. The registered manager told us they would ask the member of staff to fully complete their application.

● Other aspects of the recruitment process were followed safely. References had been received and validated. Checks on Disclosure and Barring (DBS) records had been made. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people working with people who use care and support services. Interviews were values based.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from avoidable harm as the provider did not have robust systems in place to investigate all concerns raised.

● Concerns had been raised by members of the public about how staff engaged with people outside of the service. The local authority safeguarding team and police closed the concern following their investigation. The provider did not have a consistent process in place to make sure lessons could be learnt to ensure good practice among staff.

● Staff had received training in how to safeguard people from abuse. We spoke with staff who knew what their responsibilities were to keep people safe. Staff described how important the people they supported were to them, so they would raise their concerns outside of the organisation if they felt they had not been listened to.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People had specific support needs. Staff had not always had the training they needed to make sure they were skilled in supporting people in the right way.
- Some people became anxious which impacted on their ability to communicate their anxiety, resulting in challenging situations. The provider had previously adopted a nationally recognised approach to positively support people. The registered manager told us this had now changed and a different approach to supporting people whose behaviour challenges had been adopted by the provider. This required specific training centred on the individual. However, no staff had received the training, so the approach to positive support was at risk of being inconsistent amongst staff
- An independent fire risk assessment commissioned by the provider, carried out in March 2021, recommended the numbers of staff on duty who should be fire marshal trained to ensure the safety of people and staff. Only three out of the staff team had received this training at the time of the inspection which did not comply with the recommendations made.

The failure to ensure people were supported by skilled and trained staff was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff had one to one meetings with the registered manager or senior support staff. This gave them an opportunity to discuss concerns and their personal development. Staff told us they were happy with the support they received and could ask for help or guidance at any time.

Ensuring consent to care and treatment in line with law and guidance

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.

● The process used to assess people's mental capacity to make specific decisions was not clear and recorded. Complex decisions made in people's best interests and the rationale for reaching a decision were not clearly recorded. Other interested people, such as family members or independent advocates, were not always involved in best interest decisions to ensure the MCA was adhered to and people's rights were always upheld.
● Mental capacity assessments had been completed in relation to a range of day to day decisions affecting one person, including support with their personal care needs and going out alone. The person was deemed to lack capacity to make these decisions. A record was not kept to document how the decisions were made in the person's best interests.
● Important decisions had been made for some people about the prescribing and administering of specific medicines. Staff told us the medicines had been prescribed for a long time. The choice to take such medicine would usually be made by informed decision making for people in the general population. There were no records of how these decisions had been made, when they were made, and by who, such as a medical practitioner. Records to show if staff had advocated on behalf of people to ensure the decisions were regularly reviewed were not evident. The registered manager was unable to clarify this, saying people had been receiving the medicines for many years.

The failure to ensure people were supported to make decisions that were in their best interests was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The registered manager and staff had a basic understanding of the MCA. They knew people well and were able to support them to make simple decisions and day to day choices.
● We saw staff asking people to make simple choices throughout the inspection and supporting them to do this. People were choosing the TV programmes they wished to watch and the music they wanted to listen to, controlling this through remote controls and electronic tablets. People were choosing the food and snacks they wanted to eat. Activities such as art and crafts were agreed and decided by people present.

Adapting service, design, decoration to meet people's needs
● All bedrooms had an en-suite bathroom. One person's bathroom was in need of repair and they were not able to use it. The person's bedroom was on the first floor, the communal bathroom was on the ground floor. This meant they had to go downstairs to the floor below to use the bathroom. Staff told us the issue had been reported some time ago and the person had been waiting a long time for the repair. The en-suite bathroom had been out of use since June 2021. Another person's bedroom had a damp patch on the wall. This was awaiting repair and had been since November 2021. This posed a potential risk to the person's health.
● Some areas of the service, including furnishings, were worn and tired.
Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Most people had lived at the service for many years. People's needs and choices had not been reviewed with them and their loved ones on a regular basis to make sure assessments were up to date and providing consistent guidance for staff.
● Support plans did not fully set out people's current needs. For example, one person received funding from the local authority to receive 1:1 support. This was not clearly set out in their care plan to make sure they received the individual support as identified in their current funding assessment.

● The people living at Kingsdown House had lived there for many years. Staff knew them well as most staff had also worked at the service for many years. Staff were able to describe what people liked and what was important to them.
● People's bedrooms were personal, reflecting their interests and preferences. Some people had wallpaper of their favourite film and comic characters, others had made a choice around a themed colour.
● Although easy read or picture format signs were not evident around the service, we saw that people did know where they were going and where their bedrooms were.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support from staff to eat and drink enough to maintain a balanced diet. People could have a drink or snack at any time, and they were given guidance from staff about healthy eating.
● People were involved in choosing their food, shopping, and planning their meals.
● People were encouraged and supported to help to prepare and cook the meals where safety allowed. Two people were helping to cook the tea-time meal during the inspection, following the guidance of a staff member.
● Meal times were a sociable experience where most people ate together in the dining area. Some people chose to eat their meals elsewhere and this was respected.

Supporting people to live healthier lives, access healthcare services and support
● People had health actions plans and hospital passports which were used by health and social care professionals to support them in the way they needed.
● People had access to the health care they needed, including preventative health. These included dentist, opticians and chiropodists.
● Staff made sure people were referred to specialist health teams to support their wellbeing and help them to live healthy lives, such as the community mental health team.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. 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

- Staff knew people well and how they liked to be supported. They knew what may upset people or cause them to become anxious
- Staff showed warmth and respect when interacting with people and people responded to this.
- People received kind and compassionate care from staff who were positive and enjoyed their work. A staff member said, "I am very happy here and all the staff and the registered manager are friendly and approachable. I would describe everyone as caring."
- However, the provider's processes did not promote a culture of supporting staff to ensure people were at the centre of care and always received a good service as evidenced through this report.

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

- People had a key worker from within the staff team. One person told us who their key worker was and told us they had chosen them and were very happy to have them as their key worker. The person knew when the staff member was in next and said they were looking forward to seeing them.
- Key workers met with people regularly to check their well-being, if they were happy with their support or if they wanted any changes. Consistent records were not always kept and the meeting did not feed in to care planning. The registered manager said they would ensure the documentation was better kept.
- Staff supported people to express their choices around such things as meals, snacks and the indoor activities they wanted to pursue, using their preferred method of communication and allowing them time to respond. However, the processes to ensure decisions made in people's best interests were not robust enough to protect people's basic rights, as referred to in the 'effective' domain of this report.
- People were supported to access independent advocacy to help their voice to be heard. Staff supported people to maintain links with those that were important to them.

Respecting and promoting people's privacy, dignity and independence

- Staff knew when people needed their space and privacy and respected this. People spent time in their bedroom whenever they wished and chose where they spent their time.
- People were supported to maintain their day to day independence. Staff supported people to make day to day choices and decisions. People were encouraged to do day to day chores such as cooking, cleaning their room and doing their laundry where they could. Some people were also involved in shopping and keeping the garden tidy when the weather allowed.
- However, the provider's processes were not set up to support staff to ensure people were at the centre of care and were always treated with dignity and respect as evidenced through this report.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. 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

- Care plans were not always person centred. They did not provide individual detail to describe how people liked their care and support to be provided. This could impact the quality of care if agency or new staff were providing their support.
- The registered manager had introduced a document called 'Achieve myself' to support people to achieve their goals and aspirations and work towards independence. The records were poorly kept, with crossings out and the wrong names used. One person's document used the wrong name and the goal was not correct, referring to a road safety badge but describing a cooking task.
- Despite the record keeping not being adequate and needing to improve, the current staff team staff did know people well and we saw staff using an individual approach when they were supporting people.
- People had a support plan which provided information about their life history, who was important to them and their likes and dislikes. The things that were important to people were included, such as religious and cultural needs and how to support people to access religious festivals and groups if they wished. People's sexual identity had been explored and how staff could provide specific support if this was needed.

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.

- People's care plans were not developed in different formats to suit the communication needs of the individual. All care records were in written word format. Some, but not all, information posters were displayed in easy read and picture format. This is an area to improve.
- People had various ways of supporting their communication when they needed it. Some people had their own way of communicating which staff were able to understand as they knew people well. This included words and sounds used, or people's body language.
- Some people had access to electronic communication aids in tablet form. We saw one person using this, encouraged by a staff member, when they were talking together. People were also using pictures to communicate what they wanted.
- We saw staff engaging well with people, using various methods to suit their needs, and adapting this to suit a particular time. Such as if they were upset or anxious.

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

● People had not always been able to join in their interests in the community during the COVID-19 pandemic. Many resources had closed and had not yet re-opened. This had an impact on people's usual avenues to socialise and to have a more meaningful day.

● People had started to resume some of their interests. Some people attended college courses, and these had begun again. A musical fitness class led by an external provider had also begun again. We watched people joining in energetically during the inspection.

● The registered manager and staff told us about the things they introduced in the service to prevent boredom and to support motivation during the pandemic. People were joining in many arts and crafts activities during the inspection. People were clearly enjoying themselves and proudly showing their work. One person was completing a jigsaw puzzle. Staff were attentive and supporting where needed, while encouraging people to work independently and make their own choices. People were choosing the music they wanted to play, and staff were dancing and encouraging involvement.

● One person was using the service computer to practice writing, including notes to family members and writing their name and staff names. Staff were helping the person to do this with patience and encouragement.

Improving care quality in response to complaints or concerns

● People, and those important to them, could raise concerns and complaints and staff supported them to do so.

● Information was available about how to raise a complaint and this was displayed.

● Only one complaint had been received and this had been satisfactorily resolved.

End of life care and support

● No people were nearing the end of their life at Kingsdown House. However, people had been given the opportunity to develop a plan to record their preferences and wishes when they reached the end of their life.

● Some people and their family members were happy to discuss this, and their wishes were recorded. Others were not ready to have this conversation and did not want a plan, this was respected and also recorded.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager was not always clear about their role and the role of the provider. Communication between the provider and the service was not always adequate. The provider's head office staff completed tasks which should support the registered manager's role. However, this was not always the case. The cascading of information to relevant agencies in relation to the COVID-19 outbreak in the service did not happen due to miscommunication and lack of knowledge. Concerns around recruitment had not been picked up by the provider's head office staff, who managed recruitment, or the registered manager when the information was passed to them.
- The registered manager did not have full oversight of the safety of the service. Action required from servicing and maintenance visits were sent to the provider's head office and the registered manager was not always aware when they would be complete or if they had been completed. These included actions from a fire service visit and a legionella risk assessment.
- Audits of quality and safety had been carried out, by the registered manager and the provider. However, the process was not clear, including the regularity, improvement planning, who was responsible for action needed and by when. Some areas had been identified as needing improvement, but a clear plan was not in place how to achieve this. The registered manager told us action had been taken in some areas, however, was not able to evidence this.
- The registered manager did not have a process in place to regularly monitor accidents and incidents in order to check for similarities and themes to support the prevention of falls.
- The registered manager told us a reported safeguarding incident involving a member of staff had been investigated. The member of staff had since left the provider's employment. However, the registered manager did not know what the outcome of the investigation had been and there were no records to check.
- Some of the areas of concern we found during the inspection had not been picked up by the monitoring and auditing checks in place. These included, staff administering out of date medicines, risk management, staffing levels, record keeping and recruitment processes.

The failure to closely monitor the quality and safety of the service was a breach of regulation 17 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

- Many staff had worked at Kingsdown House for a number of years. One member of staff said, "I love it here.

I can't see myself being anywhere else." Staff spoke with knowledge about people, what they liked, what their abilities were and what they needed extra support with.
● Staff spoke about people's individuality and how they supported people in different ways to enhance their strengths. They told us that teamwork helped to support people to achieve. A member of staff told us, "[The registered manager] is very approachable – their door is always open so you can go in and have a chat."
● However, staff also told us they felt the service they could provide had declined and felt demoralised by this. They felt they did not receive adequate support from the provider, communication was poor, and they did not receive the resources they needed to do their job well. This included appropriate furniture, timely repairs and adequate staffing. Staff told us this presented a stressful and frustrating situation at times.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had the opportunity to speak up about the service and how it was run at regular monthly meetings. Not everyone could verbally communicate but staff used individual means to get people's views. For example, staff spoke with people directly, using pictures or electronic communication aids.
● The provider carried out an annual survey with people and family members to gain their views of the service provided. How the provider responded to feedback was not always clear, such as the things a person said they did not like about the service. A survey of others involved in the service, such as healthcare professionals had not been undertaken in the last year. The registered manager told us this was intended to be done this year.
● Staff were able to have their say during staff meetings. Staff told us these were managed well, and they felt able to raise issues and plan improvements.

Continuous learning and improving care
● The provider had not invested sufficiently in the service, to make sure the registered manager and staff had the information and resources they needed to embrace change and deliver improvements.
● A clear vision for the direction of the service by the provider, which demonstrated ambition and a desire for people to achieve the best outcomes possible was not evident.
● Where concerns had been raised, the provider had not made sure objective investigation was carried out to cascade learning and improve care based on outcomes.

Working in partnership with others
● The registered manager was not involved in any local or national forums to expand and broaden their knowledge. They had little knowledge of what was available to add support, such as local authority engagement groups. We spoke with the registered manager about this and they said they would research what is available, they felt it would be beneficial both personally and to support innovation and improvements in the service. This is an area to improve.
● The provider had set up regular meetings internally for managers of their services locally and nationally. The registered manager regularly attended these.
● The service worked in partnership with advocacy organisations and health care organisations, which helped people using the service to improve their wellbeing.

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
● Where incidents and accidents had occurred, the records showed that families were contacted where relevant. The manager told us they were aware families needed to be contacted and apologised to when there had been shortfalls in care.
● Services that provide health and social care to people are required to inform the Care Quality Commission

(CQC) of important events that happen in the service. The provider had informed the CQC of significant events including incidents and safeguarding concerns

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 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's rights were upheld and decisions made in people's best interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure individual risks were managed safely. The provider failed to ensure the safe management of people's prescribed medicines. The provider failed to ensure the safe management of infection prevention and control procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have clear oversight of the service and to ensure monitoring and auditing systems were effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient skilled and trained staff were deployed.