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Kingsgate Residential Home

Inspection report

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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
Kingsgate is a residential care home providing personal care to people aged 65 and over at the time of the inspection. On the day of our first visit there were 24 people living in the service with one person in hospital. When we visited on the second day, 22 people were living in the service and three people were in hospital. The service can support up to 33 people.

Kingsgate is comprised of three large terraced houses and is set across three floors. People share bathing facilities and there are a number of communal lounges and a large dining room.

People's experience of using this service and what we found
At this inspection we found the provider had not taken any action to address the concerns found at the previous inspections in March 2019, and January 2020. At this inspection in December 2020, we found continued breaches of three of the regulations.

Management of risks within the environment and to people's individual needs were poorly managed. Serious risks within the environment which posed a risk of harm to people were not identified, and appropriately managed. Risk assessments in relation to behaviour that challenges were not in place.

Records of accidents and incidents were not detailed, nor consistently recorded. Opportunities to learn from incidents were missed due to the lack of thorough investigation of incidents.

Notifiable incidents were not always reported to the Care Quality Commission as they are required to by law

Staff compliance with training was poor, and not all staff had completed training in safeguarding. However, staff understood what constituted abuse and people felt safe living in the service.

Methods used to determine staffing levels were not thorough, and staff told us they did not always have time to spend with people outside of delivering personal care.

Some gaps were found in people's medicine administration records. There were protocols in place for when required medicines were needed, and staffs' competencies in relation to administering people's medicines had been assessed.

Some equipment was found to be dirty, but action was taken to address this during the inspection visit. There was a delay in implementing increased cleaning of the home in light of the pandemic and policies and procedures in relation to COVID-19 were not sufficiently detailed.

Processes to assess and monitor the safety and quality of the service being delivered remained ineffective. The provider did not undertake any quality monitoring to gain an overview of the service.

Processes were in place to engage people who lived in the service, their relatives and staff. Meetings were held for people and staff, but sometimes information pertinent to people living in the service and the staff was not discussed.

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 28 February 2020) and there were four breaches of the regulations which were safe care and treatment, need for consent, good governance and notification of other incidents. At this inspection we found the provider remained in breach of three of these regulations.

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

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

The overall rating for this service has changed from requires improvement to inadequate. This is based on the seriousness of concerns found at this inspection.

We have found evidence that the provider needs to make significant improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this report.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Kingsgate 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.

At this inspection we have identified breaches of regulation in relation to safe care and treatment, good governance, and notification of incidents.

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

Follow up
The overall rating for this service is 'Inadequate' and the service remains 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.

Following the inspection, the provider made a decision to close the service. The local authority and provider supported people to find alternative residential care homes and the last person left the service on 11 February 2021.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Kingsgate Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The first site visit was carried out by two inspectors, and the second by one inspector. An assistant inspector worked remotely and spoke with people's relatives.

Service and service type
Kingsgate 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 owner of the service was the registered provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided. There was also a manager in post who oversaw the day to day running of the service.

Notice of inspection
This inspection was unannounced.

We carried out a focused inspection to review the key questions of safe and well-led only.

Inspection activity started on 1 December 2020 and ended on 29 December 2020. We visited the service on 1 December 2020 and 8 December 2020.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority about the service.

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 us 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 used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with two people who lived in the service. We also spoke with the provider, the manager, three members of care staff and a member of maintenance staff. During the visit, we also observed the care and support people received.

We reviewed a range of records. These included the care records for four people, and the medicines records for four people. We also reviewed a variety of records relating to the management of the service. These included policies and procedures, incidents, training records, quality monitoring audits and maintenance records for the premises.

After the inspection
We had further contact with the provider, the manager, and deputy manager to assess and validate the information we reviewed.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection we found the provider had failed to ensure accurate and effective assessments of risks to the health and safety of people using the service were in place. These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

- People were exposed to the risk of scalding. On the first day of our inspection we noted the hot water from four accessible taps was extremely hot. We raised this with the manager and provider who assured us measures would be put in place to mitigate the risk. We were also informed a risk assessment for the hot water would be written. When we returned to the service on 8 December 2020, we found that no action had been taken in relation to these concerns. After our second visit, the provider informed us an electrician had visited the service and found a fault with one of the boilers, some action was taken to reduce the temperature of the water, but further work was still required to ensure the water was not a risk to people.
- On the first day of our inspection, we also found a large heater which was very hot to the touch. This posed a risk to people should they fall against it. We raised this with both the manager and provider. We were told a risk assessment would be put in place to mitigate this risk and a guard put in place. We saw the guard being fitted on the second day of our inspection on 8 December 2020.
- Records of accidents and incidents lacked detail and information was not recorded consistently. For example, one accident report failed to detail what action had been taken to mitigate the risk of a further occurrence.
- Records of lessons learnt from incidents were not detailed. For example, a review of an incident in relation to moving and handling failed to review whether staff were competent in moving and handling. Training records showed that less than 30% of staff had completed moving and handling training. The lessons learnt part of this report also failed to document additional contributing factors which were reported to us when we made initial enquiries about the incident at the time it was reported to us. Therefore, we were not assured accidents and incidents were recorded and investigated thoroughly.
- Some people living in the service showed behaviour that challenged. We found there were no care plans or risk assessments in people's care records to detail how they would like to be supported when showing distressed behaviours. It was of concern risks in relation to behaviour that challenged had not been identified or planned for.
- Person emergency evacuation plans (PEEP) did not contain sufficient detail. For example, we saw the PEEP for one person stated they wore hearing aids, however, there was nothing in the PEEP to show

whether they would hear the fire alarm if they were not wearing them.
● Daily records of people's care needs showed that people did not always receive care according to their needs. For example, two people were at risk of not maintaining a healthy nutritional food or fluid intake. There was a food and fluid chart and a second fluid chart. The fluid charts showed different total amounts of fluids consumed for both people. Both charts, for both people, also showed that people were not offered drinks in the evening.
● One of the people on a food and fluid chart was also at risk of developing pressure ulcers. To minimise this risk, their care plan stated staff should support them to reposition at frequent intervals. Their repositioning chart showed they were not being repositioned at the frequency stipulated in their care plan; and were left for long periods of time which increased the risk of them developing a pressure ulcer.

We found no improvements had been made to ensure risks to people's safety, including risks within the environment, were adequately identified, planned for and managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

● We reviewed accidents and incidents and found that CQC had not been notified of an incident where one person fell and sustained an injury.

We found that no improvements had been made to ensure that all notifiable incidents were reported to the CQC. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Systems and processes to safeguard people from the risk of abuse
● Not all staff had received training in safeguarding, less than 50% of staff had received up to date training in safeguarding.
● Staff we spoke with understood what constituted abuse; and were able to tell us the process they would follow to raise concerns. One member of staff we spoke with was not aware of all the agencies they were able to report concerns to.
● There was no poster displayed within the service which detailed the contact details for the local safeguarding authority.
● Both of the people we spoke with told us they felt safe living in Kingsgate. One person explained they felt safe as, "There was always someone around." People's relatives we spoke with also told us they felt their family members were safe. One person's relative told us, "I feel [family member] is safe here and they look after [family member] well."

Staffing and recruitment
● Staff we spoke with told us they did not always have the time to spend with people outside of delivering care. During our inspection, we observed that staff did not always have time to spend with people. However, we did observe the deputy manager having a conversation with one person whilst knitting. The conversation was flowing and centred around the person.

● Staffing levels were not adequately assessed. The dependency tool used to determine people's level of care need, and in turn, the numbers of staff required to meet people's needs, was not adequate. Without a thorough assessment of people's individual needs, we could not be assured the correct levels of staff were deployed throughout the day and night. One member of staff told us they thought there was enough staff, "If you have the right staff." They added they sometimes get time to speak with people. A second member of staff told us they didn't always have time to speak with people, and that the skill mix of staff was not always considered when devising the rotas.
● Training records showed that staff had not completed all of their training, and overall compliance was poor. We noted from training records that first aid was not listed as a required training course. This meant we were not assured staff had received the required training to carry out the roles expected of them.
● The provider was not following their own procedures in relation to the recruitment of staff. For example, the staff file audit we reviewed showed that two staff had not had a Disclosure and Barring Service (DBS) check within the past three years. The DBS hold information about employees who may have been investigated or convicted of an offence which may prevent them from working in a care setting. We also noted references had not been sought from one employee's previous two employers, as stipulated on the staff file audit.
● We received mixed views when we asked people if there were enough staff. One person told us staff got to them quickly when they required assistance. A second person told us, "I ring my bell, [and] I can wait 15 or 20 minutes before I see anyone."
● People's relatives we spoke with told us they felt there were enough staff. One person's relative explained, "I would say there were enough staff, but some of them have seemed tired, but what do you expect with so much going on, and I bet it is a tiring job. They are amazing for what they do."

Using medicines safely
● People mainly received their medicines as prescribed, however we noted some gaps on the Medicine Administration Record (MAR) charts where staff signed to say if people had taken their medicine.
● The medicines trolley was situated by a radiator, and the temperature inside of the trolley was not monitored. It is good practice to monitor the temperature inside the trolley to ensure people's medicines were stored at the correct temperature, to avoid them being spoilt.
● It was observed the inside of the medicines trolley was dirty. A medicines audit carried out on the day before our first visit identified the trolley required cleaning.
● We found an unsecured, open, full sharps bin stored on a shelf above the medicines trolley. This posed a risk as people living in the service could access it. We raised this with the manager who disposed of the sharps bin as it was no longer required.
● There was sufficient information recorded on people's MAR charts to enable staff to give people their medicines according to the prescriber's instructions. There were protocols in place where people were prescribed 'as required' medicines; these detailed when people should be offered these medicines, for example, when experiencing pain.
● Both oral and topical medicines were stored securely. Most medicines were stored in the medicines trolley, and topical medicines such as creams and ointments were secured in lockable cabinets in people's rooms.
● Staffs' competencies in relation to the safe administration and management of people's medicines were assessed, and we reviewed records to show these assessments had taken place.

Preventing and controlling infection
● We found some areas of the service were unclean. We found dirty toilet raisers, and what appeared to be faecal matter on one person's bed frame. A pile of pressure relieving boots were in one of the lounges, these were also dirty and unlabelled. We raised our concerns with the manager, and by the end of our first visit

action had been taken to clean the toilet raisers. On the second day we inspected, we found another dirty toilet raiser. We also raised this with the manager, and action was taken.

● We were not assured that cleaning schedules had been amended in response to the pandemic to account for the extra cleaning required to minimise the risk of infection. We noted a cleaning schedule for the high-touch point areas of the home had only been implemented around November 2020. The medicines trolley and administration equipment was not included on any cleaning schedule.

● The infection prevention and control policy had not been updated to reflect the additional measures required to minimise the risk of transmission of COVID-19. For example, nothing had been added to show what PPE staff were required to wear, and there was nothing in the policy to show what action should be taken in the event of an outbreak.

● We saw that staff were maintaining social distancing wherever possible and were wearing the correct PPE.

● We had our temperature taken prior to entering the home as the provider had installed a digital thermometer outside the front door. When inside our temperatures would have been taken again by a member of staff, but the thermometer was not working. On the first day we inspected, we were not asked any screening questions to see if we had experienced any symptoms of COVID-19. On the second day we inspected, our temperatures were taken twice, and we were asked screening questions.

● We were assured that the provider was accessing testing for people using the service and staff. There had been no outbreaks at the service.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has now remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found the provider had failed to implement systems and processes to effectively assess and monitor the service. These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

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

- The provider did not undertake any audits to assess and monitor the quality and safety of the service being delivered to provide an overall picture of how the service was doing.
- The monthly audit undertaken by the manager did not cover all areas of the service being delivered and it was not effective in always identifying areas for improvement. Where shortfalls were identified, there was no action plan in place to show when improvements would be made by.
- The monthly audit undertaken by the manager in October and November 2019 had identified that staff could not identify the location of the policies and procedures, and that they were not up to date. This was because the new policies and procedures had not been printed. Therefore, we could not be assured that staff had access to the most up to date information about their roles and responsibilities in relation to providing safe and effective care to people.
- Investigations of accidents and incidents were not thorough. Therefore, opportunities to learn lessons and provide a comprehensive review of incidents were missed and also no opportunity to prevent them happening again
- As part of our inspection we asked for a copy of the provider's legionella policy. This was to check they had the necessary policy and procedures in place to assess and manage the safety of the water. We have still not received this.
- The provider and manager failed to respond immediately when we found some accessible hot taps in the service posed a scalding risk. We had been told action had been taken after the first day of our inspection, but when we returned the following week, we found this was not the case.

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

- We reviewed a complaint which was not responded to in a timely manner, and the response failed to provide a comprehensive and detailed account in response to the complaint.

● After an inspection in March 2019, we imposed conditions on the provider's registration. These conditions made it a legal requirement for the provider to send us a monthly report to show how they were making improvements to achieve compliance with the regulations. These reports have not been sent to us every month in line with the conditions.

These finding constituted a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider failed to ensure that they had effective systems and processes in place that assessed, monitored and improved the quality of the services provided to people living in the home.

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

● We received varied opinions of whether the culture was person-centred and inclusive. One person told us they were not involved in the planning of their care.

●People's relatives we spoke with told us they were involved in the planning of their family member's care, and that staff had a good understanding of people's care needs. One person's relative explained, "Yes, they know [family member] well and they get to know the family too. They work with [family member] to make sure [family member] has the right care, for example [family member] found it hard getting up to [family member] room upstairs so when a downstairs room came available [family member] moved there.

● We received mixed opinions when we asked staff about the culture of the service. One member of staff told us staff morale was low, and the manager was not approachable. A second staff member told us the atmosphere in the service had improved since the deputy manager was appointed, and they had implemented new practices to ensure staff were more organised.

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

● People were regularly asked for their feedback. Daily walk arounds were completed by either the manager or deputy manager and records showed people were asked for feedback about the service.

● A survey was given to people to complete in October 2020, and the analysis showed that activities were an area for improvement. This was not discussed at the meeting held for people which took place in November 2020.

● Regular staff meetings took place. Records of these meetings showed a staff meeting took place the day after our first day of inspection, but the concerns found in relation to the hot water were not mentioned. This would have enabled staff to monitor more carefully and prevent people from being scolded until the water temperature was fixed.

● Relatives we spoke with told us they were able to maintain contact with their family members when they have been unable to visit. One person's relative told us staff facilitated a videocall with their family member. Relatives we spoke with also told us staff kept them updated when there were any changes to their family member's health, or when there were any changes made to the running of the service.

Working in partnership with others

● The service had been working with other agencies such as the local authority in an attempt to make the required improvements to achieve compliance with the regulations. Despite the input from the local authority, the necessary improvements have not been made.

● Since our inspection, the provider informed us they have been in contact with the quality monitoring team at the local authority to discuss how to effectively implement a provider audit to monitor the safety and quality of the service.