Caring Homes Healthcare Group Limited

Kingsclear

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

We undertook an unannounced focused inspection of Kingsclear on 1 May 2018. This inspection was done following receiving concerns from the local authority safeguarding team. These included, safeguarding concerns which had not been appropriately investigated or reported, continued staffing issues and the management oversight of the service. The team inspected the service against two of the five questions we ask about services: is the service Safe and is the service Well-Led.

We completed a comprehensive inspection of Kingsclear on 7 March 2018 where we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Concerns including insufficient staff being deployed to meet people's needs, risks to people's safety not being identified and met, a lack of person centred care and the overall governance of the service. The ratings from the previous comprehensive inspection for the Key Questions of Effective, Caring and Responsive were included in calculating the overall rating in this inspection. Due to the short timescales between the inspections the provider has not had the opportunity to submit an action plan regarding how they intend to address the breaches identified during the inspection on 7 March 2018.

Kingsclear is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Kingsclear accommodates up to 97 people in a new adapted building. Part of the service specialises in providing care to people living with dementia. At the time of our inspection there were 33 people living at Kingsclear.

There was no registered manager in post. Prior to the inspection we were informed by the provider and local authority safeguarding team that the registered manager had left the service without serving notice. A peripatetic manager had been allocated to the service and supported us during the inspection. They told us they intended to apply to register with the CQC as the manager of Kingsclear. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks associated with people's behaviours had not been comprehensively assessed and staff were not provided with guidance on how to keep people safe. Triggers to people's behaviours had not always been identified and acted upon. People's health needs were not always monitored effectively and there was a lack of understanding from staff regarding how pain and discomfort may affect people's behaviour.

There was a lack of management oversight of the service which meant the provider was unable to assure themselves that people were safe and were receiving the care they required. The management team in place did not have a comprehensive overview of the risks within the service. Records regarding accidents, incidents and safeguarding were not accurately maintained so the provider could not take an overall view of

the needs of the service. Although the provider had systems in place to enable them to monitor and action emerging risks, these were not been used effectively. There was a lack of leadership regarding how staff were deployed. This had led to people not always receiving their care in a timely manner and some staff feeling under pressure.

The peripatetic manager was unable to access records relating to people's needs or the care they had received. Care staff employed by the provider did not have full access to risk assessments and care plans in order to ensure they were providing the care people required and were aware of any risks to their safety. Agency staff were unable to access any records relating to people's care and were unable to record the care they had provided.

People were not protected against the risk of abuse. Safeguarding concerns had not always been reported to the local authority safeguarding team. Where altercations between people living at the service had occurred steps had not been taken to minimise the risk of this reoccurring. The provider was unable to give information regarding the number and type of safeguarding incidents which had occurred. The provider had failed to ensure that CQC were notified of safeguarding concerns in line with their regulatory responsibilities.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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

The service was not safe

People were not always protected from the risk of abuse as safe reporting systems were not in place. Where concerns had been identified these had not always been addressed promptly.

Risks associated with people's behaviours were not comprehensively assessed and acted upon. Detailed guidance for staff in how to support people was not in place.

Accidents and incidents were not always reported, investigated and acted upon.

Staff were not always appropriately deployed.

Is the service well-led?

Inadequate

The service was not well-led

There was a lack of managerial oversight of the service. The management team were not aware of all risks to people's safety and well-being.

There was a lack of leadership provided to staff which affected the way in which staff were safely deployed.

Staff were unable to access comprehensive care records and agency staff were unable to record the care they had provided.

The provider had failed to notify the Care Quality Commission of significant events in line with statutory requirements.

Kingsclear

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by information received from the local authority safeguarding team. They had received a report from a relative regarding an incident between two people living at Kingsclear. The safeguarding team visited Kingsclear as they had not been made aware of the reported incident. During their visit they found evidence of a number of other altercations between people which had resulted in injuries or near misses. The safeguarding team also raised concerns regarding the management oversight of the service and the number of staff available to support people. The above concerns mainly related to the area of the service supporting people who were living with dementia.

This focussed inspection took place on 1 May 2018 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, we reviewed records held by the Care Quality Commission which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider complete a Provider Information Return (PIR) as we inspected the service sooner than we planned. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The information shared with CQC by the local authority safeguarding team indicated potential concerns regarding the management of risk in relation to supporting people living with dementia and behaviours which may present a risk to the individual and others. During the inspection we therefore viewed accident and incident records, safeguarding referrals and individual risk management plans. In addition we viewed care records for three people including pre-admission assessments and health records.

As part of our inspection we spoke with two people who lived at Kingsclear and observed the care and support provided to people. We spoke with one relative, six staff members, the peripatetic manager and regional manager. We spoke with the local authority safeguarding team and adult social care team both before and after the inspection.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2018 we identified concerns regarding insufficient staff being deployed to meet people's needs and the way in which risks to people's well-being were managed. We also found that people's anxiety and behaviours were not routinely monitored and clear guidance for staff in supporting people was not available. During this inspection we found that although staffing numbers had increased there were concerns regarding staff competence and staff deployment. We identified continued concerns with regards to risk management and the way in which people were supported with their anxiety. In addition, we identified concerns regarding how people were safeguarded from the risk of abuse and the way in which accidents and incidents were reported and addressed.

Prior to our inspection the local authority safeguarding team received information from a relative regarding an altercation between two people living at the service. When the safeguarding team visited the service they were alerted to another person with a number of visible injuries to their skin. The person's relatives informed them that some of the bruising and skin tears were as a result of altercations with other people. The safeguarding team are currently investigating these concerns. Their investigation has also widened to include other people living at Kingsclear.

Risks relating to people's behaviours were not assessed in detail and guidance on mitigating risks was not shared with staff. One person's records showed that they had been assessed of being at high risk of displaying behaviours which may challenge others. Risk management plans identified possible triggers to the person's behaviour. However, these were recorded in a section of the person's care plan which could not be accessed by care staff. On the person's summary care plan which staff were able to view, this risk was not identified. We spoke to one staff member who told us they were unaware of the triggers identified and added they did not agree with the information within the risk assessment. They told us, "I've never heard that but I don't think it's right from what I've seen. The trouble is they don't ask us what we think and we're the ones who are working with them all the time." There was no information within the person's records to show how the triggers to their behaviour had been identified. There was no guidance available to staff on how to monitor the person's behaviour to identify triggers or how to support them during periods of high anxiety. Daily notes and incident records showed the person regularly displayed behaviours towards both staff and other people living at Kingsclear.

We reviewed records relating to another person who had been identified as displaying behaviours which may result in harm to others. Staff also informed us that at times the person experienced periods of anxiety and confusion which may result in confrontations with others. During the inspection we identified four occasions when the person had been involved in physical altercations with other people living at Kingsclear. A risk assessment regarding the person's behaviours had been completed which determined the person was at high risk of 'sudden behaviour changes causing harm or injury towards other staff and residents'. A second risk assessment stated the person presented a high risk of 'Physical and verbal aggression'. Despite these risks being identified there was little information available to staff regarding how to support the person to reduce their levels of anxiety. Records advised that staff should monitor changes in the person's behaviour and assess any potential triggers. However, we found that this was not being consistently

completed and no analysis of records had been undertaken. Guidance to staff also stated, 'Staff not to antagonise (name)' and to treat them with respect'. There was no guidance on what the person may find antagonising or proactive ways in which staff could support the person. The persons pre-admission assessment detailed they were living with a health condition which may lead to considerable pain and discomfort. The person's relative told us that these health concerns had been an on-going issue for many years. They told us they had shared this information with staff during the two months the person had lived at Kingsclear but they did not feel this had been listened to or acted upon. Until this had recently been noted by an external health professional, no action had been taken to discuss these concerns with the persons GP. The person had been living at the service for over two months. We asked the unit manager why no action had been taken regarding the persons on-going health issues. They told us, "We've been concentrating on their behaviours." This showed a lack of awareness that the person's behaviours may be as a result of them not being able to communicate their pain or discomfort.

Accidents and incidents were not always appropriately reported and action was not always taken to minimise the risk of reoccurrence. We requested to view incident records relating to the concerns which had been raised by the local authority safeguarding team. However, we found that not all incidents had been reported and tracked on the providers electronic monitoring system or within paper records. One relative told us that although they felt their family member was safe living at Kingsclear they had been informed of an incident where another person had pushed them to the floor. They had been reassured that no injuries had been sustained. We were unable to find any incident form in relation to this incident. A wider records review identified that some incidents had been recorded using the accident and incident reporting system whilst others were held within people care notes, safeguarding forms or CQC notification forms. This meant there was no consistent system being followed to ensure information was analysed and responded to.

We reviewed one person's daily care notes for a 34 day period. Notes stated, 'During this episode they hurt others (staff or other living at Kingsclear)' on eleven occasions during this period. However, only one incident form had been completed. This meant that the provider was unable to ensure that all incidents had been tracked and action taken to minimise the risk of them reoccurring. The provider had an electronic system in place to track accidents, incidents and safeguarding concerns. This could be accessed by senior staff to enable them to reassure themselves that appropriate action had been taken to mitigate risks. However, we found that not all incidents had been logged on the system which meant that trends had not been monitored and senior managers were not always aware of concerns.

The lack of effective risk management systems and accident and incident monitoring was a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Robust systems were not in place to ensure that people were effectively protected from the risk of abuse. Staff told us that they had received safeguarding training during their induction. However, staff did not demonstrate an understanding of their responsibility to report safeguarding concerns. We asked two staff how safeguarding concerns were reported. One staff member told us, "We need to date and record it and fill in an incident form. That goes to the manager and they will decide if it is a safeguarding incident or not." A second staff member told us, "You have to report it to the manager and they will decide what to do." This demonstrated a lack of understanding and knowledge regarding safeguarding being the responsibility of all staff working at the service rather than for the manager to decide what constituted a safeguarding concern. As described above, we found that incident forms were not completed following all incidents at the service.

Safeguarding concerns were not appropriately reported in accordance with the local authority safeguarding arrangements. This meant that the safeguarding team were not able to monitor instances of abuse at the service in line with their duties under the Care Act (2014). Documentation viewed showed that two incidents

had been recorded on safeguarding forms. However, these had not been received by the local authority due to issues with IT equipment at the service. Notification forms required by CQC regarding the same incidents had also been completed but not successfully sent. We asked the peripatetic manager and regional manager if forms had been completed for the additional incidents which had been identified but no documentation could be found. This meant that instances of abuse had not been shared with the local authority safeguarding team to enable them to investigate concerns and ensure people were living in a safe environment.

The failure to ensure systems and processes were in place to protect people from potential abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not appropriately deployed and were not always aware of people's needs. At our last inspection in March 2018 we identified concerns regarding staffing levels within the service. At this inspection the peripatetic manager informed us that staffing levels had been increased. To achieve these increased levels a number of agency staff had been employed within the service. One staff member providing care told us that this had not helped the situation as they were now required to support agency staff in what needed to be done. In the area of the service supporting people living with dementia we observed one permanent member of the care team was working alongside two agency care staff and an agency nurse.

Throughout the day agency staff were repeatedly asking the permanent staff member for direction regarding people's care needs and daily routines. This was clearly putting the permanent staff member under pressure. We observed staff were constantly busy completing care tasks and did not have time to sit and engage with people. We asked the agency staff what induction they had received prior to supporting people. They told us they had been given a tour of the building and shown the emergency procedures. They had not been given the opportunity to read people's care records in order for them to gain understanding of their individual needs.

In contrast, the ground floor was staffed by a permanent nurse and staff member, three agency staff and one staff member shadowing as part of their induction. We observed on several occasions staff standing talking in a group in communal areas. The peripatetic manager told us that one agency staff member should be moving between the two areas of the service to offer support when required. However, we did not observe this happening and staff told us they were not aware of this. This meant that staff were not appropriately deployed to ensure they were available to respond to people's needs.

The failure to ensure that staff were appropriately deployed to meet people's needs was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2018 we found there was a lack of effective quality assurance systems to monitor the service and a failure to embed a positive ethos and culture. At this inspection we found continued concerns in these areas. Prior to our inspection we were informed that the registered manager had resigned from their position with immediate effect. A peripatetic manager who had had some previous involvement in the service had taken management responsibility.

The management team were unable to assure themselves that people and staff were safe. When reviewing incidents which had occurred between people, the management team were unable to find information relating to the number, type and outcomes of incidents which had occurred. The local authority safeguarding team had expressed concerns regarding incidents which had resulted in people sustaining injuries. However, the management team had not gathered information relating to these incidents to assure themselves people were now being kept safe. Although systems were in place to monitor and review accidents and incidents, effective action had not been taken to ensure that staff were reporting all incidents. It was clear from reading daily care notes that some people were regularly experiencing episodes of high anxiety which on occasions was resulting in staff being harmed. However, these incidents were not being monitored by the management team in order to provide support and guidance to the people and staff involved.

As reported within the safe domain, staffing levels had increased since our last inspection in March 2018. However, there was a lack of leadership regarding how staff were deployed and how agency staff were inducted into the service. We found that people continued to be supported by staff who did not know their needs and preferences. We observed confusion regarding who was completing tasks and what needed to be done which resulted in people waiting for their care. As reported, we observed periods where staff were spending time chatting with each other in one area of the service whilst in another area staff were extremely busy, call bells were ringing repeatedly and people were waiting for staff to respond. This showed a lack of leadership and direction for staff that was impacting negatively on people's care. We asked the peripatetic manager who should be leading the shift in the area supporting people living with dementia. They informed us this should be the agency nurse on duty who had worked regularly at the service. They were unable to inform us what induction the agency nurse had received and how they had been assessed as having the skills and knowledge of the service to lead a shift. We observed the agency nurse asking the care staff for information regularly during the inspection. This meant that people were at risk of the needs not being met and of not receiving care in a timely manner.

Staff told us they felt under pressure and that there was a lack of direction from management. One staff member told us, "I've never worked anywhere so stressful. Especially the staffing. It gets better for a few days and then worse again. We haven't been given any guidelines. We have to work it out ourselves." Another staff member told us, "They could be more organised here. It's not very relaxed for anyone the way they are doing things."

The provider had failed to ensure that records were available to staff regarding people's needs and risks to

the their safety. All care plans and risk assessments were stored electronically in the service. Staff were able to input information regarding the care they had provided on hand held devices. However, they were only able to access basic care plan information and did not have access to risk assessments. This meant that staff were unaware of possible triggers to people's behaviours or health conditions which may affect their well-being.

The provider could not assure themselves that people were receiving the care they required and that this was being accurately recorded. Agency staff did not have access to handheld devices in order to input information. The unit manager told us they had recognised this issue and had requested information from IT services on how to deal with this concern. They told us, "Until we get this we aren't sure of how to do things. At the moment we are getting them (agency staff) to write everything down and we'll see how to get it on the system." Agency staff were not provided with a format for what information they should record at what time or when.

The peripatetic manager did not have quick access to information relating to people's care needs. During the inspection we requested that a number of items were looked at or printed. The peripatetic manager was unable to do this as they were awaiting log in details to be provided in order for them to access the electronic system. This meant they were unable to readily access or monitor information regarding people's needs, risks or actions taken.

The failure to ensure good governance of the service was a breach of regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the regional manager forwarded an action plan regarding how the service would be supported going forward. This included details of additional management cover to ensure a manager was available seven days each week, communication systems to enable risks to be identified and managed, staff deployment and recruitment and reviews of all care records and risk management plans. We also received evidence that the service had begun to work in partnership with other services in order to meet people's needs. We will continue to closely monitor the service provided at Kingsclear, in conjunction with other statutory services.

The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events. As reported there had been a number of safeguarding incidents regarding physical altercations between people living at Kingsclear. Our records showed that the CQC had not been informed of these incidents to ensure that we were able to monitor the service provided effectively. Evidence was provided that two notifications had been sent which due to the provider encountering technical difficulties had not been received. We identified a further four incidents which had no notifications completed. The peripatetic manager and regional manager apologised and gave reassurances that notifications would be sent in a timely manner going forward.

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

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit notifications in line with statutory requirements

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that systems and processes were in place to protect people from potential abuse

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were appropriately 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
Treatment of disease, disorder or injury	The provider had failed to implement effective risk management systems and accident and incident monitoring.

The enforcement action we took:

We issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure good governance of the service

The enforcement action we took:

We issued a Warning Notice