Innowood Limited

Kingswood House Nursing Home

Inspection report

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East Sussex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Kingswood House Nursing Home is a residential care home providing personal and nursing care for up to 22 younger adults who have mental health needs. There were 19 people living there at the time of the inspection. Most people needed support with mental health needs and some people lived with complex health needs, such as Huntington's chorea. Some people also received rehabilitation support which prepares them for returning to independent living.

People's experience of using this service and what we found
Systems and processes to assess, monitor and improve the quality and safety of the service provided were in place. However, there were areas of people's documentation that needed to be improved to ensure staff had the necessary up to date information to provide consistent, safe care. Incident forms were completed but there was a lack of overview, analysis and follow up to prevent a re-occurrence or to mitigate risk. Notifications of incidents and events had not been reported to CQC as legally required for the service since July 2021.

Improvements were needed to the management of risk to ensure people received safe care and support. Incidents and accidents whilst recorded on an incident form were not reflected in peoples' care plans. There was no analysis of cause, trends or themes, therefore, opportunities of learning from accidents and incidents had been missed. Staff were not monitoring the overall effectiveness of pain relief medicine or looking at the times as and when needed medicine (PRN) requests were made for trends or themes.

People received support from staff who had been appropriately recruited, and trained to recognise signs of abuse or risk. One person said, "I am safer here than anywhere." Medicines were being given to people by trained and knowledgeable staff, who had been assessed as competent. There were enough staff to meet people's needs. Safe recruitment practices had been followed before staff started working at the service. The home was clean and hygienic.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People, their relatives and health care professionals had the opportunity to share their views about the service. The provider and manager were committed to continuously improve and had developed structures and plans to develop and consistently drive improvement within the service.

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 4 February 2020)

Why we inspected
The inspection was prompted in part due to concerns received about the management of incidents and potential under reporting. A decision was made for us to inspect and examine those risks. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to management of risk, and good governance at this inspection.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Kingswood House Nursing Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by two inspectors who visited the service.

Service and service type
Kingswood 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received from, and about, the service since the last inspection and we

sought feedback from the local authority. We used all of this information to plan our inspection.

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.

During the inspection
We spoke with eight people who used the service, about their experience of the care provided. Not everyone who lived at Kingswood House wished to talk with us about their views, so we spent time observing how people and staff interacted and how people spent their time at the home. We observed administration of medicine. We spoke with eight members of staff including the manager, area manager, deputy managers and care staff.

We reviewed a range of management records including safety and maintenance records and audits. We reviewed eight people's care and support records. We looked at records in relation to staff training and staff supervision.

We continued to seek clarification from the manager to validate evidence found. We spoke with two visiting professionals and a member of the local authority commissioning team. We also received further feedback from two members of staff.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to 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

- Risks to people were not consistently managed well. There was a lack of follow up to incidents where some people's anger and frustration had escalated. Antecedent -Behaviour -Consequence (ABC) charts had not been completed to manage or prevent further incidents. ABC charts help identify factors that can trigger or reinforce acute behavioural incidents.
- Incidents relating to people's safety were not being analysed by staff to identify trends and themes. For example, triggers for anger and aggression or substance misuse.
- To maintain peoples independence, people were supported to go out into the community as they wished. For some people this had become a safety risk due to deteriorating health problems. This had not been pro-actively managed and there was evidence of increased risk recorded increasing to overnight absence which had placed people at risk from harm. Advice has now been sought from the necessary health professionals to keep people safe.
- Peoples' personal history had not been considered or planned for when the person arrived at the service. Safeguards had not been put into place to protect them and this had impacted on their life within the home and had contributed to their increased anxiety as they didn't feel safe.

The provider had failed to robustly assess and mitigate the risks relating to the health safety and welfare of people. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the issues identified above, there was some good examples of risk management of people who had had regular falls, weight concerns and mobility problems. For example, staff had sourced 1-1 support for one person who was at risk of falls.
- Regular safety checks had been made by staff on the environment. We saw that certificates relating to the safety of the building such as gas and fire systems were up to date.
- People had individual personal emergency evacuation plans (PEEPs) to ensure that people were safely supported to leave the building in the event of an emergency evacuation. Staff had recently completed a fire drill to practice the procedure to follow in the event of a fire.

Using medicines safely

- The management of medicines was not always safe.
- Some people had medicines prescribed to be taken only when the person needed them (PRN), such as

pain relief. There were people over a three-week period that had PRN's on a regular basis over the 24-hour period. Staff were not monitoring the overall effectiveness of the medicine or looking at the times requested for trends or themes.

● People were requesting PRN strong pain relief and were also taking prescribed antipsychotic and mood stabilising medicines. There was no risk assessment or monitoring of possible side effects or interactions, which may impact on their health and well-being.

● There was no evidence that staff assess the risks based on the level of support a person needs to take their medicines safely, such as self-administration. People who were there for rehabilitation, had no risk assessment to how they were supported to maintain involvement or independence with their medicines. This had the potential to impact on their safe return to live in the community.

● There was no risk assessment for people about where they received their medicine. At present people queued at the clinical room at medicine times and staff give them their medicines over a half door in the corridor. Two people expressed that they didn't enjoy this way of receiving their medicines as it was not private and they didn't get the opportunity to discuss how they were feeling or issues they may have with their medicines.

The provider had failed to ensure the safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were systems in place to ensure medicines were ordered, stored, given and disposed of safely. Registered nurses were the medicine givers and all received regular supervision and medicine training refreshers.

● Medicine administration records (MAR) were completed when medicines were given, the number of tablets left in the box were recorded on the MAR. This provided an ongoing audit of medicine stock.

● Some people had medicines prescribed to be taken only when the person needed them, such as pain relief. There were protocols in place for 'as needed' medication which gave guidance to staff on how to know whether the person may need this medicine.

Preventing and controlling infection

● The overall cleanliness of the home was good. Cleaning schedules were used and monitored and housekeeping team of three staff covered seven days a week.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. IPC policies and procedures were up to date and audited by the managers. However, there were no contingencies in place to manage staff shortfalls during an outbreak. The managers told us that they could not use staff from sister homes as the residents had very different support needs and staff had different skill sets. They were not aware that the local authority could provide support. The managers told us that there were times when the home was understaffed during their outbreak.

● The managers had not complied with the capacity tracker and only completed this once in May 2022. A significant outbreak occurred at the home in 2021 affecting 18 residents and several staff. Although the local authority and the UK Health Security Agency were notified, CQC were not.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

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

Visiting in care homes
Staff supported people to receive visits from their friends and family when they chose to

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of their responsibilities to safeguard people from abuse and any discrimination. Staff were aware of the signs of abuse and how to report safeguarding concerns. They were confident the management team would address any concerns regarding people's safety and well-being and make the required referrals to the local authority.
● There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority. Staff confirmed that they had read the policies as part of their induction and training.
● A staff member said, "We get training in safeguarding and we discuss any current safeguarding's at team meetings." Another staff member said, "We report to local authority anything that is unsafe or behaviours that are escalating, the residents here are all very vulnerable."
● Most people told us they felt safe. Comments included, "I am safe here, I would not be safe in the community." One person told us that "Things in my past have made me feel unsafe here." These concerns were immediately shared with the staff so they could put safeguards in place.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Staff we spoke with told us they understood consent, the principles of decision-making, mental capacity and deprivation of people's liberty. One staff member told us, "It can be difficult because most of our residents have capacity but it can change quite quickly depending on their mental health."
● The manager had recently applied for a DoLS specifically for a tracker to monitor people if they become lost whilst out, as peoples independence was an important part of the support plan. Staff didn't want to restrict the person going out but wanted to ensure their safety.

Staffing and recruitment
● There were enough staff to support people safely. Staffing levels were assessed based on people's support needs. These levels were reviewed on a daily basis.
● Feedback from people included, "Staff are here when I need help," and "There's always staff around."
● Staff said, "Staffing levels are good, we were stretched during the recent COVID-19 outbreak, but all staff are now back at work."
● Staff were recruited safely. The provider undertook checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK, obtaining at least two references from previous employers and Disclosure and Barring Service (DBS) checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong

● The management team consistently assessed staff practice and identified ways staff could improve the care and support they provided. There had been a recent medical emergency, the team had reflected on the incident and the staff response to the medical emergency and the outcome. The reflection highlighted that staff had reacted to the situation in a calm and collected way and appropriate action had been taken. As part of the learning, all staff were given a key to access the emergency equipment, which is currently kept in the nurses office.

● The deputy manager told us that in the past there had been medication errors. The deputy manager had identified that keeping a daily running total of medicines in use would highlight missed doses and missed signatures. This had mitigated risk to people and reduced the risk of errors.

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.

At our last inspection we rated this key question Good. At this inspection the rating has changed to 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.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

● The provider had successfully employed a manager who had been in post since the beginning of May 2022 and whom was in the process of registering with CQC.
● Although there were systems to monitor the running of the service, they were not always effective, and they had not identified some of the shortfalls we found on inspection.
● Systems had not identified shortfalls in the management of PRN medicines, pain relief assessments and protocols. They had not identified that reporting of incidents was poor and lacked detail to assess what had happened, how incidents were managed and what learning had occurred.
● Due to the limited record keeping of incidents and the lack of ABC charts used, we could not be sure people's care plans and risk assessments were always updated to guide staff in managing people effectively when they were expressing anger, distress and frustration. There was a lack of tried or proven de-escalation techniques mentioned or reference to how staff managed these episodes safely. There was limited analysis of these documents to ensure care and support was appropriate to each person to keep them safe and ensure their well-being.
● The reasons for people coming to live at Kingswood House Nursing Home were varied but were not clearly documented, which meant that not all risks were explored and planned for. Important personal information was not always recorded. This meant the provider had not ensured a positive approach that was person centred. One person told us they felt uncomfortable living in the home due to specific details which had not been considered within their care plan or risk assessments.

The provider had not ensured good governance had been maintained to ensure systems were assessed monitored and used to improve the quality and safety of the services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The area manager was three months into their role and was visiting the home regularly to support the

new manager and the deputy manager. The management team though new was strong, open and transparent. They were committed to improvement and immediately started to prepare an action plan.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The management team was aware of the statutory Duty of Candour which aims to ensure providers are open, honest and transparent with people and others in relation to care and support. They understood their role and responsibilities to notify CQC about certain events and incidents.

● However there had been a lack of reporting over the past 10 months. CQC had not been informed of deaths, and coroner investigations, police involvement in the premises or incidents of aggression between people who lived in the service. CQC had also not been informed of COVID-19 outbreaks which had impacted on the running of the service. From talking with the new in post manager and deputy manager they had presumed that statutory notifications had been submitted.

The provider had failed notify CQC of all incidents that affect the health, safety and welfare of people who use services. This is a breach of Regulation 18 of the Registration Regulations 2009:

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

● Feedback was difficult to gain from people from surveys and resident meetings had not been successful, so the management team ensured staff were talking to people regularly to gain their views. For example, the chef visited people daily to ask them their views on meals, the menu would be adapted following feedback.

● Surveys were sent out to families for their views, however the response was not as good as expected. Staff told us of phone meetings and email communication with families but this was difficult as some people had no families.

● There were systems to seek the views of staff. We saw records of staff meetings that had been held monthly over the past six months. Minutes showed that care was discussed and staff were invited to contribute, giving them a voice. Important messages were shared at these meetings to keep all staff informed of changes,

● Staff were encouraged to complete surveys. These could be submitted anonymously.

Continuous learning and improving care

● Staff told us that they used feedback from people to improve care, one staff member said, "They will tell us if something is not right, we learn and make changes if needed."

● The management team was positive when discussing the areas for development identified at the inspection. Immediate action was taken and included looking at simplifying the management of controlled drugs and reducing the amount of stock held.

Working in partnership with others

● We received mixed feedback from professionals. One professional told us they felt there had been a lot of staff changes and it was difficult at times to receive consistent information.

● Another professional told us, "Staff are great, respectful about the people . I think general care is good and senior staff are very knowledgeable about the people they support."

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 notify CQC of all incidents that affect the health, safety and welfare of people who use services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the service. The provider had failed to assess, monitor and mitigate risks to people. The provider had failed to maintain accurate, complete and contemporaneous records.