Angels (Kingsleigh) Ltd

Kingsleigh Residential

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Kingsleigh Residential is a residential care home providing personal care for up to 23 people. The service provides support to older people. At the time of our inspection there were 17 people using the service.

Kingsleigh Residential is a large detached property. There is a communal lounge and dining area on the ground floor. Bedrooms are on the ground and first floor. There is an enclosed garden at the front.

People's experience of using this service and what we found
The provider and registered manager had not ensured people received safe or good quality care as there was widespread and significant failings across all aspects of the service. There was a lack of oversight and governance. This put people's safety at risk and meant people did not receive a caring service.

Improvements had been made to the environment and in relation to health and safety. However, previous shortfalls continued not to be addressed and further shortfalls were identified.

The provider and registered manager had failed to follow safe recruitment procedures and ensure staffing met people's needs. Risk management was not effective to ensure risks to people were identified and reduced. For example, with catheter care, food and fluids and skin integrity. Medicines were not safely managed. People were not safeguarded from potential abuse and neglect and the reoccurrence of accidents and incidents.

Staff did not receive the necessary training or supervision to enable them to be fully skilled and knowledgeable in their roles.

The service was not well-led or managed. Records were poorly maintained. There was a lack of opportunities for people, staff and relatives to engage, feedback and develop the service. The provider had failed to adhere to the conditions on their registration.

Consent to care was not always delivered in line with guidance. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Complaints and concerns were not identified or thoroughly investigated to ensure changes were made.

People enjoyed the food on offer. We observed staff being kind and caring with people. Consistent staff knew people well and their preferences.

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 02 September 2022).

At the last inspection in June 2022 we identified continued breaches of Regulation 12 (Safe Care and Treatment), Regulation 15 (Premises and Equipment) and Regulation 17 (Good Governance). Following the last inspection in June 2022, we imposed a condition on the providers registration in relation to Regulation 12 and 17.

The provider completed an action plan after the last inspection in relation to Regulation 15 to show what they would do and by when to improve. At this inspection we found the provider had made improvements in this area and was no longer in breach of regulation 15.

However, at this inspection we found the provider remained in breach of regulations 12 and 17. Additional breaches of regulation were also identified.

At our last inspection we made 2 recommendations in relation to medicines and the application of the Mental Capacity Act 2005. At this inspection we found the provider had not ensured these recommendations were met.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection and due to concerns identified in the management of safeguarding.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kingsleigh Residential on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to Regulation 7 (Requirements Relating to Registered Managers), Regulation 11 (Need for consent), Regulation 12 (Safe Care and Treatment), Regulation 13 (Safeguarding Service Users from abuse and improper treatment), Regulation 16 (Receiving and acting on complaints), Regulation 17 (Good Governance), Regulation 18 (Staffing), Regulation 19 (Fit and proper persons employed) and Regulation 20 (Duty of Candour).

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will follow our enforcement procedures.

Special Measures
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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Kingsleigh Residential

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 Health and Social Care Act 2008.

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 conducted by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Kingsleigh Residential is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Kingsleigh Residential is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 staff members which included the registered manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 8 people that use the service, 11 relatives and 1 health and social care professional. We reviewed 8 people's care records and 8 medicine records. We looked at 6 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies, procedures and audits were 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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At the last inspection conducted in June 2022 we identified the provider had failed to ensure risks to people were mitigated. 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 this inspection not enough improvements had been made and the provider was still in breach of Regulation 12

- Risks to people had not always been adequately identified and assessed. Whilst risk assessments were in place for areas such as mobility, skin integrity and health conditions. Management plans did not provide clear guidance to keep people safe. Records did not demonstrate how risks to people were minimised.
- There was no information for staff on how to identify signs of a urinary tract infection for 1 person with a catheter in situ, what to do if the catheter was blocked, how to maintain openness of the catheter or how much the person should be encouraged to drink. This was relevant as the service had previously received a complaint and a separate safeguarding concern in September 2022 in regard to two other people's catheter care.
- Another person's care plan, whose mobility had been assessed did not reflect the guidance given by the occupational therapist (OT), which was to use a wheelchair. The care plan instead said, "[Name of person's] mobility had improved and is able to walk short distances with the support of 1 to 2 carers." There was nothing written to inform staff the method of supporting the person was not recommended and to risk assess at each intervention. We observed a member of staff supporting the person to walk, which may have placed the person or staff member at risk of harm.
- People who had been assessed at high risk of developing pressure ulcers had suitable equipment in place. However, care plan guidance did not ensure support was delivered to fully minimise this risk. For example, 1 person was cared for in bed. Their care plan did not specify how often the person needed staff to support them to change position during the day, although the frequency at night was recorded.
- Position change records did not always specify which position staff had helped the person to move to. Staff had written, "Repositioned." During a night visit to the service on 14 December 2022 1 person had not been recorded as repositioned since 11.00am 13 December 2022.
- The guidance from the speech and language therapy team (SALT) for 1 person, informed staff to, "Offer small sips from an open cup." However, the care plan guidance for staff stated, "Lidded beaker." We saw staff preparing a drink for this person using a lidded beaker which contradicted the SALT guidance. Additionally, the plan lacked guidance for staff around the position the person should be in when being assisted with a drink, when risks around coughing had been previously identified.

● People were not protected from the risks of malnutrition and dehydration due to poor monitoring and oversight. For example, people's weights were checked, but the up to date information had not been written into people's care plans. This meant accurate information was difficult to find and staff would not be clear if changes in people's weight required further monitoring or action.
● Where people needed their food and fluid monitored, records were poor and did not show that people were offered enough to eat and drink. When people declined food or drink, this was recorded but there was nothing recorded to show that staff had gone back later and tried again.
● The care plan guidance for 1 person at risk of malnutrition said, "Fortified meals. Staff to offer snacks throughout the day. Likes eating strawberry yoghurt, bananas and chocolate." The food chart for this person on 12 December 2022 showed they refused their lunch but there was nothing written to show they were offered an alternative or offered anything later that day. The fluid charts for this person showed that on 3 days in the 7 days leading up to and including the inspection days, the person had less than 500mls to drink. On 11 December 2022 records showed the person had 325mls to drink and on 13 December 2022 they had 250mls. Target amounts for people were not clear.
● We observed staff discuss 1 person's fluid intake during a handover. However, there was nothing documented to show poor fluid intake had been identified or escalated to a senior staff member for action.
● Some people were having their fluid intake and output monitored because they had a urinary catheter in situ. Records did not always show that concerns were identified. For example, the records for 1 person had been completed to show how much the person had been offered to drink. However, the column for how much they had actually drunk had not been filled in. The chart for 11 December 2022 showed they had drunk 200mls. The fluid output for the same day was recorded as 650mls. There was nothing documented to show that staff had identified or escalated the poor intake or the poor fluid output.
● The service had only conducted 1 fire drill in 2022 which involved 2 staff members. This was not in line with fire safety guidance and meant staff may not be competent and confident in responding to an evacuation.
● An overview showed people's level of support and equipment required in an emergency situation. However, individualised personal evacuation plans for each person were not in place. The service did not have anything prepared to take with them quickly to keep people safe and warm should an evacuation be required.
● Some senior staff did not regularly sign in and out of the building. Therefore, staff would not always know who was present in the building in an emergency.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the last day of the inspection, position change charts had been put in place. These showed staff had supported people to change position regularly. However, this lack of detail in records had not previously been identified within the service.
● Improvements had been made to ensure risks to people with diabetes were identified and managed. There was clear information for staff on the signs and symptoms of low and high blood glucose levels. Procedures outlined action staff should take if this occurred.
● Regular checks on fire systems, water, electricity and equipment were undertaken.
● A business continuity plan was in place. This detailed procedures to follow in emergency situations such as loss of power or IT equipment.
● The room containing the boilers at this inspection was found to be locked during the day. However, it had been left unlocked during the night. This room contained hot pipes which may be of risk to people. There was a sign on the door saying it should be locked at all times. This was raised at the last inspection.

At the last inspection conducted in June 2022 we identified the provider had failed to ensure the premises were sufficiently maintained. This was a continued breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of Regulation 15

● Recommendations in regard to the management of legionella had been actioned. Regular checks and controls of water systems were undertaken, this included water temperature checks.
● Maintenance work had been undertaken to ensure the environment was safe and comfortable for people. For example, windows and furniture had been replaced.
● Refurbishment to people's rooms had been completed and was ongoing to ensure people had a pleasant environment. A relative said, "The decorating is getting done."
● Effective systems were in place to ensure maintenance work was identified and completed promptly. This was overseen by a designated staff member. Regular checks on the environment and equipment were conducted. A relative said, "I have never seen anything, where I thought they need to fix that soon."
● An action plan was carried out each month and submitted to the Care Quality Commission (CQC) in relation to identifying and progressing improvements to the environment which was part of the conditions on the providers registration imposed at the last inspection.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Safeguarding information was not systematically held together, monitored or investigated. This meant the registered manager could not identify findings and monitor outcomes of safeguarding concerns to ensure people were kept safe. This was raised at the last inspection in June 2022 and was part of the conditions imposed on the providers registration.
● Staff had not all completed safeguarding training. 7 staff members safeguarding training was out of date and 4 staff members were not included in the training information. Therefore, it was unclear what training they had received. A staff member said, "Safeguarding training, no I have not done that module."
● Accidents and incidents were reported by staff. However, these were not reviewed by a manager promptly. This meant actions to prevent reoccurrence and keep people safe were not always taken. For example, a person slipped from their wheelchair on 15 November 2022, this was not reviewed until 09 December 2022. The person was supported at the time of the incident. However, no further actions or lessons learnt were shared to prevent this reoccurring.
● Potential safeguarding concerns that may require further investigation and reporting to the local authority and CQC had not always been identified. For example, 1 person was noted as having a large bruise on their arm on 04 November 2022. This was not reviewed by the registered manager until 09 December 2022. There was no investigation to the cause, and this was not reported externally.
● Actions from safeguarding concerns and accidents and incidents were not monitored to ensure they were completed. For example, whilst 1 safeguarding recommendation had resulted in the service improving the information held for agency staff and emergency procedures. Another safeguarding concern and subsequent recommendations had not improved catheter care for people.
● Regular analysis of accidents and incidents had not occurred. This was raised at the last inspection in June 2022. The registered manager had conducted 1 overview to look at patterns and trends of accidents and incidents in August 2022. This monitored the frequency and times of accidents and incidents for individuals. This meant that the registered manager was unable to continuously monitor an increase of incidents or accidents for individuals and if actions taken to prevent a reoccurrence were effective.
● Lessons learnt were not clearly established or shared with the staff team. As reviews of safeguarding concerns, accidents and incidents and complaints were not thorough, clear learning and reflection was not identified. Regular team meetings and staff supervisions did not occur to reflect on learning. A staff member

said, "There are no lessons learnt."
● Following safeguarding concerns or accidents and incidents additional training, supervision or monitoring of staff was not completed by the registered manager. For example, a staff member who had been involved in a medical emergency at the beginning of December had not received first aid training. This had still not been provided when we inspected. No checks had been conducted out of hours when a number of incidents had occurred.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People did not always have a call bell accessible to use, if appropriate. People had sensor mats in place and knew to use these to alert staff. A person said, "I don't know where the bell is. I have a mat and I put my foot on it and staff come." A relative said, "[Name of person] has a sensor mat [staff] come quickly."

Staffing and recruitment
● Safe recruitment practices were not always followed. We found 1 staff member did not have a Disclosure and Barring Service check (DBS). The provider did not provide evidence this had been completed after the inspection. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● We found 2 staff members did not have an interview record and 2 other staff members were not fully completed or dated. Incomplete interview records were highlighted to the provider at the last inspection. It is important that the provider ensures potential staff have the skills, knowledge and appropriate attitude for the role appointed. There had been previous incidences of staff misconduct which had placed people at risk of harm.
● There were no audits completed on recruitment files to ensure all areas required had been fully completed before staff began working. This was raised at the last inspection and was part of the conditions imposed on the providers registration.
● During a night visit to the service a different agency member of staff to the agency staff member on the scheduled rota had worked the shift. The registered manager was not aware of this until we raised it. This meant there were insufficient checks on people's identity.

This was a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A staffing dependency tool was in place to assess staffing levels in line with people's support needs. However, this had not been updated since 01 June 2022. This meant that the tool did not capture where people's support needs had changed.
● The provider acknowledged recruitment challenges in filling current vacancies. However, additional ways of recruiting and retaining staff had not been explored. A staff member said, "We can't get new staff." A survey completed by a staff member in July 2022 said, "Find out why you lose staff."
● Agency staff were not always regular or familiar with the service. Since the last inspection 2 agency staff were often working at night without a permanent staff member present. This was observed during the inspection. A relative said, "Not so safe when cared for by agency staff once or twice they did not use the right equipment. I was watching."
● The out of hours on call system was not effective as it was not shared. This meant that a response in an emergency was not always assured. A staff member said, "On a few occasions I used [out of hours on call] they didn't respond." This was relevant due to agency staffing often working at night without a permanent staff member present or, newer staff members who may require support in an emergency or unforeseen

situation.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received mixed feedback about staffing levels. Comments from relatives included, "Yes, there are plenty of staff when I go," "Every time I go, there are enough staff and odd agency staff. Regular staff have a good relationship with the residents," "No, not enough carers. Sometimes [Name of person] has to wait," and "Not enough staff. When I visit, the staff are busy."
● Staff comments included, "We are heavily reliant on agency staff; we can't get new staff," "There are not enough staff," "Staffing is pretty poor. We haven't got a full team," "Staffing is OK," Staffing levels are alright," and "Staffing is not great we are short staffed."
● Current vacancies were filled by existing staff and agency staff. Rotas reviewed, showed staffing numbers were kept at the same level since the last inspection. A staff member said, "The ratio of staff to residents is as it should be."

Using medicines safely
At the last inspection in June 2022 we recommended the provider ensured current guidance was followed for handwritten medicine administration records (MARs) and as required protocols. This recommendation had been partly met.

● Medicines were not always managed safely. Transcribed entries had not always been signed and countersigned. This meant it was difficult to assess if accuracy checks had been carried out. For example, a transcribed entry did not specify the name of the medication to be administered. Another transcribed entry did not list the times of administration accurately. These errors had not been identified.
● Protocols were in place for as required medicines (PRNs). These were personalised and detailed as to when and why people might need additional medicine. Staff had documented when and why they had administered these on the reverse of the MAR. However, staff had not recorded if the medicine had been effective or not. This meant it would be difficult to assess if medicines were working as they should be or if people needed to be reviewed by their GP.
● Staff responsible for medicines administration had not always completed their training or been assessed as competent. During the inspection we observed medicines being administered by a member of staff who had not completed their medicines training and had not been assessed as competent in medicine administration.
● The medicine room was cluttered and visibly dirty. Records showed cleaning had not been completed in this area.
● Topical medicine administration records were in place. However, these had not been signed consistently. This meant it was difficult to assess if people always had creams and lotions applied as prescribed.
● Topical homely remedies were potentially shared between people which posed an infection risk.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's allergies and any preferences for how they liked to take their medicines had been recorded. A person said, "[Staff] manage them [medicines]."
● Temperatures of medicine storage areas had been monitored to ensure medicines were being stored as directed. □
● We observed a staff member take time giving people their medicines and asking if additional medicines

were needed. A relative said, "[Staff] give medication, on time. [Staff] make sure they have taken them."

Preventing and controlling infection

● The provider's infection prevention and control policy was not up to date. Current guidance was not reflected in the policy. For example, around lateral flow testing (LFT). A staff member said when asked if they received updates around current COVID-19 guidance, "COVID-19 updates, not really." A staff meeting held in October 2022 did not give correct information to staff around current testing requirements.

● Feedback around the cleanliness of the service had improved since the last inspection. A relative said, "Yes, it is clean. Beds are always made and the bathroom is clean." Another relative said, "Yes, as clean as I expect it to be."

● During the inspection we observed the service to be clean. We observed night staff undertaking cleaning as required. Cleaning schedules were completed.

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

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● 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 responding effectively to risks and signs of infection.

● 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.

The provider was not facilitating visiting in line with government guidance. Visitors were required to book an appointment and complete a lateral flow test. A relative said, "We still have to test before we come." However, the registered manager and all staff spoken with said visitors were welcomed at any time and could visit without an appointment. One person said, "I have family and friends locally, they pop in." This was confirmed by visitors and relatives we spoke with. A visiting procedure was in place but was not dated, so was unclear when it was last updated.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 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 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection in June 2022 we recommended the provider considered current guidance and reviewed capacity assessments where required.

● Consent to care was not always sought in line with guidance. People who had been assessed as lacking mental capacity to consent to specific aspects of their care had best interest documentation was in place. However, this did not demonstrate how the decision had been reached.
● For example, some people had sensor mats in place which would alert staff if they stood up. The best interest forms did not detail why the assessor concluded the decision to be in the person's best interest or if any other less restrictive options had been considered. This was also the case for another person who had bed rails in place. People's relatives had been consulted about these decisions. However, their views were not always made clear.

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's ability to consent to aspects of their care had been assessed. However, when people had capacity to consent, there were no forms in place to show they had provided their consent. For example, there were no forms in place to show people had consented to live at the service.
● The registered manager maintained a log of DoLS applications. At the time of the inspection,1 application

was authorised and there were no conditions in place.
● The service had facilitated an advocate for 1 person to support their wishes around future choices.

Staff support: induction, training, skills and experience
● At our last inspection in June 2022 it was identified that staff had not completed the Care Certificate where appropriate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. At this inspection there was no evidence that staff, where appropriate had completed the Care Certificate.
● Training records were not well maintained as not all staff or required training was included in the information held.
● Training records demonstrated staff had not completed all mandatory training. Overall training compliance was 80%. However, mandatory training compliance in subjects such as safeguarding, infection prevention and control and basic first aid was below 65% compliance.
● Catheter care training had been identified as a learning need following an incident in September 2022, training records showed that this had been provided on 07 November 2022. However, not all staff had completed the training. This was of relevance as there were people living at the service with catheters in situ.
● Staff told us they had not had regular supervisions. Supervision is 1 to 1 time with a senior member of staff to review staff development, training, practice and well-being. A staff member said, "I've not had one recently. I had one booked, but it didn't happen. Not had one this year I think." Another staff member said, "I've not had one supervision."
● Supervision records were poorly maintained. The supervision overview currently only recorded supervision meetings from October 2022 to April 2023. This record showed that not all staff had attended a supervision since October 2022. Previous records showed staff had not regularly received supervision, including staff new in post. Staff lacked the opportunity to spend individual time with a supervisor to discuss their performance, training needs or any issues.
● Whilst internal disciplinary processes were used, when information had indicated that further supervision or monitoring of staff may be required, this had not occurred. For example, around allegations of poor staff practice or additional support staff may require in relation to learning or mental health needs.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff said they had access to training. A staff member said, "The training is not too bad."
● Staff completed an induction when they started at the service. An agency induction had been introduced to ensure relevant information was conveyed. However, the record keeping around this information was poor.

Supporting people to eat and drink enough to maintain a balanced diet
● We have referred to the risks to people through systems and record keeping in relation to food and fluid in the safe domain of this report.
● Some care plans referred to people's preferences for what they liked to eat and drink, this was not consistent in all the care plans we reviewed. For example, in 1 person's care plan it was written they should be offered the, "Puree meal of the day."
● Kitchen staff said they made sure they knew people's preferences by asking the person themselves or asking family members. They said, "I ask for feedback and I always ask for their favourite meals and what they fancy." A relative said, "The cook will ask what [Name of person] wants."
● The service was able to meet specific dietary needs or preferences, such as soft diets or vegetarianism. We

observed people being offered a choice of meals, hot and cold drinks and snacks. 2 people said, "The food is very nice." A person told us they enjoyed, "Marmalade on toast for breakfast." A relative said, "The food looks nice. [Name of person] said it tastes nice. They accommodate their preferences."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● We could not be fully assured people's health needs were escalated in a timely and effective way due to poor record keeping and lack of staff training in some areas. For example, fluid intake and catheter care.

● However, staff told us, and we observed staff contacting external health professionals such as the GP or district nurse team for support and advice. A relative said, "Staff call the GP and chiropodist. If [Name of person] has an appointment the carer will go with them."

● Hospital admission checklists were in place to ensure a safe handover process if people needed to be transferred to hospital.

Adapting service, design, decoration to meet people's needs

● Improvements had been made to the environment to ensure the design and decoration was pleasant for people. This work was ongoing and being monitored.

● People had their own furniture, ornaments and pictures in their rooms. There was access to an enclosed front garden, with seating.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Pre assessments were undertaken. However, this did not ensure staff were up to date or provided with the training to meet people's health and support needs.

● As part of a safeguarding concern in September 2022 we reviewed documentation for a person staying on respite care where not enough information had been obtained as part of the pre assessment process.

● We observed staff offering people choices throughout the day. For example, when they wished to get up, where they wanted to be in the service and what they wanted to eat. A relative said, "Staff ask as they go along."

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.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider had not ensured the systems and culture within the service drove high standards of quality care to ensure people were well treated and supported.
- The provider had not ensured people's well-being and care was paramount due to continued and further shortfalls found at this inspection.
- We received mixed feedback about the quality of care provided. A staff member said, "Not really no, I don't think the home provides quality care." However, other staff commented, "Generally yes, I think the care is good here. The relationship between staff and residents is good," "Care side of it is good, we have some good carers," and "People are well looked after but it could be improved."
- We received some positive feedback about staff. A person said, "Staff come and make sure I am comfortable." A relative said, "[Name of person] reactions to staff tells us that they are kind, respectful and compassionate. They are friendly. [Name of person] would mention if they were disrespectful." Another relative said, "Staff treat [Name of person] with kindness, respect and compassion, when I am there." A further relative said, "Staff are very caring and very attentive."
- We observed staff interacting with people in a kind and caring manner. People were laughing and chatting with staff and there was a relaxed and friendly atmosphere. For example, we observed a staff member talking and asking questions with a person about their spouse.
- On another occasion we observed a person who was worried about their money. A staff member very calmly and simply explained to the person that their money was safe. The staff member reassured the person saying, "You don't need to worry or get upset. Come and talk to me if you're ever worried."

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

- People's family members were not always involved in care plan reviews. This had been raised to the registered manager and provider at the last inspection in June 2022. Relatives said, "I don't know about a review," and "No review."
- People and relatives were involved in giving information initially towards people's care plans. This included information on people's hobbies, interests and past employment. A relative said, "Yes, I was involved in the care plan."
- Care plans detailed people's preferences. For example, care plans informed staff when people liked to wear makeup, jewellery and perfume. In a person's care plan it was written, "Likes to smell nice."

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not always respected. A telephone was located in the kitchen which staff and people

used, sometimes whilst food was being prepared. This did not allow people to have private conversations. It also meant personal information could be overheard by other people and visitors, which we witnessed. A person said, "I have not used the phone. I have seen others called to the kitchen for the phone."

● People did not always have access to have their haircut. A staff member supported some people to have their haircut and other people had their own hairdresser visit. However, a person said, "I wish there was a hairdresser, would like one. I really don't like my hair long." A relative said, "[Name of person] does not have a haircut."

● Staff supported in ways to maintain people's dignity. We observed staff knock on people's doors before entering. A relative said, "Absolutely dignity is upheld by the carers. If [Name of person] wants to go to the toilet, they shut the door and respect their wishes to have a female carer."

● People were supported to maintain their independence. A person said, "I can use the lift. I need someone to work it with me." A relative said, "They encourage [Name of person] to do things for themselves."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- Complaints and concerns were not always logged or investigated thoroughly. Findings did not ensure practice and systems were improved.
- The service had received 1 formal complaint since the last inspection. Whilst the registered manager had responded to the complaint, records held did not demonstrate how the complaint had been investigated and evidenced. For example, there were no staff statements, or records of the person's care. There was no action taken from this complaint to ensure improvements were made. This meant repeated failings were made.
- Verbal concerns and complaints were not logged and were not considered a complaint or concern. This meant that actions were not taken or communicated to the staff team. For example, a relative raised a verbal concern in November 2022. Actions were not taken to ensure the relative was kept suitably informed.
- The survey conducted with people in July 2022 said 6 out of 6 people did not know who to make a complaint to. No actions had been taken from this.

This was a breach of Regulation 16 (Receiving and acting on Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt comfortable raising issues with staff. A person said, "If I say something is not right, they [staff] will sort it."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Daily care and support records did not always show that people were supported with their oral and personal hygiene needs. For example, records for 2 people showed no support had been given in oral care for the past 16 days.
- We observed 2 people who had dirty fingernails. A relative said, "We previously had a problem with [Name of persons] nails being filthy, we wanted them clean and cut. They have been."
- Other relatives commented that people were well-kempt. A relative said, "They bathe [Name of person]. Clean nightdress. [Name of person] is always clean." Another relative said they loved one was, "Always clean when I attend."
- Care plans contained person-centred information about people's preferences for how they wanted to be supported. This included for example, the times people preferred to go to bed, how they liked to dress, and how much they were able to do for themselves. One person's care plan said, "Prefers to wear dresses, but does feel the cold so will need to wear a cardigan but will let staff know." A relative said, "Staff support [Name of person] in the way she likes."

● People's social preferences were documented. We looked at the plan for 1 person and it described in detail where the person preferred to sit in order to have quiet conversations with visitors.

End of life care and support

● End of life care plans were in place. However, these were limited and did not show that open conversations with people and their families about their choices and wishes had been fully considered. The plans contained details such as if people wanted to pass away at the service or wanted to be admitted elsewhere.

● Discussions with families about end of life care and wishes were inconsistent. Comments included, "Not at all. I should be having these discussions [about end of life care]," "No end of life plans discussed," "Yes, we have discussed end of life plans," and "We discussed [end of life plans] when they first went there."

● The service could not assure themselves they were providing end of life care as people wanted due to the lack of openness and full planning. A staff member said, "The family will tell us of people's wishes about any religious input and so on. Usually by the time it happens it's too late to ask the resident what they want."

● The service was supported with end of life support needs by the district nursing team. A staff member said, "They [district nurses] are really good."

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

● Activities were organised for people to participate in. For example, we observed a game of bingo taking place and a Christmas party was arranged for later in the week. A relative said, "A local musician comes in and they have parties." Another relative said, "The activities include nail, painting and crafts. They give [Name of person] little jobs, washing up their plate and gardening."

● Designated staff were in place to provide activities. A staff member said, "People that don't like group activities we give them time 1:1. We sit with [Name of person] and reminisce. Another person likes to read."

● However, people commented, "Just sit here. Nothing to do. Summer not so bad as we can go out. I sit here and wait to go to bed," "I am not sure what I like now. They offer me things to do," and "I lose track of days they are all the same." A relative said, "I never see them doing anything. Always in front of the television."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Communication care plans were in place. Plans described how people communicated, and any additional needs they had such as hearing aids or glasses.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last 3 inspections in June 2019, June 2021 and June 2022 the provider had failed to operate effective governance systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the June 2022 inspection we imposed conditions on the providers registration.

At this inspection not enough improvements had been made and the provider was still in breach of Regulation 17.

● The conditions imposed on the providers registration were not being met. The provider had not ensured that audits of the quality and safety of care provided at Kingsleigh Residential were completed by a person with the necessary skills, qualifications, experience, and competence to complete them as required.
● An action plan which included risks associated with the environment and legionella was being submitted by the provider each month as required by the conditions on their registration and this covered risks associated with the environment and legionella. However, the provider did not include in their action plan the findings of audits of care plans in relation to health and safeguarding risks and staff recruitment files as required. We found shortfalls and breaches of regulations in these areas.
● We found repeated breaches of regulations and widespread failings. The registered manager and provider were not ensuring they understood how to monitor quality performance, risks to people and regulatory requirements.
● The provider regularly visited the service and met with the registered manager. However, there was no oversight of the registered manager or service. No checks or audits were completed by the provider to monitor the quality and safety of the service or to ensure improvements were being made.
● Regular audits were not being completed for all areas of the service to review and assess the quality and safety of the service. A senior staff member completed monthly medicine audits. However, the registered manager had not undertaken regular audits of care plans, staff training, recruitment, infection prevention and control and daily records.
● As audits were not being completed this meant areas for improvement were not being identified and progressed. The quality of record keeping was also not being monitored. For example, repositioning records, fluid charts and resident of the day.
● There was no overall service improvement plan. This was raised at the last inspection. This meant

shortfalls highlighted to the provider and registered manager in previous inspections and by other agencies had not been taken forward in a systematic and meaningful way. Therefore, improvements and developments needed were not made or sustained.

● The senior staff team did not work cohesively together. Information was not effectively communicated. No senior staff meetings took place.

● Staff we spoke with were not always aware of the findings of the last inspection and the conditions currently imposed on the providers registration. The provider and registered manager had not met with staff following the inspection to explain the findings and how improvements would be made. A staff member said, "I'm not aware of any [improvement plan]. But I do think we [staff] should all know."

● Safeguarding information was not held together. This meant investigations were not thorough and actions were not taken to keep people safe.

● Accidents and incidents were not analysed for patterns or trends and to ensure actions taken were effective. Potential safeguarding concerns were not always identified due to ineffective systems.

● Records were poorly maintained and organised. Systems to organise and store records did not ensure records could be easily located and document retention timeframes would be met. For example, recruitment, agency, supervision and training records.

● Following it being raised at the last 2 inspections a survey had been completed with staff, relatives and people in July 2022. However, the results and feedback had not been analysed or used to drive improvements in safety and quality. Staff had raised in July 2022 areas such as the lack of fire drills, regular supervisions and team meetings which were all found at this inspection.

● The registered manager did not regularly attend handover and there was no written record. A staff member said, "No, the registered manager doesn't attend handover." This meant the registered manager was not aware of changes in people's care or the details of events in the service.

● A staff meeting had occurred since the last inspection in October 2022. This meant staff did not have the opportunity to raise issues or concerns, discuss systems and practice and be informed of changes, guidance and outcomes. A staff member said, "The last staff meeting we had was just after the last inspection, but we haven't had one since."

● A resident of the day system was in place. This is where all areas of someone's experiences of living at the home is reviewed. For example, catering, environment, laundry, care and support. Whilst parts of this were being completed fully, the providers systems and processes had not identified that other areas such as nail cleaning, resident chosen activity and mattress checks were not regularly done. In addition, forms repeatedly said different people and their family were happy with the care provided. Records did not record which family member had been contacted and when. A staff member confirmed family had not always been contacted even though a record stated they had.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not ensured the registered manager had the skills and knowledge to operate a safe and well-led service.

● The provider had not ensured the registered manager fulfilled their regulatory responsibilities. This was demonstrated by the widespread failings outlined in this report, the lack of improvement and continued breaches of regulation.

This was a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Notifications were submitted to CQC. A notification is information about an event or person which the

service is required to submit to CQC. Notifications help CQC to monitor services we regulate. However, as systems were not effective in identifying potential safeguarding concerns there may have been additional notifications required.
● The provider had displayed their CQC assessment rating at the service and on their website.

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 registered manager understood the duty of candour legislation, which is to be open and honest when something went wrong. However, this was not always implemented.
● A relative in December 2022 had been given incorrect information surrounding their family members passing, which was a notifiable incident. A true account of what had taken place was not given until later and did not consider the seniority and experience of the staff delivering this information.
● Information given to family members in relation to hospital admissions, falls and illnesses did not always provide a satisfactory level of detail and information to understand what had happened due to poor record keeping and communication systems.

This was a breach of Regulation 20 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We received mixed feedback about how the service was led and managed. A staff member said, "Things need to improve on the management side." A staff member said, "The registered manager is approachable, but doesn't have the management skills." Another staff member said, "The registered manager is not effective." Relatives commented, "The registered manager is approachable. They do communicate," "The registered manager does communicate. Got a Christmas card yesterday and an email this morning," and "The registered manager is always having a cigarette and coffee. Lots of staff have left."
● There were no meetings for people or relatives to give feedback. A person said, "We have not had any meetings." A relative said, "There are no relatives meetings."
● The staff culture was not always positive. Staff told us they were frustrated with the lack of improvement and direction. Staff did not always feel well supported. A staff member said, "Morale is variable."
● Staff said they worked well together. A staff member said, "We work well as a team." Another staff member said, "Staff are supportive of each other."
● Individual staff worked to ensure people were happy and their needs were met. A relative said, "[Name of person] is happy."
● Staff met at the start of each shift to communicate and share information about people. We observed this take place. An information sheet detailed key information about people such as if people were for resuscitation, current DoLS status and care needs.

Working in partnership with others
● Recommendations and guidance from external health and social care professionals was not always acted upon. For example, from the local authority safeguarding and quality team, occupational therapist or speech and language therapist.

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 had to ensure consent to care followed legislation. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed to ensure correct information was given to people when something had gone wrong. Regulation 20 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The provider had failed to ensure the registered manager had the necessary skills, competence and experience to manage the regulated activity. Regulation 7 (1) (2) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people had sufficient risk management plans in place in place to provide safe care and support. The provider had not ensured the safe management of medicines. Regulation 12 (1) (2) (a) (b) (c) (g)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were protected from abuse and neglect. Regulation 13 (1) (2) (3)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate effective systems to identify and learn from complaints. Regulation 16 (1) (2)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to monitor the safety and quality of the service. Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate recruitment procedures which ensured fit and proper persons were employed. Regulation 19 (1) (a) (b) (2)

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure people were supported by staff were competent and skilled and well supported. Regulation 18 (1) (2) (2a)

The enforcement action we took:

Cancellation of registration