Mr D & Mrs J Barnacle

Kingswood Lodge Residential Care Home

Inspection report

Kingswood Lodge
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Kingswood Lodge Residential Care Home provides accommodation and personal care for up to 21 older people, some of whom are living with dementia. The accommodation is set over two floors. There were 14 people using the service at the time of our inspection.

People's experience of using this service and what we found
The provider and registered manager still did not have effective systems or processes in place to assess the quality and safety of the service. The audits carried out were not always fit for purpose. This put people at risk of unsafe care.

Staff did not always have the information they needed to keep people safe. People's care plans/risk assessments were not always updated following accidents and incidents. Staffing levels had improved, but not all staff had had the essential training they needed.

Medicines were not always stored and administered safely. The premises needed further upgrading and improving. We found ripped, worn, and stained carpets, and unsafe equipment being used at the service.

Relatives comments about the service were mixed. Most relatives said the registered manager and staff were kind, caring and approachable. Some relatives expressed concerns about the condition and safety of the premises.

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 Inadequate (report published 18 January 2022). At this inspection we found the provider remained in breach of regulations.

The overall rating for the service has remained the same. This is based on the findings at this inspection.

Why we inspected
We carried out an unannounced focused inspection of this service on 8 December 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve Safe and Well-led.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the

overall rating. The overall rating for the service has remained as Inadequate.

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

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.

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 have identified breaches in relation to the premises and equipment, safe care, staffing, and governance.

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
The overall rating for this service is 'Inadequate' and the service remains in 'special measure'. 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?

Inadequate

This service was not safe

Details are in our safe findings below

Is the service well-led?

Inadequate

This service was not well-led.

Details are in our well-led findings below.

Kingswood Lodge Residential Care 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 and an expert 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
Kingswood Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before 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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with three people using the service and spent time with others in communal areas. We spoke with the provider, the registered manager, the deputy manager, a senior care worker, two care workers, and the chef. Following our inspection visit we spoke with 11 relatives by telephone.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at staff training and supervision records, and records relating to the management and governance of the service.

After the inspection
We continued to seek clarification from the provider and registered manager to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same. This meant people were not safe and were at risk of avoidable harm. The service had continued breaches and had failed to make adequate improvements.

At the last inspection risk and medicines were not always safely managed and lessons were not always learnt when things went wrong. These were breaches of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider and registered manager remained in breach of Regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- People's care plans/risk assessments were not always updated following accidents and incidents. This meant staff did not always have the information they needed to keep people safe.
- One person's mobility plan, which stated the person should be assisted by staff when walking, was not being followed. This meant the person was at increased risk of falls.
- A staff member told us another person needed two staff to support them in their bedroom, but there was no record or instruction to staff to show this. This meant staff might not know they needed to support this person in twos which could compromise the person's safety.
- The service's mobility equipment had not always been maintained or checked for safety putting people at risk of accidents.

Using medicines safely
- We again found prescribed flammable topical creams in a person's bedroom, with no risk assessments in place to show it was safe to store medicines in this way.
- One person was taking blood thinners as prescribed. However, this was not stated in their medicines risk assessment which meant staff might not be aware of the risks and side-effects of this type of medicine.
- One person needed their medicines administered in a particular way, due to their communication needs. However, there were no written instructions for staff on how to do this. This meant staff who did not know the person well might fail to administer the medicines safely.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This is a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At the last inspection the provider failed to ensure the premises and equipment were clean and properly maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider and registered manager remained in breach of Regulation 15.

● The carpet in the blue lounge remained in a poor state, being ripped, worn, and stained.
● The electronic reclining armchair, which was plugged in and charging when we inspected, had a sticker attached to the charger stating it failed PAT (portable appliance testing) in November 2020. This meant it was unsafe to use and should have been repaired or removed.
● The passenger lift had no lock or code to access it meaning there was a risk of people entering it and travelling to first floor without staff being aware.
● The ground floor shower room had a rusty frame round the toilet, missing plaster on the wall, and a rusty radiator making it difficult to clean effectively.
● The laundry room was unlocked meaning service users could enter and access cleaning products that could be hazardous to their health.

Risk in the environment was not identified or managed effectively. This placed people at risk of harm. This is a continued breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were some improvements to infection prevention and control practices at the service. The registered manager was working with the local authority's infection prevention and control team to bring about further improvements.
● 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 somewhat 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 somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.
● The provider was facilitating visits for people living in the home in accordance with the current guidance.

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

Staffing and recruitment
At our last inspection staffing numbers were not sufficient to meet people's needs or keep them safe. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had not been made at this inspection and the provider and registered manager remained in breach of Regulation 18

● Staffing levels had improved, however the training matrix showed considerable gaps in staff training. Skills for Care (the strategic body for workforce development in adult social care in England) list eight courses considered essential for staff working in the care sector. There are: assisting and moving people; basic life

support and first aid; fire safety; food safety; health and safety awareness; infection prevention and control; medication management; and safeguarding. According to the training matrix none of the 13 staff listed had completed all their essential training

● A further eight staff were not on the training matrix so it was not clear what training these staff had had.

● Gaps in staff training put people at the service at risk. For example, only 10 of the 21 staff employed had had health and safety training. This meant we could not be sure all staff would recognise risks in the environment and other risks to people's safety.

● We could not be sure the staff team had the qualifications, competence, skills and experience necessary for the work to be performed by them.

Staff were not sufficiently trained to provide safe care to people. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had introduced a recruitment checklist to ensure staff had the documentation required to work with people who use care services. The registered manager had re-applied for references for one staff member who hadn't had these when they started work at the service.

Systems and processes to safeguard people from the risk of abuse

● Of the 13 staff on the training matrix only nine were trained in safeguarding. There were an additional eight staff who had no recorded training. This meant we could not be sure if all staff had had the training they needed to protect people who use care services from abuse.

● The staff we spoke with understood their responsibility to report suspected abuse to the person in charge, and to the local authority, CQC, and other agencies where necessary.

We recommend that all staff have formal safeguarding training as soon as this can be arranged.

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.

At the last inspection there was no effective auditing system in place to identify risks and failings. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider and registered manager remained in breach of Regulation 17.

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

- People were at risk from the lack of provider and registered manager oversight of the service and lack of effective systems to make improvements in a timely manner.
- There was still no over-arching system to assess, monitor and improve the quality and safety of all aspects of the service.
- Gaps in the staff training matrix had not been identified and we could not be sure that the provider and registered manager had sufficient oversight of staff training to ensure all staff were appropriately trained and competent for their roles.
- The audits carried out were not always fit for purpose. Premises audits did not show when shortfalls were to be addressed, nor did they identify all areas where people might be at risk.
- Accidents and incidents had been logged but care plans and risk assessments had not been updated in response, so we could not be sure that staff had the information they needed to support people safely. This put people at risk of unsafe care.
- It was not clear from audits when safety checks for equipment and utilities were due to be carried out and some checks appeared to be overdue. This meant we could not be sure the premises and equipment were safe for people to use.
- One person had fallen due to poorly maintained equipment. However, there were no complete records of equipment maintenance checks. This poor oversight of equipment safety put people at ongoing risk of harm.
- The provider and registered manager had failed to continuously learn and improve care. Many of the issues we found at this inspection were present at our last inspection and the provider and registered manager remained in breach of our Regulations.

The provider and registered manager failed to have systems and processes to assess, monitor and mitigate risks relating to the quality, health, safety and welfare of people or to identify where actions were required to improve the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 provider submitted a Notification to CQC, as required, following an incident at the service. Notifications are certain incidents, events or changes at the service that the provider needs to tell CQC about. This was in line with their obligations regarding Duty of Candour. The Duty of Candour puts a legal obligation on providers to be open and transparent with people receiving care and treatment.

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

● The registered manager sent out questionnaires to relatives in April 2022 asking them for their views on the service. A residents meeting was planned for April 2022.

● Staff supervisions had taken place and staff told us communication between themselves and the registered manager had improved. A care worker told us, "This is a lovely place to work, with a great atmosphere."

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

● A daily activity schedule was displayed on the wall, but staff were not following this. The registered manager said this was because staff did not have enough time to do activities with the people using the service.

● Staff engaged with people at every opportunity and were continually kind and caring towards them. A relative said, "The staff are really lovely and work together as a team."

Working in partnership with others

● Local authority staff were visiting the service on a regular basis to support the registered manager to bring about improvements to the service.

● The registered manager worked in partnership with other professionals such as GPs and community nurses to support people to access healthcare.