Barchester Hellens Limited

Kingswood Court Care Home

Inspection report

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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

Kingswood Court is a residential care home providing personal and nursing care for up to 66 people aged 65 and over. At the time of the inspection 55 people were living at the home. Accommodation is provided in one building over three floors.

People's experience of using this service and what we found
People were not always receiving care that was person centred and they were being put at increased risks due to insufficient staff. People were seen spending prolonged periods in their wheelchairs rather than being supported to sit in comfortable chairs. We observed people spending time in their bedrooms with little interactions unless personal care or staff assistance was required. People were not being supported in a way that took into consideration their preferences such as being washed and dressed at a time to suit or spending time in different parts of the home.

Feedback from relatives and people was mixed but also echoed our observations and the delays in receiving care due to staff shortages. Staff were evidently caring in their approach, but the care was task led as there was not enough staff to spend quality time with people engaging in conversations and one to one activity.

Some people told us they did not participate in the activities on the ground floor because they were concerned they would not be returned to their room in a timely manner. Call bells and drinks were not always in close proximity to people and one person was not positioned safely to eat their breakfast as they were in a lying down position. This put people at potential risk of choking and dehydration and meant they could not always alert staff if they needed assistance.

Improvements were needed to ensure people received safe care including the management of medicines and infection control procedures. Some people were experiencing delays in receiving their medicines because of the time it took for the nurse to complete the medicine round especially when they were covering other areas in the home. Not all staff were wearing face masks in accordance to government guidance and personal protective equipment such as gloves and masks was being stored on dirty linen trolleys. This increased the risks to people and staff due to cross contamination risks.

There was a new manager working in the service. They planned to hold regular meetings with staff and people living in the home. They were being supported by the provider's regional team and a registered manager from another home to drive improvements in the service. There was an action plan in place to drive improvements. Governance arrangements were in place but had not been robust to identify the areas of concern we found at this inspection.

Assurances were provided that staffing numbers would be reviewed and increased post inspection and kept under review. This would include an additional member of staff working on each shift and a second activity co-ordinator who would be employed daily to help with activities on the middle and top floor. This would enable those people that did not want to participate in group activities on the ground floor to have one to

one time in their bedrooms.

Improvements were planned to the décor of the home and a refurbishment plan was in place to commence in November 2022. Some work had already been completed to bedrooms as they became vacant.

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 good (published 20 January 2022). The rating from this inspection had now changed to requires improvement.

Why we inspected
The inspection was prompted due to concerns shared about the staffing levels within the home which was impacting on the care of people and putting them at risk. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

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 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 relevant key question safe and well led in this report. 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 Kingswood Court Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 staffing, management of medicines, infection control and the quality assurances systems in place to monitor the service.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. 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 Court 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 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 team consisted of three 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 Court Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Kingswood Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was no registered manager in post. A manager had taken up post the

week before the inspection. They were planning to register with us.

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 and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 14 people who lived at the service and seven visitors. We also spoke with the manager, the deputy manager, the provider's representative, a nurse, two members of the care team and the maintenance manager. A further five staff contacted us after the inspection via email and telephone.

We reviewed a sample of people's care and support records. We also looked at records relating to staff recruitment and the management of the service such as incident and accident records, staffing rotas, meeting minutes, training records and audits.

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.

Staffing and recruitment

- People were not being supported by sufficient numbers of staff. There were numerous examples that showed there were insufficient staff working in the home to support people. This meant there were delays in people receiving personal care, the serving and removing of breakfast plates and the time people spent in the dining area waiting for staff to support them to return to the lounge area after breakfast and lunch.
- People remained in their wheelchairs when eating their meals and taking part in activities for pro-longed periods of time. This would indicate that there were insufficient staff to support them to move to more comfortable chairs. Not only did this indicate insufficient staff but people were at risk in respect of pressure wounds.
- One person was still in their night wear at 11am and was quite distressed that they had not been assisted to wash and dress. Another person had not been positioned safely to eat their breakfast. The lack of sufficient staff was putting people at risk.
- People and relatives relayed concerns about the staffing levels and the delays in care being delivered. One relative said they had been waiting for 30 minutes because their loved one was not ready to go out, even though this had been pre- arranged.
- Staff raised concerns about the staffing levels. At times they told us there was only 3 staff to support 25 people. On the day of the inspection there was no nurse or senior care worker on one particular area of the home therefore the nurse on the top floor was supporting people with their medicines on the ground floor. Staff said they try their best but the low staffing levels were impacting on their wellbeing due to the concerns they had for the people living in Kingswood Court.
- Staffing numbers per shift had been increased in two of the areas of the home the week prior to the inspection, during the day and an additional night nurse was employed at night. It was evident from our observations there was still a shortage of staff to respond to people's needs. The home had a dependency tool to calculate staffing, but this evidently had not taken into consideration feedback from staff and the recent increase in occupancy due to another of the provider's homes temporarily closing.
- We observed staff being borrowed to help out in other areas of the home due to the pressures from the top floor to the middle floor and to help with people that had chosen to go downstairs. One person told us they were reluctant to go downstairs due to the delays in being assisted back to the room after lunch or after an activity.

The failure to ensure sufficient skilled staff were deployed to provide people's care and support was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider completed checks on the suitability of potential staff. This included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services.

Preventing and controlling infection
● We were somewhat assured that the provider was using Personal Protective Equipment (PPE) effectively and safely. We observed three staff not wearing their masks as per guidance.
● 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 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 were assured that the provider's infection prevention and control policy was up to date.

Assessing risk, safety monitoring and management
● We were not assured that people were supported safely due to insufficient staff working in the home. This put people at risk such as spending prolonged time in their wheelchairs, call bells not being in reach of people, one person trying to eat breakfast laid down in bed (staff had not positioned the person correctly) and drinks being out of reach. This meant that people were at risk of poor care, increased risks of skin break down and dehydration.
● Infection control audits were being completed however, these had not identified that improvements were needed to ensure staff were wearing PPE correctly or that toiletries were left in a communal toilet including a bar of soap. There was a risk these may be used by multiple people. Some bathrooms were difficult to clean due to missing tiles. There was a lack of PPE stations and masks, gloves and aprons were being stored on soiled linen trolleys. These posed an infection control risk.
● We could not be assured people at risk were eating and drinking enough. Some people had been assessed as being at risk of weight loss and dehydration. Fluid charts had been put in place, but these had not been totalled to ensure people were receiving sufficient fluids throughout the day or included information about what their recommended fluid intake should be. One person had been prescribed a food supplement as it was noted they were losing significant weight. There was no food and fluid chart in place to monitor their intake to demonstrate the risk to the person was being minimised. The nurse was unable to explain why this was not in place although the person was at risk.

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 was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were assessed in respect of risks. Care plans provided staff with information about risks to people and the action staff should take to reduce these. This included risks associated with moving and handling, maintaining skin integrity and difficulty with swallowing and potential choking. Improvements were needed to ensure risks in respect of malnutrition and hydration were monitored consistently across the home.
● Robust systems were in place to ensure the home was safe such as legionella, fire, electrical and gas checks. There were robust checks on the equipment, including the lift and equipment to support people such as hoists, wheelchairs and pressure relieving equipment.

Using medicines safely

● Improvements were needed to ensure people received their medicines safely. There were delays in people receiving their medicines in a timely manner. We observed the nursing staff administering morning medicines up till 1130 am. Nursing staff told us that much of their day was spent administering medicines to people.

● Staff had not recorded the actual time of the medicines being given. This posed a risk in respect of medicines such as paracetamol and the frequency when people could have their next dose. One person was in a lot of distress because they had not had their morning pain relieving medicines. One person's pain-relieving medication for a period of two months was recorded on one medication administration record. This was poor practice and could increase the risk of errors.

● Some topical medicines on the middle floor were not consistently recorded in their care documentation in respect of what they had been prescribed. There were gaps in the recording of the topical creams. One person had been prescribed a topical cream, which needed to be applied 2 to 3 times a day. There was no record of this cream being applied since December 2021. We asked the nurse to investigate and take action.

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

● Medicines were administered by nurses and senior care staff that had been assessed as competent.

● Medicines which required additional security were appropriately stored, checked and administered. Medicines were stored and disposed of safely.

● Medication audits were completed monthly along with regular stock checks to ensure that people received their medicines when needed.

Systems and processes to safeguard people from the risk of abuse

● Systems were in place to raise safeguarding concerns to the management team and the local authority.

● Staff confirmed they had completed training on recognising abuse and the reporting mechanisms in place. However, when we spoke to staff both during and after the inspection four of the seven staff wanted assurances that their feedback would be in confidence.

● We fed this back to the regional director who said they were implementing a 'speak up champion' and were looking for volunteers who would receive training and support for the new role. Posters were seen in the home promoting this role and the provider's whistle blowing helpline.

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)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Visiting in care homes

● There were no restrictions on people welcoming visitors to their home and the provider was following the current published visiting guidance by the Department of Health and Social Care. We observed relatives at the home who were visiting family members.

Learning lessons when things go wrong

● Staff understood their responsibilities for reporting accidents and incidents. Written accident and incident documentation detailed what had happened and, what action had been taken. Body maps had been completed where there had been an injury for example a bruise or skin tear so that these could be monitored for healing purposes.

● Monthly audits of incidents were completed and helped to identify any action that could be taken to help prevent reoccurrence.

● Lessons had recently been learnt in respect of a delay in an ambulance service accessing the building. In response a notice was placed on the front door with a telephone number that could be contacted when there was no reception staff. However, there had been a delay in the service taking immediate action as this was only rectified after a second incident.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service had a history of inconsistent management and leadership. Since Barchester Hellens Limited had acquired the home in 2020 there had been nine managers. A manager had been appointed shortly prior to our inspection. Another registered manager working for Barchester was supporting the newly appointed manager along with the regional management team.
- There was a program of checks being completed to ensure the quality of the service. However, these had not fully identified the shortfalls in staffing as discussed in the safe domain. As a consequence of this some people were experiencing delays with their care delivery and were at risk from poor care. Not all infection control risks had been identified and action had not been taken to mitigate the risks to people and staff. There were shortfalls in medicine management that had not been identified or rectified by the home's governance arrangements.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate there were effective systems to monitor the service by the provider or the manager. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Daily 'stand-up' meetings were held where the management team reviewed key issues such as any risks relating to staff, new incidents or accidents and any concerns regarding people's presentations. This was to ensure there was a whole home approach and the sharing of information to manage risks. A member of staff told us, "He (the manager) always checks the staff and residents to see if they were okay". This was echoed by two other members of staff.
- The manager and the deputy manager told us they undertook daily walkarounds to observe the care being provided and to maintain a strong presence within the home. Records were seen confirming these had taking place and included areas for improvement and follow up.

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

- We could not be assured that everyone in the home experienced person-centred care where choices and preferences were respected. For example, some people were not getting personal care in a timely manner based on their preferences. We observed one person sitting in the dining room from 9.45am to 11.20am with their uneaten breakfast in front of them. One person was wearing no footwear and staff only rectified this

once the inspector prompted them to do so. This person was on their way to the ground floor to take part in activities. Other people spent time in their bedrooms with little interaction other than when tasks were being completed.

● People told us about the delays in their care and the lack of attention to detail such as call bells, dirty cups being left in rooms and drinks not being in close proximity. However, some people were positive about their care telling us, "The staff are nice friendly people. They do their best" and "I am satisfied with it all". There was also a number of compliments received by the home that showed people had received positive care and support.

● Relatives feedback was mixed in respect of the care delivery and their satisfaction with the home. Comments included, "There is a problem getting staff to take Mum from A to B. There are not enough staff" and "He's very happy, and if he's happy, then I'm happy" and "Sometimes he is not shaved but generally speaking the staff are superb". Not all relatives were aware of the change of manager.

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 manager understood their responsibilities under the duty of candour to be open and honest. Since being in post they had notified us of incidents and accidents that had occurred within the home.

● As discussed in the safe domain not all staff were confident in raising concerns and some were fearful of losing their employment. A member of staff told us when they had raised concerns about an incident that had occurred, they had felt this had not been adequately addressed. Assurances were provided that the senior management team and the new manager were in the process of investigating this and liaising with the local safeguarding team.

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

● We were told staff and resident meetings were taking place regularly within the home. A relative said, "They do have residents meeting and information about the activities are put in his room".

● The newly appointed manager had developed an action plan, which included ensuring there were regular staff and resident meetings to enable people to express their views on the service and to keep them updated on any changes. This was along with the speak out champion role that was being implemented.

Continuous learning and improving care

● The manager and regional director told us the home was being refurbished and this would start in the Autumn. This would include bedrooms, bathrooms and communal areas. Some bedrooms had been refurbished with new flooring and furniture. Some bathrooms were temporarily out of action and were part of the refurbishment plan.

● The manager told us during the inspection there was one activity co-ordinator and activities were organised over seven days. There were plans to recruit a further activity co-ordinator to help with people that preferred to spend time in their bedrooms. Post inspection feedback the manager told us this would be increased to two activities staff working across the home to increase one to one activities for people.

● The new manager had developed an action plan to make improvements to the home. This covered areas such as ensuring staff inductions were completed, weekly monitoring of any pressure area wounds, weight management and staff supervision. The actions were shared amongst the team including the deputy manager and nurses and included clear timescales.

● As part of the action plan the manager had identified the need to recruit additional staff. The manager told us they had organised two open days to encourage new staff to visit the home, one had taken place and a further one was organised at the end of August 2022. In response they told us they had potentially three new starters. Recruitment of a full team would mean that people would be supported by consistent staff

that knew them well. The manager was passionate about providing person centred care that was safe.

Working in partnership with others

● The service worked with professionals and commissioners to ensure people's needs were met. Where changes in people's needs or conditions were identified appropriate referrals for external professional support was made such as the falls team and the care home liaison team.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that is reasonably practicable to assess and mitigate risks in respect of the safe management of medicines, the monitoring of whether people had sufficient to eat and drink and infection control. People were at risk of skin damage due to spending long periods of time in their wheelchairs. Regulation 12 (1) (a) (b) (d) (h) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate governance systems to identify shortfalls in the quality of care provision and safety in respect of our findings at this inspection. Regulation 17 (1) (a) (b) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. Regulation 18 (1)