B & C Holt Ltd

# Kingston Nursing Home

## Inspection report

7 Park Crescent
Leeds
West Yorkshire
LS8 1DH

Tel: 01132666520

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18 August 2020
19 August 2020
20 August 2020
24 August 2020

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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
Kingston Nursing Home is a care home registered to provide personal and nursing care for up to 47 people aged 65 and over, some of whom are living with dementia. During our visit there were 29 people living at the home.

People's experience of using this service and what we found
People did not always receive safe care. Before and during this inspection we identified and reported safeguarding concerns. People's medication was not always administered safely and we could not be sure all staff administering prescribed medication were competent to do so. Risks to people's care were not always managed safely and staff's knowledge was not robust. During this inspection, we could not be sure people would always be appropriately supported in the event of a fire. The environment was not always clean and free of odours. Staff were not recruited safely.

We identified concerns around staffing levels. People and relatives told us staff were kind but did not have time to be involved in activities. People told us they felt "bored." This could be a risk to people's mental health.

We found widespread shortfalls in the way the service was managed. There was a risk of people receiving inappropriate care. Records were not always accurate or complete. Some people's care plans lacked information about people's needs, which meant staff were not provided with clear guidance to support and care for people.

There was no registered manager but an interim manager was in post and a new home manager had recently been recruited. The nominated individual did not always have good oversight of the day to day running of the service.

Quality assurance processes were not effective in identifying and addressing all the issues found at this inspection and in driving improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published 4 October 2018).

Why we inspected
Before our inspection we received information of concern in relation to people losing weight and timely action not being taken; risks to people's care not managed safely including management of medication; and environmental safety risks and governance. Before the inspection, we discussed concerns with the provider and completed an Emergency Support Framework assessment but were not sufficiently assured. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We found evidence during this inspection that people could be at risk of harm. We reported these concerns to the provider who took immediate action to make improvements and promote people's safety. We also informed the local authority, clinical commissioning group (CCG) and the local fire authority of our concerns. We found the actions taken by the provider had been effective in mitigating urgent risks, however further improvements were required. Please see the Safe and Well Led sections of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment and good governance.

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

Follow up
The overall rating for this service is Inadequate and the service is therefore 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?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# Kingston Nursing Home

**Detailed findings**

## Background to this inspection

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

Inspection team
This inspection was conducted by two inspectors, one inspection manager and one pharmacist inspector.

Service and service type
Kingston Nursing 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 did not have a manager registered with the Care Quality Commission. An interim manager was in place and we spoke with them during our inspection

Notice of inspection
This inspection was unannounced. We telephoned the interim manager one hour before we arrived at the service, so we could discuss any risks to people and the inspection team, for the provider to advise us which door to use and where to put on our personal protective equipment (PPE).

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including previous inspection reports, notifications received by the CQC and the provider's recent internal audit and action plan. A notification is information about important events which the service is required to tell us about by law. We used recent feedback from other stakeholders. These included Healthwatch Leeds, the local authority safeguarding team and commissioners. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We visited the service on 18 August 2020. Between the 19 and the 25 August 2020, we sought further information and documentation from the provider. We spoke with four people who used the service about their experience of the care provided and three relatives. We spoke with eleven members of staff including care workers, nurses, cook, interim manager, operations director and nominated individual.

During our visit, we spent time observing care in the communal lounges. We spoke with one healthcare professional visiting the service.

We looked at care records for eight people living at the home and looked at medication records for seven people. We looked at training and recruitment records for staff. We also reviewed various policies and procedures and the quality assurance and monitoring systems of the service.

After our first inspection visit, we shared our initial findings with the local authority and CCG, including one safeguarding concern. We also shared fire safety concerns with the Fire Authority.

After the inspection
We continued to seek clarification from the provider to validate evidence found and updates regarding immediate actions we asked the provider to take.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's care were not managed safely.
- Before our inspection we were made aware of concerns that several people had lost weight and had not received adequate support with their nutrition. These concerns were reported to the local safeguarding team. During our inspection, we could not be sure people always received the nutritional support they required as per their care plans. Nutritional risk assessments and records were not always accurate or informative to staff. The provider told us they were in the process of implementing a new electronic system to improve recording of this area of people's care and ensure that any concerns were alerted and acted upon quickly. The provider was also in the process of arranging further training for staff around safe nutrition and weight loss.
- Some people living at the home had risks associated with their swallowing, including people who required their drinks thickened to prevent choking incidents. We could not be sure these risks had been appropriately assessed and safely managed. Some care staff responsible for preparing people's thickened drinks had not been formally trained or had their competency assessed to complete this task. We shared our concerns with the provider and they told us they would continue to review people's choking risk assessments and care plans and ensure all were accurate. Staff responsible for the preparation of thickened drinks would be provided with additional training and supervision.
- Risk of falls were not always managed safely and the provider had not always implemented learning from incidents. Staff were not consistently following the new procedure implemented in the event of a head injury; this had been implemented by the interim manager a few weeks before our inspection in response to a fall. People who needed support or were at high risk of falls were not always supervised when they were in communal areas. We could not be sure equipment to prevent falls was in working order. After our inspection, the provider told us they had purchased new equipment to help reduce the risk of falls.
- Information about people's moving and handling requirements was not always detailed. Staff gave us contradictory information about this area of people's care and we could not be sure staff would always follow safe moving and handling procedures. We raised one safeguarding concern because we observed an unsafe moving and handling manoeuvre during our inspection visit. Moving and handling training was not always up to date, but the provider showed us staff had been booked in for this training to be completed the week following our site visit. Staff identified as requiring refresher training were supporting competent staff with moving and handling transfers.
- During this inspection we found concerns around fire safety at the home and staff's knowledge about what to do in case of a fire. We shared our findings with the Fire Authority.
- We found concerns with the safety of the environment. Items that placed people at risk of harm, such as cleaning products or gloves, were not always stored appropriately.

The registered person(s) failed to provide care and treatment in a safe way as they did not have adequate systems to assess and managed the risks to the health and safety of people using the service or mitigate the risks. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they were working to put in place appropriate arrangements to manage specific risks to people's care, environment and safety.

Using medicines safely

● Medication was not always managed safely.

● We found concerns around the recording and administration of people's 'as and when required' medication, time specific medication and controlled drugs. For example, during our inspection visit, we observed people who required their medication at a particular time being given this medication outside of the indicated times. Staff were not recording the times paracetamol had been administered, therefore staff were not aware of when people had last received pain relief. The recommended time gap of 4 hours between doses of pain relief was potentially not being followed by staff. People were at risk of being overdosed. We asked the provider to review how medicines were administered and recorded and they told us of the immediate actions they were taking.

● Medicines were not always stored at correct temperature. We shared concerns with the provider and they told us they had purchased new equipment to resolve this issue.

● Staff's knowledge was not robust and we could not be sure all staff were competent in the safe handling and management of medication. For example, staff responsible for administering medication were not able to confirm how many people required their medication given covertly and why. The provider said they were in the process of having all their staff's competencies to administer medication reassessed and confirmed they were going to contact the CCG's medicines team to access additional support in this area.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff were able to describe signs of abuse and neglect however, their training had not been effective because they had not identified or acted appropriately on the concerns we found around people losing weight and unsafe moving and handling procedures. The interim manager was clear on their responsibilities about reporting safeguarding concerns and told us the work they had planned to improve staff's knowledge in this area.

● People told us they felt safe living at the home. One person said, "Yes, I feel safe." Relatives also told us they felt their loved ones received safe care. One relative said, "I feel comfortable [person] is there [at Kingston Nursing Home]." However, our findings from this inspection was that people did not consistently receive safe care.

Staffing and recruitment

● Staff told us there were not enough staff and there was high usage of agency staff. During our inspection visit, we observed staff were not always present in communal areas to support people and manage the risk of falls. We also observed people who required assistance with their meals asleep, with their meals left in front of them.

● The provider was using a dependency tool to calculate the number of staff required according with

people's needs. After our inspection visit, the provider told us they had increased staffing levels to ensure adequate supervision and support of people. The provider also told us the work they were developing to introduce electronic recording tools to ensure staff's time was focused on people and also offering further training and support to staff to improve their performance.

● Recruitment was not always done safety. The provider was not always completing all the relevant pre-employment checks before allowing staff to start working. The provider had already identified this was an area that needed further work and they were clear on their responsibilities in relation to safe recruitment.

Preventing and controlling infection

● The home was not always free of odours. Some communal areas of the home were not always clean.

● During our inspection visit, we observed some staff not complying with infection control procedures and furniture was not always placed in a way that promoted social distancing. The provider told us the immediate actions they had taken to ensure infection control was followed by all staff and also informed us of the plans they had in place to improve the environment and ensure it was always free from odours.

● Personal protective equipment such as hand sanitiser, gloves and aprons were available in several areas of the home.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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 this inspection we found systematic failings in the management of the service, which meant people did not always receive safe care. Some of the issues identified during this inspection had already been identified by the provider, however actions taken had not been effective, were not sufficiently embedded or had not been taken in a timely way.
- There had been a change in the management of the service and there was no registered manager in place at the time of this inspection. There was an interim manager and a new manager was in the process of being recruited. Some staff told us they felt well support by management; other staff told us they did not feel supported or listened to. Most staff told us staff morale was low. We did not see evidence of how the nominated individual kept effective oversight of the management of the service and followed up on known issues.
- We found the quality assurance processes in place had not been effective in identifying issues found at this inspection and drive the necessary improvements, for example with the administration of medication and care plan audits.
- The provider had not kept appropriate oversight of staff's training. We informed the provider about the concerns we had around staff's practices, lack of knowledge and poor skills.
- Timely action had not been taken to address environmental concerns. This included the replacement of fire safety equipment, cluttered corridors and radiator covers.
- People's care records had not been kept up to date. People's care records did not always clearly record their needs or the care they had been offered or received. This put people at increased risk of not having their needs met.

We found the governance systems in place were not operating effectively to ensure people receive safe and consistent care to always meet their needs. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim home manager and provider told us about their plans to improve the oversight and management of the service, the resources they needed and how they planned to allocate them. We continued to be in contact with the interim manager and provider for updates on the progress of their actions.

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

outcomes for people
● People's care needs were not always being met as detailed in this report and this had an impact on their safety.
● We observed some caring interactions between people and staff, however most of the interactions observed during our inspection visit were task orientated. All the people we spoke with told us they were not involved in activities with staff or other meaningful activities during the day and said they felt bored.
● We found little evidence of person-centred care being provided at the home. We saw some people choosing what they wanted to eat, but no other evidence of involvement in their care. For example, people's bedrooms were not personalised. Two people shared a room; the room was not personalized in any way; the bed linens were the same and one staff member was unsure which bed belonged to which person.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We did not find evidence people or relatives had been engaged or encouraged to be engaged in sharing their preferences of how the service was run. For example, the provider told us about their plans to complete building works and make improvements in other areas of the home but we were not provided with evidence of how people had been involved in these plans, how changes were being communicated or risk assessed.
● Staff had the opportunity to discuss the running of the service at staff meetings however, they did not always feel listened to.
● Relatives told us they had not been asked to complete a satisfaction survey.

Working in partnership with others
● We saw evidence in some people's care records showing the service worked with external health and social care professionals such as social workers, speech and language therapists and GPs. Visits to the service were limited due to Covid-19 but reviews were continuing via telephone. However, we were also aware the provider was receiving support to improve relationships and have better working practices with some healthcare professionals.

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;
● Before this inspection we had concerns about the provider not always following the correct procedure when safeguarding concerns had been identified. On review of recent statutory notifications submitted and information gathered during this inspection, we were assured the interim manager was aware of the location's reporting responsibilities to the Care Quality Commission (CQC).

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<br><br>Risks to people's care were not always managed safely and staff's knowledge was not robust. People's medication was not administered safely and we could not be sure staff administering prescribed medication were competent to do so. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There were widespread shortfalls in the way the service was managed. Records were not always accurate or complete. |