SHC Clemsfold Group Limited

# Kingsmead Care Centre

## Inspection report

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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

Kingsmead Care Centre is a residential care service that is registered to provide accommodation, nursing and personal care for older people and people with learning disabilities or autistic spectrum disorder, physical disabilities, and younger adults.

The service was registered for the support of up to 34 people. At the time of the inspection 19 people were using the service. The service consisted of one building. There was a designated part of the building called Kingsmead Haven, where all the people using the service with learning disabilities or autistic spectrum disorder lived. The service was in a residential street on the outskirts of a large town.

Kingsmead Care Centre is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found

There was unsafe assessment, monitoring and management of risk for people with support needs regarding constipation, behaviours that may challenge, aspiration, respiration, skin integrity, mobility and posture.

Staff practice regarding risks associated with people's deteriorating health was not consistent to ensure that people's well-being was being monitored and any concerns acted on.

Medicines were not always managed safely. People had not always received their medicines as intended when they needed them.

Staff practice, and reporting systems to safeguard people from abuse, were not always effective to ensure people were safe from harm. Lessons were not always learnt, and actions not taken to investigate safety incidents and prevent them re-occurring. Staff did not always have the required competencies or knowledge to meet people's individual needs safely.

Service management and the provider's wider quality assurance and governance systems had not always ensured actions were taken to address any issues and risks in a timely manner. People's care records were not always up to date or accurate.

The provider had failed to act upon known areas of concern, non-compliance and risk to improve the quality of care for people at Kingsmead Care Centre. This had exposed people to on-going poor care and risk of avoidable harm.

The provider had acted to manage infections during the Covid-19 pandemic. Additional infection prevention

and control measures in line with Department of Health and Social care guidelines had been put in place to ensure people's safety.

Staff always wore personal preventative equipment (PPE) when supporting people. The provider had ensured there were adequate stocks and supplies of PPE available.

Staff had alerted appropriate external agencies in when they had displayed signs and symptoms of Covid-19. This had helped prevent infection and maintain people's health and well-being.

A relative told us, "The manager has kept the place safe during Covid-19 they are incredibly strict about infection control and the home is always very clean all time".

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:

The model of care and setting did not maximise people's choice, control and independence.

The model of care delivery at the service focused on people's medical, rather than their social support needs.

The location of the service was not geographically isolated. However, people relied exclusively on staff to be able to leave. Opportunities for people to access the local community were limited.

Staff wore uniforms and name badges to say they were care staff when supporting people inside and outside the service.

The size of the service was larger than current best practice guidance. There were identifying signs on the road before the service's private drive, the service grounds and on the exterior of Kingsmead Haven and Kingsmead Care Centre to indicate it was a care home.

Right care:

Care was not always person-centred or promoted people's dignity, privacy and human Rights.

Staff did not always respond in a timely or compassionate or appropriate way when people experienced pain or distress.

Right culture:

The provider told us they planned to make changes to ensure they could provide compassionate and

inclusive support that promoted people's choice and independence.

Staff and the manager said they cared about any issues affecting people living at the service and wanted to make improvements. We observed staff supporting some people in a positive manner during our inspection visits

However, significant work was still needed to change the existing culture, ethos, attitude and practice of staff at Kingsmead Care Centre in order to achieve this vision.

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 13 February 2020). The service has been rated requires improvement or inadequate for the last four consecutive inspections.

At the last inspection we found multiple breaches of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating.

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

We carried out an unannounced comprehensive inspection of this service on 3 and 5 September 2019. Breaches of legal requirements were found. We undertook this focused inspection to confirm the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.

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

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 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 four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations 12, 13, 17, 18 in relation to: safe care and treatment, safeguarding people from abuse, good governance and staffing.

We have also identified a breach of Care Quality Commission (Registration) Regulations 2009 in relation to failing to notify CQC of incidents regarding abuse or allegations of abuse in relation to service users.

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Kingsmead Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

Follow up

We will continue to monitor information we receive about the service until we return to visit. If we receive any concerning information we may inspect sooner.

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 act 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 section below.

# Kingsmead Care Centre

**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

This inspection took place between 19 and 30 October 2020. The inspection team consisted of four adult social care inspectors.

On 20 and 21 October 2020 two inspectors carried out an inspection visit to the service. Between 19 and 30 October 2020 four members of the inspection team reviewed care records and spoke with staff remotely.

Service and service type

Kingsmead Care Centre 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.

The service did not have a manager registered with the Care Quality Commission. This means the provider held sole legal responsibility for how the service is run and for the quality and safety of the care provided.

The service had a manager who had been in post since 2019 and was in the process of registering with the CQC.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because we needed to work with the provider to agree the safest way to inspect during the Covid-19 pandemic to minimise the risks to people who live at the service, staff and our inspection team.

What we did before the inspection

Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us since the last inspection by the provider as well as the local authority, other agencies and health and social care professionals. We requested medicine and care records, incident reports, rotas and quality assurance records. We worked with the provider to plan the safest way to inspect the service during our site visit.

During the inspection

We spoke with the service manager, the clinical lead, registered nurses (RGN) and various support staff. We reviewed people's care and medicine records. We spent time talking to and observing people being supported, including during lunch. We visited some people's bedrooms.

After the inspection

We continued our review of people's care and medicine records, training records, rotas, incident reports and quality assurance records. We spoke with the manager, an RGN, two support workers and four relatives of people using the service via telephone.

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 requires improvement. 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, staffing

● Risks relating to people's constipation needs were not assessed, monitored or managed safely. Many people using the service were at risk of serious harm if they became constipated.

●Actions identified to help prevent people becoming constipated were not always taken by staff. People living at this service with profound and multiple learning disabilities were more likely to become constipated. There was a risk they could have harmful medical complications if they became constipated.

●Staff had supported a person to use a machine to help them breathe when they were constipated, despite specific directions that the machine should not be used in these circumstances. Each time this had happened the person had been placed at risk of serious and avoidable harm.

●People who were constipated for several days had not been given laxatives when they needed them. This increased the risk of people having harmful complications caused by being constipated for a long time.

●Staff had not always acted to escalate concerns for appropriate medical support when people were constipated. This was because staff had not known this was necessary. This meant people had not got help to ensure they were as safe as possible.

●People's continence care plans and constipation protocol care plans contained inconsistent advice about when to seek medical advice if they were constipated. This increased the risk people may not get help as quickly as they needed it.

●Staff had not always recorded people's bowel movements. Staff could not check if people were constipated, how long since they last had a bowel movement or if they needed support to relieve their constipation.

●Where people had been constipated for long periods, staff had not always recorded what support they had given to people to show they had kept them safe.

● Staff assessing one person's constipation needs had not considered important information about their medical conditions. This meant there was not enough information to make sure staff knew how to prevent

harm to the person if they were constipated.

● Risks to people with respiration (breathing) support needs were not always assessed, monitored or managed safely.

●A person required support with their breathing every night and had oxygen as needed (PRN), due to their respiration difficulties. Staff needed to support them to use a machine that helped them breathe or give them oxygen from a cylinder. If the person did not have enough oxygen this could cause them serious harm.

●Actions had not always been identified or taken by staff to make sure this person had enough oxygen.

●Staff had not always recorded they had supported the person to use the machine that helped them breathe at night. Staff said they were not able to check the person had been helped to use their breathing device, and they could not make sure they had got as much oxygen as they needed.

●Staff had not assessed the risk to know what to do if the person did not have enough oxygen or if there were problems with their breathing equipment. Staff told us different information about what they should do in this situation. This increased the risk the person might not be supported with their breathing needs safely.

●There had been a recent incident where the machine to help the person breathe had not been available for three days and nights. During this time, staff had not always taken additional precautions to make sure the person had received enough oxygen. This had left the person at risk of serious harm.

●There were inconsistencies in the person's protocols and care plans about how and when to give them PRN oxygen and what equipment to use. Staff told us different information about when and how they would give PRN oxygen. This increased the risk the person might get not get the right support if they were having difficulties breathing.

●The person had been assessed as requiring PRN chest physiotherapy to help them breathe by a GP in June 2020 and again by physiotherapy staff at the service in October 2020.

●There was no information in the person's breathing care plan or risk assessment about their needing PRN chest physiotherapy or how staff should give this to them. This increased the risk staff might not know the person needed this support or how to safely give this to them if they were having trouble breathing. The person had not received chest physiotherapy recently but may have needed it.

● Risks to people with swallowing difficulties and might choke were not always monitored or managed safely. One person had problems swallowing and could choke on food or drink, which could be very harmful.

● Actions identified to help stop the person choking in their Speech and Language therapists' guidelines were not taken by staff. The person always needed to be sat upright and observed when they ate or drank in case they choked.

●Staff left drinks for the person to have while they were alone and in bed. Staff recorded they did this regularly. It could not be confirmed the person had always been sat upright while they were in bed. This meant the person could have choked many times and had been placed at risk of significant harm.

● Risks relating to people's physical and non-physical behaviours that may challenge were not always assessed, monitored or managed safely. Several people could display behaviours causing emotional distress or physical harm to themselves, or other people and staff at the service.

●There was not enough guidance or information available for staff about what people's behaviours may mean and how to safely help them from becoming distressed or causing harm. This increased the risk people might get hurt, continue to display potentially unsafe behaviour and people and staff would not learn how to prevent this happening.

● Staff were supporting one person in an unsafe way by physically supporting them when they presented behaviours that may challenge. The potential risk of harm from this action had not been identified or monitored, to prevent the person being hurt or restricted unnecessarily.

●One person had been involved in several similar incidents where their behaviours had placed them, staff and other people at high risk of harm. The person's care needs had not been reviewed and staff did not know how to keep the person and others safe if this situation occurred again.

● Actions identified to help prevent people displaying these behaviours or hurting themselves or others were not always taken by staff. One person was not supported to have the equipment they used to stop them hurting themselves. Staff did not know where the equipment was and had to spend some time looking for it when we asked them about this.

●Staff were not always monitoring people's behaviours that may challenge when they happened. It could not be checked people were being supported safely. There was not enough information for staff to carry out reviews to help the person and try to prevent this happening again.

● Risks relating to people falling and seriously hurting themselves were not always assessed, monitored or managed safely. Several people were at risk of harm or injury from falling due their age and health conditions.

●People's mobility and falls related care plans and risk assessments contained inconsistent advice about the support they needed to prevent falling. Staff told us different information about the support people needed to reduce the risk. This increased the risk people may not get the right support to prevent them falling and possibly injuring themselves.

● Actions identified to help prevent falling and hurting themselves were not always taken by staff. One person always needed staff to support them when they moved around, in case they fell. Staff told us and had recorded they did not always help the person as directed. The person had fallen over several times this year and been injured in doing so.

● One person communicated by non-verbal means and needed two staff to support them to move from one surface to another. They had recently seriously injured in a suspected fall or when being helped by staff to move.

● Staff had not acted to assess their pain or offer help effectively, including giving regular pain relief or quickly escalating concerns for further medical review after the injury first occurred.

●Following the incident, staff had reviewed how to manage risks to the person from injury through falling or

when being helped to move by staff. However, the person's plans had not been updated to include information about how to recognise, act and monitor when the person was in pain if injured in this situation.

●Risks relating to people's skin integrity were not always assessed, monitored or managed safely. Many people at the service were at risk of developing pressure sores or having skin breakdowns due to their age and health conditions.

●For these people, many had a pressure mattress to help stop this happening. People's skin integrity care plans and risk assessments contained inconsistent advice about the right setting for their mattress to help prevent pressure sores. Staff told us different information about the right setting people needed and could not confirm people's pressure mattress settings would help prevent injury. Staff and managers had not checked this to make sure this risk was being manged safely.

● Risks associated with ensuring people's health and well-being was maintained were not always assessed and monitored safely. Staff had not taken people's vital health observations, such as blood pressure, oxygen saturation and heart rate, when there were increased risks people may suddenly become unwell.

● For example, people's vital health observations had not been taken and assessed when they had received oral suctioning or when they had experienced an epileptic seizure. Staff may not recognise and act if people's health declined suddenly and they needed support to access healthcare support and services quickly. This increased the risks to people's safety and welfare.

Learning lessons when things go wrong

●Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not always effective. This increased the risk that incidents would not be investigated and acted on to prevent them from happening again.

●During this inspection in October 2020 we identified issues relating to safety incidents that had either not been reported or had not been adequately acted on regarding people's constipation, respiration, choking, behaviours that may challenge, skin integrity, healthcare monitoring, mobility and postural support needs.

●We had identified issues and risks associated with behaviours that may challenge, mobility and postural support needs, and healthcare monitoring during our previous inspection in September 2019. However, we found the same issues remained at this inspection.

●The themes of risks and concerns found at this inspection relating to people's behaviours that may challenge, choking, respiration, constipation, skin integrity, monitoring healthcare and postural and mobility support needs have been highlighted in inspection reports about many of the provider's other services. This information had not led the provider acting to prevent similar risks to people at Kingsmead Care Centre being reduced.

The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Due to our urgent concerns about the risk of harm to people with constipation and respiration support

needs we asked the provider for immediate assurances about what they would do to make sure people were safe. The provider sent us an action plan telling us how they would address the issues quickly. We are continuing to monitor the progress of this plan.

●During the inspection, we bought issues regarding people's skin integrity risks to the manager and clinical lead's attention. They acted to make people's support safer by immediately reviewing people's skin integrity needs, identifying correct pressure mattress settings and introducing daily checks of this.

●At our last inspection we identified risks to people with epilepsy. Staff were not monitoring people during the night and would not be able to know if they had a seizure and needed support. At this inspection, we found the provider had acted to provide equipment that allowed staff to monitor people's seizures at night effectively.

● Two relatives we spoke with told us they had not had any concerns about their family members safety or wellbeing since they had been living at Kingsmead Centre. One relative said, "From what I can see I have no concerns".

Staffing

● There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.

● People living at the service required regular weekly physiotherapy and hydrotherapy support from staff at the service to help improve or maintain their posture and other health needs.

●The provider had not deployed enough physiotherapy staff to meet people's needs,

● The risk of there being no trained physiotherapy staff to meet people's needs had not been assessed on an individual basis. This placed people's safety and well-being at increased risk.

● One person's care plan identified they required two weekly physiotherapy sessions weekly and a third hydrotherapy session every other week. Due to Covid-19 risks, people were unable could not access the hydrotherapy pool since March this year. The provider had agreed to provide land-based physiotherapy sessions to replace people's hydrotherapy.

●The person had not received this number of their physiotherapy sessions in August or September this year due to lack of physiotherapy staff.

●Actions to reduce the risk of any missed physiotherapy sessions, including replacement sessions for hydrotherapy had not been agreed or put in place.

● A relative told us, "[name] should have two sessions of physio a week, but I'm not sure if they still have this. I'm not there every day but I think their motor skills have diminished because they have not had them".

●People living at this service required support to safely manage behaviours that may challenge to ensure their own and other people and staff's physical and emotional safety and well-being.

●Staff had not received adequate training or support to be able to deliver safe or effective support for

people with behaviour's that may challenge. This placed people and staff's safety and well-being at increased risk.

●Staff did not demonstrate they were skilled enough to meet people's behaviour that may challenge support needs safely or effectively.

●Staff had received behaviour support documentation training to help them complete behaviour monitoring forms. Despite this, staff were not competent and could not complete behaviour support documents to a good standard.

The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We are receiving information about on-going work between the local NHS Trust and the Provider to look for solutions to assess people's physiotherapy needs and associated risks while the provider is lacking staff. The provider has told us about on-going work to ensure there are enough physiotherapy staff deployed to meet people's needs safely.

Systems and processes to safeguard people from the risk of abuse

● Systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective.

●Staff had significantly disregarded people's constipation and respiration support needs.

●Staff had neglected to provide proper treatment for people's choking, skin integrity and behaviours that may challenge support needs.

●Staff had not always reported these incidents of neglect or improper treatment. Immediate review and investigation to protect people from any abuse or improper treatment had not taken place.

●Staff could not tell us how they would recognise and report potential safeguarding abuse incidents.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

●Medicines were not always managed safely.

●People's as required 'PRN' protocols did not give staff clear directions. This increased the risk people may not receive their medicines safely, or as intended.

●One person had not received support to be given laxatives when they had become constipated and needed them. This placed their safety and well-being at high risk.

● Medicines were ordered, stored and disposed of safely. Nurses had their competency to administer

medicines regularly assessed.

●People had Medication Administration Record (MAR) and included information about the medicines they needed, how their medicines should be taken or used and how often. Staff signed MAR to show they had received their medicines as intended.

Preventing and controlling infection

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

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

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

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

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

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

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

● We were assured that the provider's infection prevention and control policy was up to date.

● A relative told us, "The manager has kept the place safe during Covid-19 they are incredibly strict about infection control and the home is always very clean all time".

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 requires improvement. 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, 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

●At the last inspection in September 2019, we had found that the provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 12 and 17 in relation to safe care and treatment and good governance.

●Following the inspection in September 2019, we had specific concerns about unsafe support for people with behaviours which may challenge, epilepsy and end of life support needs. We had imposed conditions telling the provider that they must audit all their care plans and assess, monitor and act to help ensure people with these needs were supported safely and effectively. We asked them to send us monthly reports to tell us how they were doing this.

●The imposition of conditions had not been effective in driving improvement or preventing repeat themes of concern re-occurring in relation to people's safety or the quality of care at Kingsmead Care Centre.

●At this inspection in October 2020 we did not find concerns regarding end of life care for the people who required this and we found some areas of people's epilepsy support had improved. However, we found risks to people who required support for their behaviours that may challenge remained high and their needs were not being met safely or effectively.

●At this inspection in October 2020 we found the quality and safety of people's support had deteriorated further from our previous inspection in September 2020. People's health and welfare was at risk of harm in relation to failings to provide safe support for people with constipation, respiration, choking, skin integrity, healthcare monitoring, mobility and postural support needs.

●There were repeat breaches of regulations 12, and 17. We found there were now also breaches of regulation 13 and 18 in relation to safeguarding service users from abuse and staffing and a breach of CQC Registration Regulations 18 regarding failing to notify the CQC of incidents.

● At this inspection in October 2020, we had extremely serious and urgent concerns regarding failures to provide safe support for people with constipation and respiration support needs at Kingsmead Care Centre.

●These failures had not been recognised or prevented by the provider prior to our inspection. We needed to request immediate assurances of action the provider would take to reduce the risks to these people.

●Due to a history of repeated failures to provide safe and well-led care for people, despite the receipt of assurances, we remain highly concerned about people with respiration and constipation needs safety at the service. We are continuing to closely monitor the progress and effectiveness of the actions the provider told us they would take.

●The risks and concerns found at this focused inspection follow themes which have been highlighted in repeated inspection reports over the last two years about many of the provider's other services.

●In December 2018 we imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at several services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing and how they are acting to resolve any risks to people's safety and wellbeing.

●These provider level conditions and repeated reporting of information about themes of unsafe care for people being supported provider's organisation had not led to similar risks to people at Kingsmead Care Centre being reduced.

● Systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively.

● The service manager and clinical lead carried out a regular variety of internal audits to check the quality and safety of the support people were receiving.

●The management and staff at the service had received consistent additional support from managers and support teams within the organisation to check and carry our other audits help assure the delivery of good quality and safe support for people.

●However, these quality assurance systems and processes had not always identified or prevented significant safety issues occurring or continuing at the service.

● Where issues had been identified, there had not always been effective action to maintain or improve the quality and safety of the support being delivered.

●Staff at all levels had not demonstrated they understood or fulfilled their responsibilities. Staff had not always met people's support needs or reported and acted in response to quality and safety issues.

●Staff accountability had not been managed effectively. Staff continued to not always have the right skills, knowledge or experience to manage risks and deliver safe care for people.

● There was not accurate and contemporaneous records in respect of each service user in place. People's

care plans, risk assessments and monitoring forms regarding constipation, behaviours that may challenge, respiration and mobility and postural support were not always accurate, complete or up to date.

Working in partnership with others

●We found specific examples during this inspection regarding the provider failing to work effectively with partnership agencies to ensure people's physiotherapy and respiration needs were met and associated risks managed safely. This has been reported in more detail in the Safe section of our report.

● The local authority and local NHS partnership trust provided feedback staff had not always acted when they made recommendations to improve people's support.

●Partnership agencies shared concerns regarding the provider's communication and information sharing not being open and transparent, including when things had gone wrong.

●Some relatives felt staff communication with them about their family member's support could be improved. One relative said they did not always know what support was being delivered for their family member. They wanted more regular updates from staff and assurances their relative was getting the support they needed and wanted.

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

●The provider had recently invested in an independent learning disability specialist organisation to review their service delivery across their services.

●This review had highlighted significant and multiple shortfalls in the provider's model and approach to delivering care to people.

●The review concluded significant changes were needed to be able to deliver safe, person-centred, open, inclusive and empowering support which achieved good outcomes for people that fully considered their equality characteristics.

● Both the manager and the nominated individual acknowledged the validity of the reviews' conclusion, how this was reflected in the findings at this inspection of Kingsmead Care Centre and the corresponding levels of concern this presented.

The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved.

The service had not ensured there was a positive and open culture that achieved good outcomes for people. People's equality characteristics had not always been considered when engaging or involving people using the service, the public or staff.

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

● The provider had not always informed relevant partnership agencies such as the local authority safeguarding team, local NHS trust partnership or CQC about notable safety incidents, risks or events that stop the service, as per their statutory and contractual responsibilities.

●Notifications had not been sent to CQC as required regarding people not being provided with their assessed physiotherapy or hydrotherapy needs due to staffing issues.

●The local authority and CQC had not been notified when staff neglected to meet people's respiration and constipation needs, or when people had been exposed to risk of harm.

The failure to ensure that all statutory notifications of incidents related to services of a regulated activity being provided at the location were submitted as required is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The service had not had a permanent registered manager in post since September 2018. There had been a manager at the service since August 2020, whose CQC application was in the process of being processed.

●The manager told us they hoped to deliver "Caring, dedicated and compassionate support for people. I treat this as their home and respect this. It is very important to me we will offer people the best support. I will continue working with staff to help them understand and demonstrate this."

●Staff said they cared about any issues affecting people living at the service and wanted to make improvements. We observed staff supporting some people in a positive and friendly manner during our inspection visits.

●Staff said they found the manager approachable, listened to them and they felt included in the work the manager was doing to try and give better support for people at the service.

●All of the relatives we spoke with gave positive feedback about their interactions with the staff and management when they went to the service, and they were always made to feel welcome.

●A relative told us, "the manager is very hands on, and I take my hat off to them as they work very hard". Another relative told us they felt all staff tried to provide good support for people.

●The nominated individual and the provider's senior management team told us they were currently undergoing an internal review of their structure and approach to delivering support, to try and make improvements in safety and quality across their organisation.

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<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>Failure to ensure that all statutory notifications of incidents related to services of a regulated activity being provided at the location |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Kingsmead Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users and thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users. |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Kingsmead Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider failed to ensure systems and processes protected people from abuse and improper treatment. |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Kingsmead Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved.<br><br>The service was not always open and transparent with service users and other relevant persons and had not always worked effectively in partnership with other agencies.<br><br>The service had not ensured there was a positive and open culture that achieved good outcomes for people. People's equality characteristics had not always been considered when engaging or involving people using the service, the public or staff. |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Kingsmead Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff |

**The enforcement action we took:**

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Kingsmead Care Centre is now de-registered and the provider is no longer able to provide regulated activities at or from this location.