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Kingsbury Court

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

About the service
Kingsbury Court is a nursing and residential care home providing accommodation, personal care and nursing care to older people with physical support needs, some of who live with dementia. The home can support up to 60 people. At the time of our inspection there were 52 people using the service.

People's experience of using this service and what we found
People's experience of care was not always consistently good and safe due to staffing issues. There were not always enough suitably skilled staff effectively deployed in the home to ensure people were safely supported to mobilise freely, to manage their anxieties and day to day needs when they wished to have support and to take care of their wellbeing. This posed a range of risks to people, for example around falls, health deterioration or social isolation.

There was a new manager in post who made a range of positive changes around how people's care was overseen. We saw positive changes were being made around how the quality was monitored, what support staff received on a day to day basis and how audit actions were followed up and completed. However, this was not consistent in the previous months and some outstanding actions had impacted on people's experience of care they received and still needed addressing.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and their relatives told us they felt safe with staff and in the home and overall staff were kind and caring. Where people needed support around their medicines, they received this safely. People's individual risks were addressed in their care plans and action was taken when needed to keep people safe. People's care was affected by staffing issues which we addressed with the provider.

New staff were recruited safely. Staff overall followed good infection prevention and control practice. Staff felt more supported in their roles since the new manager was employed and commented the culture of the service was slowly improving.

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 07 August 2021)

Why we inspected
We received concerns in relation to staffing and risk management. 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 safe and well-led sections of this full 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 Kingsbury Court 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 monitor the service and will take further action if needed.

We have identified breaches in relation to staffing and governance at this inspection.

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

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.

Kingsbury Court

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Kingsbury Court 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. Kingsbury Court 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 not a registered manager in post. However, there was a home manager who had applied to register with CQC and supported the inspection.

Notice of inspection
This inspection was unannounced.

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

During the inspection
We spoke with nine people who used the service and seven representatives of the people about their experience of the care provided. We spoke with 14 members of staff including the home manager, senior managers, a nurse, care staff, housekeeping staff and the chef.

We reviewed a range of records. This included elements of 13 people's care plans and multiple medicines records for people supported with their medicines. We looked at recruitment checks and training records for three staff members. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

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

● Staffing levels and deployment in the home was not always effective to ensure people's needs were fully and safely met. People told us they were not always able to access support timely. One person said, "Definitely not (enough staff). Sometimes you have to wait quite a while as normally the staff are too busy. They haven't got enough time." Another person said, "There is not enough (staff). You don't get the right care. Dinner time is the worst." A relative of a person said, "staff were sometimes rushed off their feet."

● Staff we spoke with had mixed opinion on staffing levels and allocation across the three floors of the home. However, many staff members voiced concerns around how staffing affected their ability to provide people with safe and good quality, person-centred care. For example, around their mobility or daily personal care.

● One staff member said, "There are not enough staff, people are asking for help, there are too many people walking. They need supervising. With breakfast more and more residents need assistance. There is not enough time for the residents." Another staff member said, "We are all at risk due to shortness of staff running here and there."

● Staff told us when some people needed longer to support to mobilise, staff would consciously decide to leave them in bed as they had no time to support them. Staff members confirmed with us four people were not supported to get out of bed on the day of the inspection due to lack of staff to monitor their whereabouts as they were at significant risk of falls. One staff member said, "The main aim is to ensure they (people) don't fall. We do not have enough staff. They (staff) are all new and they need some support. Look, it's safer for them to be in bed." This meant people would not be encouraged to access support to mobilise safely which could increase other risks, for example around their health or dementia deteriorating. We observed multiple people were in bed on the day of the inspection for the whole duration of our visit.

● Where people were able to mobilise safely, some of them required staff to be present in the communal areas to support them around their safety. We observed on the day there were many times there was no staff around the communal area on the ground floor available to support which increased risks to people, both around falls and any altercations if people got distressed. We also saw one person was waiting a long time for support with their continence care despite us raising this with staff. Other people did not receive basic support with their routine morning care by midday. Some people were waiting over an hour for their tea and snacks.

● Some people spent the whole day in bed with no evidence of any interaction or meaningful engagement offered by staff apart from basic care and daily support. One person told us, "It will soon be lunch, something to look forward to as I get bored. I have to stay in bed and I don't know why. I can't walk as it has been so long without the practice."

● Although for some people this was their choice or need, it was not clear how staff worked with people to

offer them to spend their day in any other way. People's daily care records were task-based and did not indicate what support and interaction was offered to people to prevent risk of isolation and negative impact on their wellbeing. One relative said, "I feel if I didn't visit as often as I do, how much exposure [my relative] would get to people. [Staff] wake them in the morning and give them breakfast and personal care. 80% of their time they are in bed. They (the home) have staffing issue and lack activity people – so [person] won't see staff. [Person] tells me they don't see anyone. What I feared was isolation and it is exactly that. On my last three visits, I have phoned and asked them to hoist [person] on the wheelchair so I can take them out into the garden. [Staff] have said they don't have time to do it. They obviously don't have enough staff to do that. Twice out of the last three visits they have not been able to do it."

There were insufficient numbers of suitably qualified, competent, skilled and experienced staff and they were not always effectively deployed in order to provide people with holistic, good quality and safe support and care. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed new staff were recruited to support the existing staff team and they would be implementing the findings of a review of their staffing structures and allocations, dependency assessments and support provided to staff on a daily basis.

● New staff were recruited safely. Every new staff member had to undergo an application, interview and pre-employment checks process. Staff had their references, employment history, identity and criminal checks (DBS) completed with support of the provider's recruitment team. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt safe in the home. One person said, "I find [staff] very pleasant, I feel safe. Staff are very nice to me." Another person told us, "I feel safe, it's a safe environment. No one can get at me. I never feel unsafe." A relative of a person echoed this opinion, "I feel she is safe, and she feels safe."
● The management team appropriately reported, recorded and investigated all safeguarding concerns. The new manager was aware of the local multidisciplinary safeguarding policy and discussed it with the staff team during recent meeting to raise their awareness.
● Staff we spoke with knew how to recognise and report any concerns around abuse or neglect and told us they felt comfortable to speak up when needed.

Preventing and controlling infection
● We were somewhat assured that the provider was making sure COVID-19 outbreaks can be effectively prevented or managed. Where people had an infection, this was not always robustly risk assessed around their individual circumstances. Although overall outbreak management guidance was implemented, people's individual needs were not always fully considered which could increase the risk of infection spreading. We raised this with the provider who implemented an individual risk assessment on the day of the inspection. We have also signposted the provider to resources to develop their approach.

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

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

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

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

● We were assured that the provider was responding effectively to risks and signs of infection.

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

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

● People were supported to have visitors in line with the local and national COVID-19 guidance.

Assessing risk, safety monitoring and management

● We received mixed feedback from people and their relatives around the care they received but overall people told us they felt safe and staff knew how to help them to keep safe and well. One relative said, "The new manager has made a difference. [Staff] put a pressure mat in [person's] room to notify them when she was moving about. They would come and help her. She also had an alarm to press when she wanted help." Where people were at risk of falls, there were appropriate risk assessments in place and this was regularly reviewed by the management and nursing team.

● Other relatives also confirmed when people were at risk of falls, they had access to appropriate equipment to alert staff they needed help to mobilise safely. One relative added, "[Staff] responded immediately when she put her foot on the pressure mat."

● People's individual risks were assessed and regularly reviewed, for example around their specific health conditions, mobility, skin integrity or high-risk medicines. Where needed, people were supported to change position, to have a drink or a meal and staff knew about their individual needs. However, we identified some discrepancies in people's daily care records which we addressed in Well-Led key question in this report.

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.

Using medicines safely

● People were supported safely with their medicines. One relative commented, "[Staff] support [person] every morning. [Person] told me they would come in early. They waited to make sure she swallowed it." We observed staff who were assessed as competent to support people with their medicines did so in line with good practice requirements. For example, staff washed their hands, checked medicines and records appropriately and communicated with the person.

● People's medicines were stored appropriately. This included high risk medicines or medicines which required to be stored in a fridge. Where required, medicines were dated on opening to ensure they were used safely as per manufacturer's instructions.
● Staff were trained in management of medicines and the home was supported by local pharmacy and people's GP to regularly review individual prescriptions as well as systems and processes in the home. Staff completed electronic records when supporting people with their medicines and medicines were regularly audited by management and external support partners.

Learning lessons when things go wrong
● The home manager reviewed all accidents, incidents and adverse events in the home to identify lessons learnt. For example, they reviewed when people had falls or when they suffered infections and discussed this with the nursing team weekly. Actions were agreed to prevent further risks to people, for example the manager monitored if individual risk assessments were reviewed and referrals for additional support were sent to other healthcare services.
● The new management team identified some trends in timing and circumstances of people falling and addressed some of them, for example night staff levels had been increased. However, there was further improvement needed in how staffing was monitored which we addressed in this report.

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; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had failed to ensure consistent and effective governance of the service before the new manager had started. Hence, not all shortfalls had been fully identified and addressed at this inspection. The home had been through a series of changes in management and the new home manager started shortly before the inspection. The provider's senior managers were supporting the home in the interim.
- Although we saw a range of improvement actions had been implemented in recent months, these had not been fully complete yet. This meant people's care was not consistent and they were put at increased risk of harm or receiving care which did not effectively address all their individual needs.
- One staff member said, "I don't feel supported as there are not enough staff." Another staff member said, "[The home manager] is a new manager, we have had no stability and structure." This was echoed by other staff members and confirmed in peoples' and relative's feedback. Although the provider addressed recruitment issues, action was not always robust and timely enough to provide people with safe and quality support and staff with support they required.
- Although actions were taken to improve people's care, there were a range of outstanding improvements still needed. For example, the governance and oversight systems did not always enable the management and senior staff to effectively monitor and identify improvemnt needs around the quality of people's day to day records, consistency of their risk assessment records and the timely follow up around referrals to other healthcare professionals.

Although work had commenced at the time of the inspection, the governance systems and processes were not fully embedded and effective yet. People were at risk of not receiving consistently good care as shortfalls were not always effectively identified and addressed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new manager improved how people's care was overseen. For example, they ensured weekly clinical meetings were in place to discuss people's changing needs and risks and they worked to build closer relationships with the social care and healthcare professionals supporting the service.
- The new manager worked in an open and transparent way, in cooperation with the local authority safeguarding team. Any adverse events were appropriately communicated to people, their representatives and reported externally when required, including to CQC.
- The new manager encouraged staff to speak up, work in open and honest way and we saw evidence of

those topics being refreshed with staff during a meeting.

Continuous learning and improving care; Working in partnership with others

● The new manager reviewed the improvement priorities for the home and we saw evidence of continuous improvement actions being completed. For example, they finalised completion of overdue fire safety and health and safety audit actions. They correctly identified individual care reviews and staffing reviews as another priority for the service and started working on those improvements, although not all were fully implemented at the time of the inspection.

● The management team also improved communication in the service, for example by working with staff team to implement a structure of effective meetings, including daily meeting with the manager or all staff meetings. New communication streamlines were also introduced, such as a communication folder for staff including relevant updates and resources.

● The management team made recent improvements I how they worked with other social care and healthcare partners. For example, they improved their communication and links with specialist teams in the local area, worked closer with the local GP or local authority safeguarding team. There were clear plans how the new manager wanted to strengthen this links going forward.

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 new manager started making positive changes and was visible in the home. One staff member commented, "The best manager I have worked with in years. [The home manager] is a good person and a good manager." Another staff member told us, "There has been a big change for the good. [Senior manager] does clinical and [the home manager] recruitment. I have learned so much from them."

● The new manager was aware the staff morale was affected by changes in the home and staffing difficulties. They worked with their team and made themselves available which supported all staff to improve how they worked together. For example, they walked around the service to observe care and meet with people and staff. One staff member said how the management supported them to voice their opinion freely, "Yes, I can talk to the manager. He is very good that way. He always has time for you."

"● People's relatives told us they felt communication with the home was overall good and they were involved in their loved one's care when appropriate. One relative told us, "There has not been a time when they have not responded to me." The new manager continued to update people's representatives around important changes in the home, for example via email.

● Some people we spoke with knew the manager, some did not but we were assured the new manager was aiming to meet with people to discuss their feedback. One relative said, "I have spoken to the manager on several occasions about concerns. They have been very understanding and supportive. If there has been anything I need answering they have done so in a timely manner.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems and processes were established and operated effectively to ensure people received consistent, safe and good quality care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to provide people with safe and quality care and support.