Mr D & Mrs J Barnacle

Kingswood Lodge Residential Care Home

Inspection report

Kingswood Lodge
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

People's experience of using this service and what we found
This was our third inspection where the provider and registered manager did not have effective systems or processes in place to assess the quality and safety of the service. The principles of good quality assurance were not understood and there was little or no evidence of learning and service improvement. Audits were incomplete or non-existent.

Care plans and risk assessments remained a concern. They did not always reflect people's current care and support needs. They had not always been updated following accidents and incidents. The information in some of them was incorrect or missing. This put people at risk of unsafe care.

Some medicines were still stored unsafely. Medicines records were incomplete, and the quality of recording was poor. A person's turning chart had not been fully completed and we could not be sure they had been repositioned as required.

The condition of the premises remained a concern. Although the provider had made some improvements, we found broken and stained tiles in a bathroom, water damage in a person's bedroom, an unsafe, unsecured cupboard in another person's bedroom, and other hazards and unhygienic areas throughout the premises.

Staff training was still an issue. The registered manager was unwilling or unable to share the staff training matrix with us so we could not be sure that staff had had the training they needed to provide safe, good quality care.

Some relatives thought the service was safe, but others had concerns about falls management, the quality of the care and support provided, and communication. A relative said, "Care plans are wrong and a mess. No activities. No trips out. Poor communication with management."

During our inspection we asked the registered manager to provide us with records to demonstrate the service was running effectively. These were not sent to us. We intended to go back to the service to carry out further checks but the provider closed the service before we had the chance to do this.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update.

The last rating for this service was Inadequate (report published 17 June 2022). At this inspection we found the provider remained in breach of regulations.

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

Why we inspected
We carried out an unannounced focused inspection of this service on 15 March 2022. Breaches of legal requirements were found. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow-up
The overall rating for this service is 'Inadequate' and the service remains in 'special measure'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

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.

Kingswood Lodge Residential Care Home

Detailed findings

Background to this inspection

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

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

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

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

Notice of inspection
This inspection was unannounced.

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

information to plan our inspection.

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

We reviewed a range of records. This included people's care and medication records, staff records, and records relating to the management and governance of the service. Not all the records we requested were made available to us during or after the inspection.

We planned to return to the service for a second day to complete our inspection. However, before we had the opportunity to do this, the provider closed the service and the local authority assisted the people using it to move to different care homes.

After the inspection
We continued to seek clarification from the provider and registered manager to validate the evidence found. However, the information we requested was not sent to us.

Inadequate

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

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

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

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

- At our last two inspections care plans and risk assessments were not up to date or reflective of people's needs. This meant staff did not always have the information they needed to keep people safe.
- At this inspection a person had fallen and injured themselves resulting in their support needs changing. Staff said they now accompanied the person when they walked and monitored them to ensure they did not attempt to walk unaided. However, the person's care plan for mobility and falls management had not been updated to show this, and the last review stated the person was independently mobile with a frame.
- The person's undated 'at a glance' resident profile, kept at the front of their care file, had also not been updated and stated the person 'mobilises well with their frame'. The person's 'Review of Risk Assessment for Falls', completed after the person had fallen, was incorrect. It stated the person was 'independent/chair bound', as opposed to 'walks with assistance', and was 'physically fit', rather than had 'recent limb fracture or injury'.
- This meant information about the person's current mobility needs was incorrect, and, as at our last inspection, a person's care plan did not reflect their current support needs.
- There were multiple gaps in another person's repositioning chart so we could not be sure they had been repositioned as required. In addition, the person's skin integrity care plan didn't match their current needs, despite being recently reviewed.

Using medicines safely

- At our last two inspections we found prescribed flammable topical creams in a person's bedroom, with no risk assessment in place to show it was safe to store medicines in this way.
- At this inspection we found generic risk assessments in place for these creams. However, they did not explain all the associated risks, or the measures required to keep people safe. In addition, the creams were not being stored safely as instructed in the risk assessment.
- A person's record for PRN ('as required') administration of painkillers was completed incorrectly. This running record was not in date order and showed the medicine being given in August 2022, in September 2022, and then again August 2022. There was no explanation in the records as to why entries had been made

retrospectively. The person's medication care plan said the painkillers were to be given 'when needed', however there was no PRN protocol, pain chart, or other record to show when this should be. This meant it was not clear how staff were supposed to know when the person needed their painkillers.

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

● There were some improvements to care and medicines records. A person who needed two staff to support them in their bedroom now had a care plan making this clear. Another person who needed their medicines administered in a particular way, due to their communication needs, also had an appropriate care plan.

Preventing and controlling infection
At our last two inspections the provider failed to ensure the premises and equipment were clean and properly maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Some areas of the service were unhygienic and in need of repair. The ground floor bathroom had broken and stained tiles and peeling paintwork. There was water damage on the ceiling in a person's bedroom. Hallway carpets were stained. There was a large crack in the wall of the downstairs television lounge. Skirting boards and door frames throughout the premises were damaged with cracked paint and exposed woodwork.
● The cupboard under a sink in a person's bedroom was wobbly, not secured, had chipped paintwork and was dirty inside. The person using this room was at high risk of falls and having this unstable piece of furniture in their bedroom could put them at further risk.
● There was a fabric chair in a person's ensuite that would be difficult to clean. Staff said this was the person's own chair. However, the provider and the registered manager had the responsibility to ensure that all equipment used at the service was suitable and fit for purpose.
● The dining area was cluttered with a hoist and wheelchairs stored behind the dining table where people sat. This could make it difficult for people to get to and from their seats and presented a tripping hazard.

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

● There were some improvements to infection prevention and control practices at the service. The ripped, worn and stained carpet in the blue lounge had been replaced. The electronic reclining armchair which failed its portable appliance testing in November 2020 had been removed from the premises. The rusty toilet frame in the downstairs shower room had been replaced and the laundry room was locked.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last two inspections we rated this key question inadequate. This meant there were widespread and significant shortfalls in service leadership. At this inspection this key question remained the same. The service had continued breaches and had failed to make adequate improvements.

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

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

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

- People were at risk from the lack of provider and registered manager oversight of the service and lack of effective systems to make improvements in a timely manner.
- At our last two inspections there was no over-arching system to assess, monitor and improve the quality and safety of all aspects of the service. At this inspection the situation remained the same. The registered manager said they did not know how to put such a system in place. We advised them to seek advice and support in order to do this.
- At our last inspection gaps in the staff training matrix had not been identified. This meant we could not be sure the provider and registered manager had sufficient oversight of staff training to ensure all staff were appropriately trained and competent for their roles. At this inspection the registered manager said further training had been carried out and this was recorded on the service's training matrix. We requested a copy but did not receive this during or after the inspection.
- At our last inspection accidents and incidents had been logged but care plans and risk assessments had not always been updated in response. At this inspection a person's fall was recorded and the accident and incident form stated their care plan and risk assessment had been updated. This was not the case. Their care plan had not been updated and their risk assessment had been updated incorrectly. This meant the accident and incident record had also been incorrectly completed and was not fit for purpose.
- At our last inspection it was not clear from audits when safety checks for equipment and utilities were due to be carried out and some checks appeared to be overdue. At this inspection there was no improvement. An audit showed testing for legionella, portable appliances, and gas safety had not been carried out as required. Fire drills hadn't taken place, and baths and profiling beds hadn't been serviced. The registered manager said some of these tests had been carried out and they would send an updated audit to show this. We did not receive this during or after the inspection. This meant we could not be sure the premises and equipment were safe for people to use.
- The provider and registered manager had failed to continuously learn and improve care. Many of the

issues we found at this inspection were present at our last two inspections and the provider and registered manager remained in breach of our Regulations.

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

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

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

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

● A relative said they raised concerns about the service with the registered manager two weeks ago with no resolution yet. They told us, "Concerns not resolved even though I keep asking. Formal complaints ignored. [Managers] don't follow up on things."

● Relatives said to their knowledge there were no residents' meetings at the service, and they had not received any quality assurance surveys. The registered manager told us at our last inspection these were being sent out in April 2022. We were unable to discuss this with the registered manager as the service had closed before we could complete our inspection.

● Staff said they liked working at the service and were well-supported by the provider and registered manager.

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

● As at our last inspection, there were no regular activities for people at the service. At this inspection the situation remained the same. All the relatives we spoke with confirmed this.

● Relatives said the staff were caring and kind. A relative told us, "[It's] home from home. The staff are lovely." Staff treated people with dignity and respect and spent time talking with them.

Working in partnership with others

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

● A tissue viability nurse was supporting a person using the service. The registered manager said they would give us the nurse's details, so we could contact them for feedback. However, we were not given this information.