Kingsley Care Homes Limited

Allonsfield House

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

About the service: Allonsfield House is a residential care home providing personal care for up to 42 people. At the time of the inspection there were 35 people living in the home.

People's experience of using this service:
Recommendations had been given to the provider by the Local Safeguarding Authority to implement following an alert of abuse being upheld by their team. The recommendations were developed to ensure people were kept safe and the same concerns were not repeated. The provider had not taken steps to ensure all the recommendations were implemented and the risks to people were reduced.

Risks to people's health and wellbeing were not always identified and appropriately assessed to ensure care planning was effective to meet people's needs.

The provider did not have suitable arrangements in place to ensure the effective management and implementation of required actions around fire safety, staff training in this area and appropriate assessment for fire evacuation.

Systems were not suitably developed to ensure lessons could be systematically learnt from areas of concern, including information to be taken to keep people safe from accidents and incidents and any complaints received.

Systems for the governance and oversight of service provision were being redeveloped and some gaps in auditing and monitoring of the service were evident. There was not an accurate picture of the quality of the support delivered to people.

There had been a high turnover of staff and agency staff were being used to cover the rota. Checks to agency staffs suitability to work with vulnerable people were limited.

An action plan had been developed specifically for the service but it did not include key improvements required following recent incidents.

The provider had an electronic system for managing and recording medicine administration and we found this worked well for keeping practice safe.

We reviewed rotas and found they were consistently covered with either permanent or agency staff. On the day of the inspection people's needs were met in a timely way.

There had been steady improvement in the ethos and values base at the home since the new registered manager came to post with staff and people in the home sharing positive relationships.

The provider had been developing more positive relationships with local professionals including the local pharmacy and district nursing teams.

Rating at last inspection: The last inspection report which was published 15 December 2018 found the service to be requires improvement overall and required improvement in the effective, responsive and well led key questions. Following this focused inspection, the overall rating had deteriorated to inadequate.

Why we inspected: We completed this inspection following concerns in relation to support provided to people. Specifically, how and when external specialist support was requested. How the provider ensured the support provided by the specialist team was included within the risk assessments and risk management plans for the person and how the implementation of advice was both followed and monitored. A person had died and this is subject to an ongoing investigation. At this inspection we reviewed the areas which were required to improve, to reduce associated risks moving forward. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

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

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

Enforcement: We formally asked the provider for specific information in relation to the action they had taken to address concerns. We found the provider in breach of three regulations. Regulation 12, safe care and treatment, Regulation 13, safeguarding people from abuse, Regulation 17, good governance.

Follow up: 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six 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.

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

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.

Allonsfield House

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service had died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk, seeking appropriate specialist advice and implementing the advice given. This inspection examined those risks and associated concerns.

Inspection team: The inspection was undertaken by two inspectors.

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

Allonsfield can support up to 42 people and at the time of the inspection had 35 people living in the home. The home is over a large footprint with one part being an old thatched roof property. The provider has made extensions to the building to accommodate more people. The home supports older people some living with varying forms of dementia and other mental health needs.

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: The first day of the inspection was unannounced.

What we did: Prior to the inspection we developed a plan from the information we held about the service to

support the inspection. This included any notifications received and information from other professionals including the Local Authority Safeguarding team.

During the inspection we reviewed five people's care records looking specifically for information to answer the key lines of enquiry for the safe and well led key questions. We spoke with seven people that lived in the home and one relative. We also spoke with 18 staff including members from the regional management team, registered manager, team leaders, care staff and catering and maintenance staff.

We looked at information in relation to accidents and incidents, safeguarding, health and safety, safe staff recruitment and management information. We looked around the building including in communal areas and people's bedrooms.

After the inspection: Following the inspection, we sent the registered manager a request under our section 64 powers. We requested additional information to assure us the provider had taken appropriate steps to protect people after serious incidents.

We had discussions with the local fire brigade to assure ourselves the building was appropriately protected and people would be safe in the event of a need for evacuation.

We also requested some additional documents which were received prior to writing this report.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- A safeguarding alert had been raised and substantiated by the Local Authority Safeguarding team in relation to a serious incident. Recommendations made by the local safeguarding authority to reduce the risk of a similar incident occurring had not all been implemented by the provider and registered manager.
- Incidents had not been reported to the Local Safeguarding Authority in line with their guidance, to keep people safe.
- Relatives and staff had contacted the Care Quality Commission to raise concerns about people not being safe. The commission had raised alerts to be further investigated that had not been raised by the registered manager.
- Systems were not effective in collating information from accidents, incidents and complaints to improve people's health and wellbeing.

When procedures and processes are not established and operated effectively to protect people from abuse it is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

- When professional guidance had been sought and changes to people's needs had been identified, risk assessments were not routinely updated to ensure people received the support they required. This included changes to continence needs.
- When people were at risk of harm they were not protected by updated risk assessments with guidance for staff to follow to reduce risks of harm. This included when people had lost weight, when they had received medical treatment or had acquired pressure ulcers.
- Accident and incident records were inconsistent and did not always result in changes to the support provided if this was required. For example, one person had fallen and acquired a head injury, no monitoring of the injury or the person's presentation had been implemented. Records were not routinely updated to provide staff with the information they needed to safely support people. One person had a tooth extracted and clear guidance was provided in the medical note on the system. However, this information was not used to update the information visibly on the handheld devices. There was evidence to show the support of the person, following the tooth extraction, was not followed. Staff told us the care planning system was difficult to use. One staff member told us, "Care planning is alright but time consuming, things get missed because of the system."
- We discussed fire evacuation in detail with the provider's management team and they were confident staff knew how to safely support people. We spoke with seven staff and found this was not always the case. The local fire service had inspected and recommended that one part of the building should be evacuated in a different way to that which the home currently had in place. This meant this had not been practiced at the time of the inspection. The fire officer had been given different information about the mobility of people in

this part of the building upon which to make their assessment to the information given to the commission.
● The safe evacuation of the building in the event of an emergency had not been properly considered and staff had not received appropriate training.
When risk assessments are not completed or reviewed when circumstances change there is a risk people will not receive the support they need. When areas are not identified as a concern then action is not taken to reduce risks. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing and recruitment
● In general staff were safely recruited. However, agency staff checks on suitability were limited. This was discussed with the registered manager and we were assured steps would be taken to gather the required information.
● There were enough staff to meet people's needs during the course of the inspection. Staff shortfalls were covered with agency or permanent staff to show consistent numbers of staff were on duty.
● We had concerns around the numbers of staff on duty at night, specifically if there was an emergency. We had received contradictory information to the fire department as to the available staff on duty through the night to support in the event of an emergency. Advice for evacuation had changed following the fire departments review of procedures.

We recommend the provider ensures there are enough available staff on duty to follow the revised evacuation procedures.

Using medicines safely
● Medicines were administered correctly and in a dignified manner. Staff were knowledgeable about the systems they used to ensure the safe handling of medicines.
● We discussed with staff and the quality manager the recording of fridge temperatures and the relevant best practice guidance. Ideally the temperature should be taken once a day with the minimum and maximum temperature recorded for the last 24 hours.
● A new system had been developed to ensure people had adequate supplies of their required medicines following previous identified concerns. We saw this system had been introduced and had led to a better relationship with the local pharmacy.

Preventing and controlling infection
● The home was clean and presentable. Domestic staff had schedules to ensure the home was kept to an acceptable standard of cleanliness.
● Staff were using the appropriate and recommended personal protective equipment to reduce risks of the contamination and spread of infection.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the last inspection we found systems to audit the service were not effective at identifying concerns. A new system was yet to be developed and implemented which meant a number of aspects of service provision did not have effective oversight.
- The provider had an electronic care planning system which was capable of producing a number of reports which could identify if people were getting the support they needed. There was not any evidence the reports were generated in a systematic way to drive improvements. The benefit of the reports was also dependant on the correct information being inputted into the system. At the time of the inspection there was not a structured and effective procedure in place to monitor the service provided and ensure it met people's needs.
- We were told by the regional director and management team that the provider was revisiting audits for governance and oversight and the electronic system was being checked to ensure it was accurate. The measures in place to evidence this were in themselves not effective as a number of issues remained.
- The registered manager told us that they did not have systems in place to monitor people's health care needs including pressure ulcers and risks of malnutrition. The regional director told us a recent clinical governance meeting had agreed to introduce a tool to monitor people's risk of malnutrition but it was not yet in place.
- We asked the registered manager how they ensured actions were completed and were effective in addressing any concerns and were told they reviewed the last audit. The registered manager acknowledged the effectiveness of this could not be measured as some audits had not been completed.
- We asked to see the health and safety risk assessment for the premises at the time of the inspection. When we received the report it did not identify any concerns. This is in contrast to the findings of the inspection.
- The health and safety audit specifically asked the question around the biannual fire evacuation being completed. The response was yes, yet an evacuation had not been completed in all the records we reviewed.
- During the inspection we reviewed information in relation to fire risk in detail. We found information and action taken to reduce risks associated with the risk of a fire and how it should be managed, did not follow the provider's own policies. For example, practiced fire drills did not always have a dedicated fire marshal and were not completed in a role play fashion to help give staff the confidence in supporting people in the event of a real fire.

● We were told by the quality manager that they completed monthly audits on the home but none were available to view. We requested copies of the reports to be sent. We reviewed these reports when received. All four of the reports reviewed did not identify any outstanding actions in relation to safeguarding concerns.

When there are not developed and embedded systems of governance and oversight there is no way to measure if the service is delivering the support people need. When there is not a suite of quality audits and monitoring tools to assure the service delivered, there is no way to ascertain if any action is required to drive improvement. When there is not a system to evaluate any actions taken there is no way to ensure actions taken have the desired impact or are effective in their aim. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

● The previous report and rating were available in the foyer of the home.
●Team meetings were completed and staff told us the management of the home had much improved since the new registered manager had come to post. Staff told us they felt supported and listened to.

Working in partnership with others
● The Local Authority had been supporting the home since the last inspection and had provided support in identifying what was needed to implement the recommendations following the substantiated safeguarding. However, the recommendations had not been implemented by the time of this inspection and the registered manager was initially unclear they had received the recommendations. Training had been delivered by the Local Authority to support improvement in the home. We were told by the Local Authority this had been positively received by the staff attending and more was scheduled.
● The provider had developed good relationships with a local pharmacy to improve medicines management.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We were told information had been shared via memo with staff following a death relating to an upheld accusation of abuse. We were also told information had been shared with staff in team meetings. We asked to review this information. The memo did not reflect the seriousness of the concerns. We were provided with minutes to one meeting. The meeting included general concerns in the home and was not specific or in relation to the safeguarding concerns.
● No formal information had been shared with staff following the safeguarding alert being substantiated and the recommendations being made by the local safeguarding authority to reduce the risk of reoccurrence.
● Resident and relative meetings had taken place in February and March 2019. Information was shared on the new chef in post and the ongoing improvements to the building and environment.
● The "You said, we did" principles had begun to be applied to surveys received from staff and these showed work in progress to drive improvements from a staff perspective.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all risk assessments were reviewed and amended when people's circumstances changed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Procedures and processes were not established and operated effectively to protect people from abuse

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Robust and effective governance systems were not in place.