Salveo Care Ltd

Kingfishers Nursing Home

Inspection report

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Date of inspection visit:
24 November 2022
28 November 2022
01 December 2022
05 December 2022

Date of publication:
12 January 2023

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
Kingfishers Nursing Home is a care home providing personal and nursing care to older people with a range of physical and mental health needs, including support for people living with dementia. The service supports up to 35 people and at the time of our inspection 32 people were using the service. The care home operates from a large, detached house which has had a purpose-built extension added in the 2000s.

People's experience of using this service and what we found
We found environmental risks to people using the service were not fully managed. We also identified concerns in relation to the safe management of medicines, and the management of safeguarding concerns and accidents and incidents. Whilst we were satisfied immediate actions were taken when incidents occurred, the service had failed to consistently analyse potential themes or trends to identify wider learning.

People told us they felt safe, and most relatives were satisfied their family members received safe care. A relative commented, "My view is that [family member] is quite safe…it is just the general atmosphere there and the interaction with staff that makes me feel that she is safe."

Some people and relatives told us the service was sometimes short staffed. A relative commented, "I don't feel there are enough staff. The carers are absolutely brilliant. They are doing the care that they need to do to look after [person], but there is rarely any time for them to spend talking to her." People and relatives also indicated the response time to call bells was variable, with a relative commenting, "Experience has shown that if the call bell is pressed, the response is not that quick." We have made a recommendation in relation to staff deployment.

The service was working to mitigate the impact of staffing vacancies through use of regular agency staff, continuous recruitment and initiatives to maximise staff retention. Staff were safely recruited and a structured induction process was in place to equip staff with the skills required to provide safe care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, however the systems in the service were not operated effectively to support this practice.

People were supported by a service which lacked effective oversight by the registered manager. Some records were found to be not accessible or incomplete following the registered manager's departure. Audits had been inconsistently completed. We found some incidents had not been reported to CQC in line with requirements, and the service had failed to provide an appropriate written response under their duty of candour for some incidents.

Some staff and relatives raised concerns regarding the responsiveness of the registered manager. Comments from relatives included, "I always thought [registered manager] was marvellous and listened, but

he did not always carry through what he promised, such as emails that he said he would send but which never came" and "I thought [registered manager] was a very nice…man, but he did not communicate effectively with me. It appears to be well run, but I am not sure that tasks are delegated appropriately by management."

The registered manager left the service on the first day of our inspection. The provider was committed to ensuring that, following the registered manager's departure, any lessons learnt would be acted upon and that governance arrangements would be further improved. Prior to our inspection the provider had already provided additional support via an interim support manager and care consultant. Further investment was planned to improve governance, including a new call bell system.

Some systems were in place to gather feedback and a relatives meeting had been recently held. People and relatives told us there had been ongoing concerns regarding the quality of the food. The service had an action plan in place to address this area of concern. The provider had also taken steps to seek and respond to staff feedback. The service generally worked well with professionals and built links with the local community.

People, staff and visitors were protected from the risks of infection. The service presented as generally clean throughout. Staff received training in relation to infection control and wore appropriate personal protective equipment (PPE). Systems were in place to respond to outbreaks of infection, such as COVID-19. A relative commented, "Visiting is back to normal, but we have to wear PPE. I went in yesterday and I only had to wear a mask and have my temperature taken. We do have to wear all the PPE if there is an outbreak."

People and relatives provided consistently positive feedback about the caring nature of staff. Comments from relatives included, "I would say that they are very caring and there are a couple in particular who are outstanding with their patience and kindness" and "They are amazing, are caring, patient, considerate and compassionate."

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

Rating at last inspection
The last rating for this service was good (published 4 July 2019).

Why we inspected
We received concerns in relation to safe care and the management of the service. 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 Kingfishers Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches at this inspection in relation to safe care and treatment, safeguarding people from harm, governance, consent, meeting the duty of candour and in informing the Commission of information they are required to.

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.

Kingfishers Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 1 Inspector, 1 Medicines Inspector and 2 Experts by Experience who provided telephone support to gather feedback from relatives. 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
Kingfishers Nursing Home 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. Kingfishers Nursing Home 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post, however the registered manager left the service on the first day of our inspection, and was therefore not involved in the inspection process.

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 and Healthwatch, and reviewed information publicly available on the Healthwatch website. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used 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 of this information to plan our inspection.

During the inspection
During the inspection we spoke with 10 people using the service. We also spoke with 23 relatives and 22 members of staff including 6 health care assistants, 1 senior healthcare assistant, 1 laundry assistant, 1 chef, 2 nurses, 2 care home advanced practitioners, 2 agency care workers, 2 housekeepers, the head housekeeper, the management consultant, the interim support manager, operations manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also received email feedback from 3 additional members of staff.

We observed infection control and medicines practices, reviewed the environment and looked at 11 people's care records on the electronic care plan system, either in full or in part. We looked at 3 staff recruitment and supervision files. We also examined a variety of other records including 9 medicine administration records, accident and incident records, audits, staff rotas and cleaning schedules.

After the inspection
We continued to review records shared electronically and continued to seek clarification from the provider to validate evidence found. We looked at a range of records including meeting records, policies and procedures and staff training records. We received feedback from 4 professionals who had contact with the service.

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.

Systems and processes to safeguard people from the risk of abuse

- The service had failed to consistently review incidents to determine whether the criteria was met to share information with the local authority safeguarding team. This included two instances of unwitnessed falls resulting in fracture, and some unexplained injuries, including bruising. Where safeguarding referrals had not been made, we found accident/incident records did not contain a rationale or explanation to show if or how this had been considered. This meant we were not assured the registered manager understood local safeguarding reporting policy and procedures.
- We requested supporting evidence in relation to safeguarding concerns managed by the registered manager. During our inspection, the provider was unable to locate internal investigation information to evidence actions taken by the registered manager in response to some concerns. This included the internal investigation for an incident of unexplained bruising in February 2022. The incident form status remained "Incident under investigation / analysis (open)". This meant we could not be assured the registered manager had taken all necessary steps to fully investigate the incident and mitigate potential risk to the person and others.
- The local authority (LA) made recommendations following a concern of unexplained bruising in April 2022. The provider could not locate an internal investigation, and we could not evidence the registered manager had acted upon the LA's advice. For example, the LA recommended, "moving and handling refresher training is provided to all staff." The staff competencies training matrix showed moving and handling competencies for care and nursing staff pre-dated the April 2022 safeguarding concern for 23 of 30 staff who had undertaken this training. This meant we could not be assured the service had implemented the LA's suggestions to minimise the risk of similar incidents. Following our inspection, the provider told us they were unable to locate the original correspondence, which had been sent to the registered manager, meaning the provider was unaware of the recommendations until these were shared by CQC during the inspection.

The service had failed to operate effective systems to identify, investigate and appropriately respond to allegations of abuse. This was a breach of Regulation 13(1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. The service reviewed internal records and contacted the local authority safeguarding team to seek guidance on whether any retrospective safeguarding referrals would be required. The operations manager confirmed the local authority's recommendations would be incorporated into an action plan.

● Staff received training in relation to safeguarding adults and understood their responsibility to report concerns to the management of the service. Staff had access to relevant policies via an electronic device. Staff told us they would feel comfortable speaking with the current management team to raise concerns.
● The service had worked with the local authority following whistleblowing concerns during 2022. The provider was committed to acting upon learning identified via whistleblowing and had held drop-in sessions to encourage staff to share any concerns. We found the provider had taken steps to put an action plan in place, and had also appointed an external consultant to review management arrangements at the service.
● We reviewed records for a recent safeguarding concern during November 2022, where a person was left unsupervised by an agency staff member which placed them at risk. The interim support manager had taken immediate appropriate action and evidenced actions taken, including correspondence with the agency and local authority.

Assessing risk, safety monitoring and management
● On the first day of our inspection we found drink thickeners were insecurely stored. Thickeners can pose a risk of choking from accidental ingestion. The provider acted promptly to remove the thickeners to a secure location. A risk assessment was in place, however this lacked specific detail about where thickeners should be stored, advising, "The place in which thickeners are stored should be assessed, where residents are not at risk of being able to access the thickener."
● Fire drills had not been undertaken in line with the provider's fire safety policy, which stated drills should be held monthly. The last fire drill was recorded in May 2022. This meant some staff new to the service had not participated in a fire drill.
● Risks in relation to legionella were not fully managed. The provider had specified the next water sample check for legionella was due in January 2022, however this had not been undertaken. This was identified in response to our request for records and the provider requested a contractor immediately attend. Records showed water temperatures were monitored monthly. The calorifier checks noted a calorifier temperature of 58 degrees Celsius between May to November 2022. The instructions for the checks stated the calorifier temperature should be at least 60 degrees. No comments or actions had been added to the check sheet to indicate how any potential risk from the consistent lower temperature had been explored.

The service had failed to ensure that premises used by the service provider are safe to use for their intended purpose. This was a breach of Regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback. Thickeners were removed to a secure location and the provider took steps to address the concerns in relation to fire and water safety.

● Other health and safety checks, such as monthly checks of window restrictors, and maintenance of lifts and hoists had been appropriately undertaken.
● Systems were in place to assess a range of risks, using recognised best practice tools. Care plans and risk assessments were reviewed monthly as part of a resident of the day process. Types of risk assessments included bed rails, dependency of needs, mental health, nutrition, moving and handling, falls, choking, oral health and continence. A relative commented, "[Relative] has become very unsteady on her feet…the staff are doing everything they can to address the fact that she is having falls and are trying to reduce the risk."
● People told us they felt safe, and most relatives were satisfied their family members received safe care. Comments from relatives included, "I feel that she is very safe there. She has got a proper hospital bed where the sides come up to minimise the risk of her falling out of it" and "She is definitely protected and I feel that she is safe. The nature of the care staff, reassures me as they are genuinely caring people."
● Risks associated with people's medical conditions were reviewed and the service made referrals to

external healthcare professionals where required to assist with the safe management of risk. The service monitored people's weights and audits showed where action plans had been agreed where weight loss could place people at risk of malnutrition. We observed people received regular drinks throughout the day and staff understood the importance of offering regular fluids.

● People and relatives spoke positively about the support provided by nursing staff. A relative commented, "I feel the nurses know their job. My [family member] had a chest infection and the nurse was on it immediately. The problem arose with the GP practice because the antibiotics took time to arrive." Another relative commented, "The nurses are excellent and do their job well, given the pressure they are under."

● Some staff had trained as care home advanced practitioners (CHAPs) which assisted nursing staff with the management of risks. CHAPs supported the nursing team with tasks such as wound care, administering medicines, seeking medical advice and making referrals to specialist services such as speech and language therapy. A nurse explained they worked well as a team, commenting, "They are amazing…very supportive."

● Permanent staff we spoke with had a good knowledge of people's needs and risks, and could describe how they responded to risks. Staff told us they had received training relevant to their role, such as the use of equipment required for safe moving and handling of people.

● Some people required encouragement to engage with support or experienced periods of distress which could lead to verbal or physical behaviours toward staff. Staff described how they could identify signs of distress and how they would offer reassurance. A family member advised, "My [relative] is sometimes difficult to manage and will refuse to have her hair done, but staff will gently persuade her and she will respond to them." A second relative added, "They seem to understand…and know how to use distraction techniques to administer personal care and to also reassure...as [person] suffers from hallucinations."

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 not always working within the principles of the MCA and we have reported on this under the Well-Led section of this report.

Using medicines safely

● Medicine reviews were carried out by clinicians from the local GP practice. However, reviews were not always carried out at regular intervals as per national guidance, and we found the service did not have an effective system in place to monitor when medicines reviews were overdue.

● Record keeping of medicines in stock was not up to date. For one person there was no stock available of the topical medicine prescribed to them for pain. The staff had failed to identify that there was no stock of this medicine and contact the GP to order it.

● The provider did not quality check equipment as per the manufacturer's instructions. The staff did not quality check blood glucose monitors as per the manufacturer's instructions. This meant there was a risk blood glucose meters used for monitoring blood glucose levels may not work as intended or provide an accurate reading.

● Care plans were not person centred in relation to medicines. For example, some people were prescribed palliative care medicines for end of life. There was no information in the care plan for staff about what

medicines were prescribed and when to initiate these medicines. Also, for one person prescribed an anticoagulant their care plan did not provide information to staff on how to monitor and manage its side effects. Anticoagulants are medicines that help prevent blood clots.
● Guidance in the form of protocols or in care plans was not always in place or person centred for medicines prescribed to be given on a when required basis. For example, one person was prescribed three different pain killers, however, there was no differentiation on when the different pain killers needed to be administered. This meant when required medicines may not always be administered consistently.
● There was no process in place to receive and act on medicines alerts.

Medicines were not always managed safely which placed people at risk of harm. This was a breach of Regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was responsive to our feedback and provided a detailed update of action taken. This included updating a medicines review tracker, re-registering the service for national medicines safety alerts, updating as and when required medicine protocols, and commencing monthly testing of blood glucose monitoring devices.

● Staff received training and were competency assessed to handle medicines. There was a medicine management policy in place.
● We observed staff give medicines to people in the morning. Staff were polite, gained consent and signed for each medicine after giving it on the medicine administration record (MAR).
● Medicines including controlled drugs were stored securely and at appropriate temperature.

Learning lessons when things go wrong
● Accident and incident records were poorly maintained, with numerous records across several months showing a status of 'Open', meaning records were partially completed with no management sign-off. Accident/incident analysis audits were inconsistently completed and the last fully completed, accessible audit was dated 1 April 2022. These audits had not been fully effective in identifying the concerns we found, such as the absence of required CQC notifications and safeguarding referrals for some concerns. Whilst individual records showed actions immediately taken by staff, such as seeking medical attention, there was inconsistent evaluation of incidents to explore themes, trends and wider learning.
● The incident/accident system was not operated effectively because we found incidents which had not been logged as an accident or incident. This included one person's injury in April 2022 described as a 'burn wound' and an incident of missed medication in November 2022. Whilst we were satisfied immediate actions were taken, such as caring for wounds, the recording errors meant there was a risk the registered manager would not have full oversight of incidents to ensure all necessary actions had been implemented.
● Records were not accessible of general advice given at daily staff handover meetings, such as instructions the registered manager noted had been given about call bell response times. There was also limited evidence available of staff meetings. This meant we could not evidence how lessons learnt had been addressed with staff on an ongoing basis, to improve the quality and safety of the service.
● The service had been asked by the provider to document evidence of lessons learnt, such as actions taken in response to feedback, in a folder entitled "You Said We Did". At our inspection this was found to contain only 1 entry, relating to staff training workshops, dated September 2022.

Systems had not been operated fully effectively to assess, monitor and improve the quality and safety of the services. This was a breach of Regulation 17(1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was responsive to our feedback. The operations manager explained feedback would be used to inform staff training and develop an action plan for the service.

● The service had introduced daily heads of department meetings, known as 11 at 11 meetings, on 31 October 2022. Minutes showed that reminders of good practice and learning had been shared. For example, in response to learning from a complaint, the service had introduced a competency assessment to ensure staff understood how to support people with their hearing aids. Minutes showed the senior care team had been asked to commence the competency assessments on 18 November 2022.

Staffing and recruitment

● Most relatives were satisfied their family members were safe, although concern was expressed about staffing levels and use of agency staff. A family member commented, "The staff are aware of my [relative's] issues and [relative] should be checked every half hour...this doesn't happen and that is because of staffing levels." One person required half hourly checks due to risks of choking. Care records showed half hourly checks were inconsistently completed, particularly during the overnight shift where some checks were logged over 1 hour apart.

● People told us staff response times to call bells was variable. People's comments included, "Expect within 10 mins…can be 20 mins", "Fairly quick sometimes…could be up to half an hour", "Quite quick, someone does come" and "long time…can be 15 minutes – 45 minutes". Call bell audits showed most calls were attended within 3 minutes, with an audit for the period 17 October to 23 October 2022 showing 779 calls answered within 3 minutes and 72 calls answered in over 5 minutes. The provider planned to install a new call bell system which would enable closer monitoring to ensure people received a consistently prompt response.

● Some staff advised that staffing levels and workload were sometimes manageable, but expressed concerns around staffing shortages and reliance on agency staff. Staff told us they worked hard to ensure people's basic needs were met, but some staff told us this meant they worked through their breaks, or used breaks to catch up on recording. Staff prioritised key tasks such as fluids and pad changes. A staff member explained this meant there was sometimes insufficient time for less urgent tasks such as nail care. The nominated individual told us they were satisfied staff did have sufficient time for breaks.

● Concern was expressed about the morning personal care period, that some people did not receive personal care until late morning. Whilst this may be some people's choice to get up later, a staff member commented, "[It] affects more independent [people] more, with capacity, can see what time it is, can see 11.30am and still in bed, 'why haven't I been washed and changed yet'." Comments from people included, "In [the] morning sometimes have to wait long time to have to get up" and "Prefer to be [up a] bit early… have to take turn".

● An agency induction process was in place, however at the time of our visit, records were not accessible to demonstrate several agency workers had been given an induction. This meant we could not be assured all agency workers had received an appropriate induction.

We recommend the provider reviews their staff deployment to ensure there are always enough competent staff on duty, and that staff have the right mix of skills to make sure that practice is safe.

● Prior to our inspection the service had reviewed how staffing levels were calculated, and had introduced a dependency tool. The interim support manager advised that following the registered manager's departure they intended to have increased oversight of dependencies to ensure the monthly 'scoring', used to calculate staffing levels, was an accurate reflection of people's needs.

● A system was in place to allocate staff to daily duties. A care home advanced practitioner (CHAP) explained when they were responsible for this allocation they considered staff experience, placement of

agency staff and how to meet people's preferences for staff gender. The service aimed to deploy regular agency staff to improve consistency.

● Staff were safely recruited. Staff completed an application form, attended for interview and preemployment checks were carried out. These included references from previous employers, a medical questionnaire and disclosure and barring checks. 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. The provider was working to support continuous recruitment to reduce reliance on agency staff.

● Staff told us they undertook extensive e-learning prior to starting their roles and benefited from a period of 2 or more weeks shadowing. An induction checklist was in place, however this was not accessible for the three staff files we reviewed on-site. A matrix for staff competencies showed gaps for several staff in areas such as moving and handling and donning and doffing PPE.

● Staff spoke positively about daily handover meetings. Staff described receiving detailed handovers to ensure they were aware of any risks and concerns in relation to people on a day-to-day basis.

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 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 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.

Visiting in care homes

● The service supported visiting in line with government guidance. People received visits from their relatives and were supported to access their local community. On arrival, visitors were prompted to check their temperature and wash their hands at a dedicated sink next to the front door. Visitors were encouraged to wear appropriate PPE such as a mask and supplies were readily available for visitors in the reception area.

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.

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 failed to carry out all required steps in relation to notifiable safety incidents. This was because they did not provide a written account, including an apology to people or their representatives, in relation to some incidents of serious injury. The provider could only locate two duty of candour letters. This meant the service could not evidence whether the registered manager had provided a written account for other incidents, including 3 incidents of fracture.

● Relatives told us they did not always feel they had received required information. Relative comments included, "I am not always told about problems that have arisen" and "I feel that not all important information is passed on to me."

● We reviewed recent accident and incident forms. Several forms for incidents including medicines errors, falls and unexplained injuries did not evidence that people's representatives had been informed. The large majority of the accident/incident forms we reviewed contained the phrase, "Are the family / friend / next of kin / representative required to be informed?: Not yet confirmed". This meant we could not be assured the service had shared sufficient information with people's representatives to meet their duty of candour.

The service had failed to provide people and their representatives with an appropriate written account when notifiable safety incidents occurred. This was a breach of Regulation 20(1) (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was responsive to our feedback and agreed to develop an action plan in response to the concerns raised.

● A duty of candour policy was in place. We reviewed the two duty of candour letters accessible during the inspection. These showed the registered manager had provided factual details about the incidents and included an apology, along with a summary of actions taken. When a notifiable safety incident occurs, an apology is required as part of the service's legal duty of candour, as an expression of sorrow or regret, and does not imply fault.

● Some relatives indicated nursing staff were informative and provided necessary updates when accidents or incidents occurred. A relative commented, "When he is not very well, I feel that they raised that with me quite quickly. I can call one of the nurses easily and if you ask a question, they will revert promptly." Another relative added, "I certainly get informed if anything untoward has happened to [family member] or if she is ill…I will get a phone call."

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

● The service had failed to comply with the requirement to notify the Care Quality Commission (CQC) of incidents that affected the health, safety and welfare of people using the service. For example, 7 concerns between the period 7 April 2022 and 28 September 2022, that met the criteria for allegations of abuse were not shared with CQC. In addition, we also identified 2 incidents of serious injury which had not been notified to CQC.

Effective systems were not in place to identify or report incidents to CQC in accordance with requirements. This was a breach of Regulation 18 (Care Quality Commission Registration Regulations 2009).

The service was responsive to our feedback and submitted the missing notifications retrospectively.

● The service had failed to document mental capacity assessments (MCA) and best interests decisions where it was stated people lacked mental capacity. For example, the service had applied for a deprivation of liberty safeguards authorisation (DoLS) for one person whose care plan included, "[Person] lacks capacity… [Person] is unable to make complex decisions due to his cognitive impairment". The provider could not locate any MCA or best interests documentation for this person during the inspection. Another person's records contained consent forms signed by a relative for use of equipment, flu immunisation, and photography. The provider could not locate MCA or best interests records for the person during the inspection.

● Some people had appointed an enduring or lasting power of attorney to make decisions on their behalf in relation to finances and property, or health and welfare decisions. We found some records were inaccurate or lacked evidence to confirm specified powers of attorney were in place and registered with the appropriate body. This meant the service did not have a full reliable record to confirm who was legally appointed to support decision making.

● A DoLS application should only be made where there is a reasonable belief a person lacks mental capacity to consent to care and treatment. Records showed the service had submitted DoLS referrals for people believed to have mental capacity. For example, the DoLS referral for one person read, "[Person] at present has full capacity. [Person] is able to understand and communicate her needs, wishes, preferences at present." Another DoLS referral included, "[Person] has capacity and is able to make decision regarding his needs, wishes and preference."

The service did not always implement the Mental Capacity Act 2005. This was a breach of Regulation 11(1) (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was responsive to our feedback and agreed to develop an action plan in response to the concerns raised.

● Staff understood the importance of seeking consent, and offering choice, when delivering day-to-day care and support. People told us staff asked their permission before supporting them, and offered choices, such as options for food and drinks. We observed staff knock at room doors and politely ask for consent before assisting people. A relative advised, "The staff are very sensitive in the way they will ask [person] questions about anything. They ask her and will wait for a response." A second relative added, "[Family member] has capacity. The communication is a little tricky as she can't really hear very well, but they do write things down for her."

● The service had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user. Following the departure of the registered manager, the provider struggled to

locate some documentation, such as relating to the registered manager's investigation of complaints, accidents and incidents and safeguarding concerns. An action plan, dated August 2022, reflected that the office had become disorganised, and we were advised an amount of paperwork had been removed for sorting and archiving. This meant some records were not easily accessible.
● Staff members carried out medicine audits. However, the audits were not robust and had failed to identify the concerns relating to medicine management we found during our inspection.
● We also found other audits had not been fully effective in identifying the concerns we found. For example, audits had failed to identify the absence of MCA and best interests recording, the inaccurate recording of power of attorney information, the absence of required CQC notifications and the failure to identify and refer all relevant incidents to local authority safeguarding team.
● There was a lack of consistent and effective registered manager oversight, evidenced by inconsistent auditing of the service. This meant we were not assured audits had effectively assessed and improved the quality of the service. Some audits were not completed in frequencies in line with the provider's policy, such as for safeguarding and complaints. Where audits had been delegated, in some cases the section at the end of the audit for the registered manager to confirm they had checked the findings was left blank. Some audits identified issues however lacked an action plan or confirmation all required actions had been completed.

The service had failed to effectively assess, monitor and improve the quality and safety of the services. The service had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17(1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection an interim support manager, operations manager and the nominated individual were proactively working to address areas of concern following the departure of the registered manager. Staff provided positive feedback regarding the provider's approach. A staff member commented, "[Provider] owner is so…dedicated to residents… always telling us [treat] residents like your mother [or] grandma… there's so much care."
● Prior to the registered manager's departure, the provider had also taken steps to increase management support on-site via an interim support manager and had commissioned a review by an external consultant. A service action plan and registered manager action plan had been in place which was monitored by the provider. The provider had further changes scheduled to improve governance, including the implementation of an improved call bell system and an electronic maintenance management system.
● Daily heads of department meetings, known as 11 at 11 meetings, had been introduced 31 October 2022 to ensure all departments understood the plan for each day, including any required actions or concerns. This helped to ensure there was a shared understanding of expectations and team working between departments.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Relatives expressed concern about a lack of responsiveness when concerns were raised with the manager. Comments from several relatives included, "The management team are not responsive to problems I raise. It's just yes I will and nothing happens", "I do know who to complain to but it is not always acted on", "I had an issue with the manager. He was not responsive to requests and gave no feedback if [the] problem was dealt with or not", "I would constantly email [manager] and get no response" and "I have, on occasions, been in the home and the manager has not even acknowledged me."
● There was variable feedback from staff around whether the registered manager had been approachable. A number of staff told us they had not felt supported or that the registered manager had not been responsive. Comments from staff included, "[I] felt very unsupported…if asked [something the registered manager]

would say 'I'll do it tomorrow' but never did", "[Registered manager] never supported any of us at Kingfishers when it came to the home, staffing or any concerns. I feel that everything was just brushed under the rug", "I don't believe that he provided staff with support…I feel that communication was poor and things that were being reported where not acted on. We had no regular staff meetings and no meetings to discuss accident and incidences to help staff understand and learn from them." One staff advised, "[Registered manager was] always open for a chat, friendly and approachable."

● Staff provided positive feedback about the provider management team in place. This included comments from staff around personal support they had received from the operations manager, as well as support to resolve outstanding requests which had been initially made to the registered manager.

● Staff spoke about people with warmth and respect. We observed caring interactions and received several compliments about the kind and compassionate approach of staff. Comments from people included, "Carers here best in world…they keep me alive…nurses [are] brilliant", "Staff here [are] very nice…service and support by staff [is] excellent" and "Carers very nice, [they] call me by my first name". A relative added, "The nurses are very caring towards my [family member]. She is treated with love and kindness."

● People were encouraged to personalise their rooms and relatives were made to feel welcome when visiting the service. A relative told us, "I am happy with the care my wife receives from the staff. They are very helpful and kind to me as well. I feel we are both looked after." A relative whose family member received palliative care told us, "They cared for myself and my daughter as well as [family member], everything was done with kindness and dignity."

● The provider ensured the environment was maintained to a high standard which helped to promote good outcomes for people. For example, work was underway to develop the reception area between the lounge and dining room, to install an improved drinks system to enable people and visitors to access refreshments more independently. The provider was also investing in technology to help improve outcomes, such as an improved call bell system which would enable better monitoring and analysis of response times.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● A resident of the day process was in place which included a monthly review of each person's care plan. Some relatives confirmed they were involved in care planning. Comments from relatives included, "I do look at my mother's care plan and my opinion is asked for", "My [relative's] care plan was done with me and I feel it was very comprehensive" and "I have had some problems with my wife's care plan. Things missing and information not always precise enough."

● Records showed a single relative meeting had been held during 2022, in October 2022. The meeting provided updates and sought feedback from relatives across a range of topics including care plan reviews, activities and plans for the upcoming Christmas season. The meeting minutes also indicated a survey would be shared with residents and relatives.

● Records were not accessible of meetings held with people using the service, meaning we could not evidence how people's views had been consistently sought and used to improve the service. Some people and relatives raised concerns regarding the quality of food offered. The operations manager explained they were responding to feedback and food quality was being closely monitored as part of an action plan.

● People indicated they would feel comfortable raising concerns but some people felt management should be more visible to them. A person commented, "[I] had met [registered manager], not a fruitful discussion… [manager] didn't get involved to discover real problems, would be nice [if] whoever in charge [be] seen and more available." Another person commented about the registered manager stating, "Very pleasant, don't see him much."

● Records showed the service supported people to access care from a range of professionals including GP, physiotherapy, chiropody, eye care and speech and language therapy. A professional commented, "If [there is an] urgent requirement, I get email or a call straight away…nurses [are] knowledgeable." Another

professional commented, "I usually get a telephone call from [the] nurse in charge if [they are] concerned about someone, they clearly explain what they think the problem is." One professional provided less positive feedback, explaining the service did not consistently follow agreed communication pathways to access support. The operations manager confirmed the service would engage with this professional to improve communication.

● A staff survey had been undertaken and the provider had engaged a consultant to engage with staff for their feedback. The provider also held drop-in sessions to enable staff to share their views.

● There was minimal written evidence available of staff meetings. A staff member advised, "If do staff meeting, think missed two for various [reasons], don't do minutes, have to hear through grapevine about any changes made through chit chat, find that a bit odd." Recent heads of department meetings, known as 11 at 11 meetings, had been more thoroughly documented.

● The service had developed links with the local community. A local church visited fortnightly and a hairdresser regularly attended. The service was building a relationship with a local nursery who were planning their first visit during December 2022. A schedule of activities was in place in the run up to Christmas.

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 18 Registration Regulations 2009 Notifications of other incidents Effective systems were not in place to identify or report incidents to CQC in accordance with requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not always implement the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to ensure that premises used by the service provider are safe to use for their intended purpose. Medicines were not always managed safely which placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service had failed to operate effective systems to identify, investigate and appropriately respond to allegations of abuse.

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 service had failed to effectively assess, monitor and improve the quality and safety of the services. The service had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service had failed to provide people and their representatives with an appropriate written account when notifiable safety incidents occurred.