Harbour Healthcare 1 Ltd

Kingswood Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Kingswood Manor provides accommodation for up to 44 people who need help with nursing or personal care. At the time of the inspection 39 people lived in the home. Some of the people living in the home lived with dementia.

People's experience of using this service and what we found
People's needs and risks were not adequately assessed, monitored or appropriately supported in the delivery of care. Staff lacked clear information about people's needs and risks and records showed they did not receive the support they needed to keep them safe and well.

Accident and incidents and safeguarding events were not accurately recorded or monitored. There was little evidence that any learning from these events was shared with the staff team to prevent similar incidences from occurring in the future.

Medication management was unsafe. People did not always receive their medicines as prescribed, or in a safe way, which meant people were placed at increased risk of pain or discomfort from the conditions these medicines were intended to treat.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. People's consent was not sought in line with the principles of the Mental Capacity Act 2005.

Infection control standards were poor. Parts of the home and its equipment were unclean, malodorous and in need of repair.

The home itself is not dementia friendly. There were no signs or pictorial aids to help people navigate around the home or dementia friendly devices to help them determine the date or time of the day. There was also a lack of any meaningful activities for people to participate in to prevent social isolation and loneliness.

Staff were not always recruited following the completion of satisfactory pre-employment checks. Some staff training was not up to date and the provider used a high number of agency staff to cover gaps in the rota.

People had mixed opinions about the staff team. Some said staff were lovely, whereas others told us some were, but others were not. Some people said that staff did not always listen to them or respect their wishes when providing care.

Staffing levels were not always safe. This impacted on the timeliness and effectiveness of people's care. Some people told us that it was difficult to obtain staff support during the night when they needed it. It also

meant the provider's ability to keep people safe or to evacuate them to a place of safety during an emergency such as a fire was compromised.

Systems in place to monitor the quality and safety of the service were not effective and did not ensure risks to people's health, safety and welfare were identified and managed. Managerial oversight by the manager and the provider was ineffective. This placed people at risk of avoidable harm.

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

Rating at last inspection and update
The last rating for this service was good (published 10 June 2023).

At this inspection, we found that the quality and safety of the service had significantly declined. Multiple breaches of the regulations were found, resulting in a rating of inadequate. At this inspection, breaches of regulations 9 (person centred care); 11 (Need for Consent); 12 (safe care and treatment); 17 (Good governance); 18 (Staffing) and regulation 19 (Fit and proper persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, were found.

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

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

Why we inspected
This inspection was prompted by a number of safeguarding incidents reported to us by both the provider and the Local Authority which raised concerns about the safety of people's care and the management of the service. As a result, we undertook a comprehensive inspection of the service.

We also 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 have identified breaches in relation to the safety of people's care and risk management, the management of medicines, environmental safety, infection control, the implementation of the mental capacity act, staffing levels, staff recruitment, staff training and the overall governance of the service.

Immediately after the inspection, we asked the provider to submit an urgent and immediate action plan for improvement. The Local Authority were also informed about our concerns to ensure people were safeguarded from potential harm.

We also placed conditions on the provider's registration with a clear requirement to immediately improve aspects of people's care and treatment which continued to place them at risk.

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

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.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will 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 of their 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? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not responsive.	**Inadequate**
Is the service well-led? The service was not well led.	**Inadequate**

Kingswood Manor

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 undertaken by two inspectors, a member of the medicines team 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 Manor 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. Kingswood Manor 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 CQC 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.

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 professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager, regional manager, deputy manager, a nurse, 2 chefs, a senior carer, 2 care assistants and a domestic member of staff. We spoke with 7 people who lived in the home and 7 relatives, about their experience of the care provided.

We reviewed a range of records. This included 5 people's care records and multiple medication records. We looked at 3 staff files in relation to safe recruitment and a variety of records relating to the management of the service.

After the inspection visit.
We continued to seek clarification from the provider to validate evidence. We continue to review evidence in relation to people's care, and the management of the service. We also liaised with the Local Authority to share information about the service and our inspection.

We concluded the inspection on 19 October 2023.

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 inspection we rated this key question good. At this inspection, the rating for this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
- Staff lacked adequate, correct and up to date information on people's needs, risks and care. This placed people at significant risk of receiving inappropriate and unsafe care.
- People's medical needs were not clearly described, and staff did not have adequate information on what these conditions were or how to care for people safely.
- The environment in which people lived was not adequately maintained or clean. For example, some of the home's window frames were rotted with cracks in the glass; carpets and flooring in some areas were stained and one person's bedroom was affected by wasps. The provider had commenced an environmental improvement plan.
- We found two people in bed without their bed brakes on and some people did not have accessible call bells in place to ring for help if they needed it. Records showed that the welfare checks specified in people's care plans to keep them safe and well were also not regularly undertaken.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
- Records relating to safeguarding and accident and incidents were not accurate and there was little evidence they were investigated and followed up by the manager to ensure appropriate action had been taken.
- There was no evidence that any learning from safeguarding, accidents and other incidents was shared with the staff team to prevent them from happening again.

The provider had not ensured risks to people's health, safety and welfare were adequately assessed, and mitigated against to prevent avoidable harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
- We were not assured that the provider was supporting people living at the service to minimise the spread of infection.
- Effective infection prevention and control measures were not in place. Parts of the home were unclean and malodorous. For example, some of people's personal items, commodes and sink areas were dirty and one communal shower room contained a wash bowl smeared with what looked like blood.
- Cleaning schedules for the home were in place but these showed gaps in the cleaning of the home. Some areas of the home required enhanced cleaning regimes to prevent cross infection, it was impossible to tell if this was done in accordance with best practice.

Infection control standards were poor and did not protect people from the risk of the spread of infection.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On the first day of the inspection, there were insufficient supplies of personal protective equipment (PPE) in PPE dispensers in communal areas. On the second day this had been rectified, but some of the PPE stations were disorganised with PPE not stored appropriately. This increased the risk of cross contamination.

Using medicines safely
● People who were prescribed time sensitive medicines did not always receive them at the correct times or with a safe time interval between doses. For example, one person's Parkinson's medication was not always given at the right time, which increased the risk of them experiencing discomfort and negative symptoms from this condition.
● Other people were given doses of their pain relief too close together or too far apart placing them at risk of overdose or not having their pain properly controlled.
● People were unable to have doses of their prescribed medicines because there was no medicine available for them. One person could not have their pain relief for severe pain and two people could not have their prescribed laxatives which placed them at increased risk of severe pain or constipation.
● Insulin was not always administered safely because the blood sugar levels and the site of the injection were not always recorded. This placed them at increased risk of their insulin not being consistently absorbed.
● Some people had swallowing difficulties and needed to have a pureed diet. Tablet medicines were being administered without staff seeking professional advice to ensure they were safe to give as opposed to soluble or liquid medicines. This placed them at risk of choking.
● People did not always have appropriate plans in place for medicines which were given "when required" or with a choice of dose. This placed people at risk of not receiving these medicines as intended.

The management of medication was unsafe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were no effective systems in place to ensure enough staff were on duty at all times to meet people's needs. This was especially a concern at night. People's feedback confirmed this.
● There were not enough domestic staff on duty to ensure standards of cleanliness and infection control were maintained. We spoke with the manager about this who acknowledged there was a shortfall in domestic staff at the time of the inspection.
● There were two chefs on duty Monday to Wednesday and one chef with kitchen assistant support for the remainder of the week. Catering staff told us there were not enough of them on duty and it was a struggle. They told us they had reported their concerns to management, but nothing was done.

Staffing levels were not always safe or sufficient. This was a breach of Regulation 18 (Staffing) (of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff were not always recruited in a robust way to ensure they were safe and suitable to work with vulnerable people. For example, gaps in employment were not always investigated and previous employer references not always verified.
● Agency staff were regularly used to fill gaps in the rota. Not all of the agency staff had staff profiles in place for the manager and provider to be assured of their suitability.

Safe recruitment procedures were not followed to ensure only fit and proper persons were employed. This was a breach of Regulation 19 (Fit and proper persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Visiting in care homes

- People's friends and relatives were supported to visit in-line with government guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection, the rating for this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's needs, risks and choices were not adequately assessed, or care planned. Care was not always provided in a safe way in line with standards and guidance. Advice and guidance in respect of people's needs had not always been sought or acted upon in a timely manner.
- A weekly multi-disciplinary meeting took place with staff and a range of healthcare professionals, to discuss changes or concerns about people's needs and care. One professional told us that agency staff sometimes attended the meeting, and did not have sufficient knowledge of the people they were caring for to discuss any concerns. This was not good practice. It increased the risk of people not accessing the professional support they needed to keep them safe and well.
- Referral to other healthcare professionals was not always made in a timely manner to seek advice and support in relation to people's care.

Supporting people to eat and drink enough to maintain a balanced diet

- Information about people's nutritional needs and risk was sometimes unclear and contradictory. This increased the risk of people not receiving the right level of nutritional support.
- People's dietary intake was recorded where monitoring was required, but there was little evidence of clinical or managerial oversight to ensure people's intake was sufficient.

People's needs and risks were not properly assessed or managed to ensure that people's health and well-being were supported in accordance with standards and best practice. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a system in place to ensure catering staff knew when people had specific dietary requirements or preferences.
- A menu was printed on a noticeboard in the communal corridor. This menu was in small print and was not very visible. No pictorial menus were available to help people select meal choices. People we spoke with however told us they were given a choice at mealtimes by staff and that they could ask for an alternative if they did not like what was on offer.
- Most people spoken with said the food was nice, and they got enough to eat at mealtimes.

Ensuring consent to care and treatment in line with law and guidance

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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● When there were concerns about a person's capacity to consent to a specific decision, mental capacity assessments had not always been undertaken. Best interest decisions had also not been made with involvement of relevant people. For example, decisions relating to cardiopulmonary resuscitation and the use of bed rails had been made without consideration of the MCA and the best interest process.
● There were no effective systems were in place to ensure DoLS applications were made and renewed appropriately. It was difficult to tell which people living in the home had an active DoLs in place. This lack of accurate, up to date information increased the risk of people not receiving the right level of supervision.
● Some staff or family members had provided consent for the delivery of care, the taking of photographs, the sharing of personal information without following the MCA and best interest process to ensure they were legally able to do so.

People's legal right to consent to and make decisions about their care and treatment had not been supported in line with the MCA. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Some staff had not completed sufficient or up to date training to do their job role. For example, two staff members had completed less than 20% of the required training for a care assistant yet were actively working in the home.
● Records showed staff had received supervision in their job role and an appraisal. However, some had returned to work following concerns about their conduct without appropriate 'return to work 'risk assessment and management plans in place to mitigate any further concerns.
● One staff member was also wearing a uniform that did not reflect their role within the home which would have been misleading and confusing for people living in the home and their relatives.

Adapting service, design, decoration to meet people's needs
● The premises required improving to support those living with dementia. There was little signage or aids to help people orientate themselves to their surroundings.
● A lift provided access to all floors of the home. Bathrooms had been adapted to help ensure all people could access them.
● People's rooms were personalised with items of their choice.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection, the rating for this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were not always supported to express their views and make decisions about their care. When asked if they felt they listened to, one person said, "No joking aren't you, we are just about living here". Another said, "No they don't listen to your wishes, they make you get washed when they want you too, rather than when you are ready". Another person confirmed this.
- Regular meetings to gather feedback on the service and the support people received did not take place to enable people living in the home and their relatives to share their views and experiences.
- People were not always encouraged to be as independent as possible. For instance, one person was continent and could independently use the toilet. Their daily records however showed that on some occasions they were placed in a continence pad.
- We saw that some people had particular preferences with regards to their daily routines and we saw that these were respected as much as practically possible.

Ensuring people are well treated and supported; respecting equality and diversity

- Daily records and other records relating to people's care did not always show people received the care they needed to keep them safe and well. This did not indicate a caring or nurturing culture.
- When asked if staff were kind, people's comments included, "Some (staff) are very kind, some are not as much", "Older experienced staff members are nice, younger ones not so much – like they're not interested and just can't wait to go home", "Staff are 'lovely' and "Staff work hard and are helpful,
- We observed some positive interactions between staff and people who lived at the home but found that staff had little time to chat to people or interact with them in any meaningful way.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. The rating for this key question has deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care was not always planned or delivered in accordance with their needs and preferences. Records relating to the delivery of care showed that person centred care was not always provided.
- Records showed people did not receive the continence care, repositioning support, personal hygiene care and pain relief they needed to keep them safe, well and free from discomfort or pain.
- There were no adequate systems or checks in place to ensure people's care was safe and person centred. This meant people continued to receive poor and unsafe care that did not meet their needs or preferences.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Basic information about people's communication needs was written in their care plans. However, there was a lack of consideration of how to support people who were unable to communicate verbally or who lived with dementia. For example, there was a lack of accessible picture menus available to assist people to make appropriate mealtime choices and a lack of dementia friendly signage around the home to help people around the building independently.
- The gestures and non verbal cues of people who were unable to communicate verbally were not always recognised and respected to ensure consent was given prior to care being delivered or used by staff to identify when the person was trying to communicate their needs and wishes.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were exposed to the risk of social isolation. They were offered little in the way of meaningful activity and during the inspection the majority of people spent all day sat in the lounge or alone in their bedrooms.
- People were able to have regular visitors and we saw that visitors were welcomed into the home.

Improving care quality in response to complaints or concerns

- The people we spoke with told us they did not know who the manager was if they needed to raise concerns or make a complaint.

● Relatives we spoke with gave similar feedback. One relative they had "No idea" who the manager was. Another said they think they met the manager a year ago but was not sure. This lack of visible management suggested an apathy to learn about the service and people's experiences of care in order to identify areas for improvement.

People's care was not planned or delivered in a person centred way to meet their needs, wishes and preferences. People's views, experiences and concerns about the support they received were not actively sought to drive up improvements. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There was a complaints procedure in place to advice people how to raise concerns. We saw that some complaints had been identified, investigated and responded to by the manager

End of life care and support
● There was no evidence staff had undertaken training to ensure they had the skills to effectively support people at the end of their lives.
● There was nobody receiving end of life support at the time of the inspection.

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 inspection we rated this key question good. At this inspection the rating for this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care

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

- The systems in place to monitor the quality and safety of the service were not effective. This placed people at significant risk of unsafe care and treatment. People's decision making was not supported in accordance with the mental capacity act and people lived in an environment that was not well maintained or clean.
- Staffing levels were not safe. Some staff were not recruited or trained appropriately to meet the needs of the people living in the home. This increased the risk of unsafe care and avoidable harm.
- The findings of this inspection raised serious concerns with the management of the service and the safe delivery of care. The manager, regional manager and provider failed to ensure risks to people's health, safety and welfare were mitigated.
- The manager was not a visible role model for staff in the delivery of care and the majority of people spoken with did not know who they were.
- A culture of learning and continuous improvement was not promoted. For example, information from accident, incidents and safeguarding events was not accurately collected, analysed and learning shared with the staff team to improve practice and safety.

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

- People's care was not planned or delivered in a person centred way to ensure people achieved good outcomes.
- Accurate and complete records were not effectively maintained regarding people's care and treatment which impacted on the care they received.
- People were not empowered to be involved in their care and their feedback was not sought to ensure their care continued to meet their needs.

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 manager and provider had not always notified CQC about notifiable events with regards to people' care due to a lack of accurate accident and incident reporting systems. Providers are required by law to submit the required notifications to CQC without delay. The information provided in notifications helps CQC to decide if further action is needed to ensure people's safety.

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

characteristics; Working in partnership with others

● Some referrals were made to other professionals when required for their specialist advice and support, however professional advice was not always followed or sought appropriately.

● People living in the home and their relatives were not engaged or involved in the service and there were limited opportunities for them to share their feedback and experiences of support they received.

● Staff meetings took place but did not reflect that staff were equal participants in the meeting or that they were able to share their views.

The governance arrangements in place were not robust. The management and leadership of the service was poor. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.