SHC Clemsfold Group Limited

# Kingsmead Lodge

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This focussed inspection took place on 3 December 2018 and was unannounced.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have been made. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and September 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find. Kingsmead Lodge is a care home that provides nursing and residential care.

There was a comprehensive inspection undertaken on the 12 and 13 September 2018. Due to an increase in reported concerns since that inspection and information that suggested people at the service were potentially at increased risk, we undertook this focussed inspection on 3 December 2018. The areas of concern informed our planning and we looked at the safety and quality of the service in the domains of Safe, Effective and Well-led.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Kingsmead Lodge provides nursing and personal care for up to 20 people who may have learning disabilities, physical disabilities and sensory impairments. Most people had complex mobility and communication needs. At the time of our inspection there were 13 people living at Kingsmead Lodge. People living at the service had their own bedroom and en-suite bathroom. The home had two areas 'west' and 'east' wing, however, operated as one home and people had access to all communal areas such as the activities room and dining areas.

There was no registered manager at the time of this inspection. The service is required by a condition of its registration to have a registered manager. A registered manager is a person who registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection we were informed that a new manager had been employed and was starting their role at the end of September 2018. However, we were told the manager had started their employment but had left their post in November 2018. At this inspection the service was being managed by a peripatetic manager who had been in post for one week. A peripatetic manager is one that works, or is based, at different locations for definite periods within the same company. We were told that the current manager would remain in post while the provider recruited for a permanent registered manager.

Kingsmead Lodge has not been operated and developed in line with all the values that underpin the Registering the Right Support and other best practice guidance. Kingsmead Lodge was designed, built and registered before this guidance was published. However, the provider has not developed or adapted Kingsmead Lodge in response to changes in best practice guidance. Had the provider applied to register Kingsmead Lodge today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs. People with learning disabilities using the service should be able to live as ordinary a life as any citizen.

At the last inspection in September 2018, the service was found to be in breach of legal requirements and was given a rating of 'Inadequate'. The provider wrote to us after the inspection to inform us the actions they were taking. At this inspection we found that the concerns around the quality and safety of care provided to people remained and continued. We identified the continuation of four breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider was in continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.This was due to a failure to notify the Commission of authorised Deprivation Liberty Safeguards (DoLS) which the provider is required to do by law.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

People living at Kingsmead Lodge had a learning disability, physical disabilities and some people had complex health needs. People were fully dependent on staff to meet their needs and to provide care and support that ensured they remained safe.

At the last inspection we had continuing concerns over the management of medicines. Since that inspection, we have been alerted to, and identified, continued mismanagement of medicines. Medicine administration errors continued to be reported that involved the under administration of medicines and the failure to ensure medicine administration records were updated.

Concerns about the management of risk continued. There was a continued failure to use the National Early Warning Score (NEWS) system consistently, particularly at times when its use would have provided a clearer indication of what actions were needed when a person's health deteriorated.

Concerns around infection control procedures when staff supported people with percutaneous endoscopic gastrostomy feeding tubes (PEG) and percutaneous endoscopic jejunal feeding tubes (PEJ) management had been addressed. However, infection control procedures had not always been applied effectively elsewhere.

There remained gaps in training that had yet to be addressed since the last inspection. Some people displayed behaviours which may challenge others yet not all staff had received specific training on how to manage such behaviours safely and effectively.

Systems and quality assurance processes to monitor and oversee care remained ineffective and were not sufficiently robust to ensure consistent and quality support throughout the service. The provider had failed

to ensure the necessary improvements had been made to the care provided since the last inspection.

Staffing levels were sufficient to meet the care needs of people although concerns were highlighted over the impact of the reduction to nursing levels at the service.

The provider did not always complete the required statutory notifications to the CQC when incidents occurred.

The provider had not always ensured that all people, their representatives and health professionals had been involved in making decisions in their best interests. They had not always ensured that people's consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005.

People's care needs, in relation to their physical disabilities, had continued for the most part to be promoted through the environment of the service.

People nutritional needs were well met and they were supported to have enough food and drink.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms 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?

**Inadequate**

The service was not safe.

There continued to be aspects of unsafe care and treatment that the provider had not addressed.

Infection control measures were not always safely managed or overseen.

Staff had not safely and consistently used systems to determine what actions were needed when a person's health deteriorated.

There were sufficient staff to manage peoples care needs, although concerns were highlighted about the changes to the levels of clinical staff.

### Is the service effective?

**Inadequate**

The service was not effective.

There continued to be some gaps in training. This included a lack of training to assist staff in managing behaviours which might challenge.

The provider did not work consistently in accordance with MCA legislation.

People's needs were assessed prior to moving to the service and reviewed when needed. However, information and guidance was not always used in how risks were managed safely and effectively.

People's nutritional needs were met by staff. People's care needs, in relation to their physical disabilities, had continued for the most part to be promoted through the environment of the service.

Staff worked with healthcare professionals and services when needed. However, staff responses and intervention were not always completed in a timely manner.

### Is the service well-led?

**Inadequate**

The service was not well-led.

The service did not have a registered manager in place.

The provider had failed to put in place an effective and robust auditing system to identify, measure and improve the quality of the service delivered to people.

The provider had received support from specialists in health and social care. However, they had not implemented the suggested improvements, and risks to people's health, safety and welfare had not been sufficiently mitigated.

Care records were not always completed accurately. This included inconsistencies in responding accurately to people's health conditions.

The provider had failed to implement learning from incidents. This impacted on people's safety.

# Kingsmead Lodge

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This focused inspection took place on 3 December 2018 and was unannounced. This inspection was prompted by information we received and, in part, by a number of notifications the CQC had received, which suggested that the safety and quality of the service had worsened since the last inspection on 12 and 13 September 2018. The information shared within these notifications indicated potential concerns around the safety of people, the management of clinical risks and support, and of continued shortfalls in quality assurance systems and of the governance framework. At this inspection, we therefore inspected the key questions within the Safe, Effective and Well-led domains.

The inspection team consisted of two inspectors and a specialist advisor. The specialist advisor had specialist clinical experience in supporting people with complex heath needs.

Prior to the inspection, we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with two people who lived at the home to obtain their views of the care they received. Due to the nature of some people's complex needs, we were not always able to ask people direct questions about the care they received. To obtain these, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received.

We spoke to the acting peripatetic manager, the deputy manager (and acting Registered Nurse), a team leader, another registered nurse, a senior care worker and care worker. During the inspection, we observed medicines being administered to people. We reviewed records about people's care which included seven

care plans. We looked at a range of clinical records as well as care and nursing notes, relating to the specific concerns we had received. We also looked at agency recruitment records and profiles, safeguarding records, accident and incident reports, quality assurance documents and medicines records.

Inadequate

# Is the service safe?

## Our findings

At the last inspection in September 2018, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all was reasonably done to mitigate risks to service users. There were failings to ensure all staff had the competence and skills to provide care safely. At this inspection we found that risks to people remained.

At our last inspection we found that risks to people had been assessed although they were not managed safely or consistently. There were people living at the service that required enteral feeding and had percutaneous endoscopic gastrostomy (PEG) feeding tubes fitted. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and throat. Another person had a percutaneous endoscopic jejunal (PEJ) feeding tube fitted. We previously observed unsafe infection control procedures when staff supported people with this aspect of their care. We had also observed poor staff management of people's feeding tubes that increased the potential for bacterial contamination and the development of infections.

At this inspection, the manager informed us that staff were now using disposable caps to isolate the area of the feeding tube to ensure that infection control risks to people were being minimised. We also observed a person being supported with enteral support and appropriate practices were used. However, there remained areas of concern around the safe management of PEG/PEJ. Prior to the inspection, we were notified of an incident that highlighted significant concerns about the availability of guidance available to clinical and care staff. This incident also highlighted shortfalls in the communication systems in place to enable staff to deliver safe and effective support. A person's enteral feeding tube had been disconnected, rather than closed, by an agency registered nurse prior to that person attending a day centre. Staff had been alerted to this by the day care staff and arrangements were made for the feeding tube to be re-connected. The agency registered nurse managing the enteral feed was on their first shift at the service and had been asked by staff to flush the feeding tube prior to the person leaving the service. Although the agency registered nurse sought guidance from another more established registered nurse on the person's feeding regime, the registered nurse subsequently took instructions from a housekeeper, who also supported the person, on whether the feeding tube should have been disconnected. The agency registered nurse acted on the verbal directions of the housekeeper as the person's care plan did not contain sufficient guidance or specific protocol for disconnecting the tube or the extent of enteral feeding support that the person would receive at the day centre. There were no records to show that the agency registered nurse had received an induction prior to them starting work and the acting manager confirmed that she was unable to locate any evidence of an induction.

At the previous inspection we identified that an oxygen cylinder had been unsafely stored in a person's bedroom. Although this was now stored in the clinical room, we observed that the mask was dirty and laying on the floor. We observed loose plastic ear inserts for digital thermometers in a clinical equipment box containing other health devices that increased the risk of contamination and infection. There were no antibacterial wipes present in the box to clean down the equipment after each use. The provider had also failed to undertake any infection control audits for the two months following the last inspection. Given the

serious concerns highlighted in the last inspection around PEG/PEJ management and infection control, the failure to undertake quality checks and audits of infection control procedures demonstrates that not all was reasonably done to mitigate the infection control risks to people.

At the previous inspection, we found that the provider had not correctly implemented the National Early Warning Score (NEWS). This is a standardised system for recording and assessing baseline observations of people to promote safe and effective clinical care. The NEWS will include a baseline for what a person's temperature, pulse rate and oxygen saturations should be and what actions registered nurses should take if checks show results outside of the baseline and a person's health deteriorates further. At this inspection we found that there was continued failure to use this system consistently, particularly at times when its use would have provided a clearer indication of what actions were needed when a person's health deteriorated. For example, we saw records of an incident where NEWS recordings for one person had indicated that GP support should be sought. After four hours, the visiting GP assessed a high level of deterioration, prompting an emergency admission to hospital for respiratory failure. The deterioration of the person in the interim period had not been identified as no further NEWS recordings had been undertaken, putting the person at significant risk. The manager acknowledged that the consistent use of NEWS would likely have generated a higher score and therefore would have prompted staff to seek immediate emergency medical support. The manager told us, "Staff could have potentially got (the person) into hospital four hours quicker. It's a learning tool. If you had plotted those vital signs on a NEWS chart, it probably would have scored a six. Anything that rises by three on the NEWS chart is an automatic 999 call. Staff had written the observations in the notes but not on the NEWS chart. I'm going to develop the incident as a learning tool and use it for teaching.

Observations of further recordings highlighted the failure to use NEWS. Recordings showed that another emergency hospital admission occurred when the person became unresponsive. NEWS was not completed at the initial point of the person's deterioration, or thereafter until emergency medical treatment was sought, and vital signs had not been recorded in the nursing notes. For example, we looked into an incident where concerns had been raised about the response to a person vomiting. Staff informed us that the incident occurred after the person had just started a liquidised diet. Although the senior carer we spoke to was able to recall the incident, they were unable to identify information about the person vomiting within carers or nurse's notes.  NEWS chart vital signs checks were not increased in frequency or recorded around the time of vomiting. This meant a system that had been introduced to ensure staff made the correct decision when a person's health deteriorated, continued to be implemented incorrectly and inconsistently by staff and had not been managed by the provider. The impact of this was that risks to people's safety and health were not properly addressed.

The management of medicines was inspected in detail at the comprehensive inspection of 12 and 13 September. The judgements were reflected in the report following that inspection. At the last inspection we found that medicine records, and the administration of medicines were not always being completed safely and appropriately. We also found some medicines were not being stocked adequately and that there were gaps in guidance for PEG administration. At this inspection, medicines were appropriately prepared and administered through the PEG. The administration was completed using an appropriate speed through the PEG, in accordance with guidance, while observing correct infection control procedures. Medicines for pain relief were now stocked appropriately. However, information received prior to the inspection, as well as records we saw during the site visit, highlighted continued concerns regarding the safe administration and oversight of medicines.  We observed two reporting forms, completed since the last inspection, that detailed three separate errors in medicine administration. One person's medicines had been under-administered on two occasions, while another person had not been given alternate administration, as prescribed, when they initially refused medicines. On another occasion, MAR (Medication Administration Records) had not been

updated correctly following the admission of a person for respite care leading to non-administration of a particular supplement on two occasions. These errors meant that that risks to people's safety remained due to the inconsistent administration and management of medicines.

Prior to the inspection, the CQC had been alerted to a serious concern about a staff member providing clinical care without the appropriate registration with the Nursing and Midwifery Council (NMC). A failure in managerial oversight had led to people receiving medicines over a two-week period from a nurse whose registration had lapsed. Shortfalls in auditing and reviewing had meant that this had not been identified within appropriate timescales. The provider took action after recognising the issue and ensured that the nurse completed care work only until the registration issue had been completed.

We looked at the service's management and response to accidents and incidents. At the previous inspection we had found examples of where the provider had failed to take all the necessary action required when an incident or accident had occurred. At this inspection we found that incident forms did not always contain sufficient information about what actions had been taken. Records did not always document what subsequent actions the provider had undertaken to mitigate any future risks. For example, one form recorded that medicine for one person had been refused and that the alternate administration method was not given as prescribed. The outcomes and actions to prevent reoccurrence detailed only that no harm had occurred, but did not detail why this had occurred or what actions had been taken to ensure that future errors were mitigated. Another person had reported to have attended day service with a damp in-situ sling put on by night staff, although no details were recorded of how and why this occurred.

We also found there had been a lack of consistency in the oversight and management of incidents and accidents. Staff had been completing incident forms manually then passing these to the deputy manager to record electronically. Where incidents had occurred, information was then passed to the provider's quality assurance team to review and identify trends. At the inspection, we were given a selection of paperwork relating to incidents and accidents although, due to the volume of documents that had not been sorted or collated, the manager told us that they couldn't be sure if the information represented all the incidents and accidents that had occurred. In respect to the management and oversight of this area, the manager told us that, "There has been no clear lead for some time." Another senior staff member told us, "Different people report different things in different ways. There has been no steady structure and has been dependent on the manager. Some would say to raise an Untoward Event from, some would say do this and would act on it in different ways." This meant that there had been an inconsistent oversight and management of incidents and accidents. The impact of this was that people remained at risk because the provider could not be assured that actions form incidents were being dealt with appropriately or in a timely manner.

The above evidence shows that not all was reasonably done to mitigate risks to service users. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about safeguarding issues and the different types of abuse. Staff were aware of the high level of needs and vulnerability of the people they supported and that they relied on staff to ensure they remained safe. However, the manager informed us of a conversation they had with a staff member on the day of the inspection, where the staff member had informed the manager that bruising had been found on one person. The staff member was unclear whether the incident met the threshold of a safeguarding concern. The manager told us that they needed to instruct the staff member to complete an incident form as the staff member had questioned why this was required and appeared reluctant to do so due to its implications. This highlighted a concern that there wasn't a clear understanding of the processes and systems in place when reporting concerns and safeguarding issues.

Since the last inspection, no concerns had been raised about the safe recruitment checks undertaken by the provider. The provider continued to ensure that appropriate recruitment checks were undertaken, reflecting the judgments made in the previous report. Staff were only able to start employment once the provider had made suitable recruitment checks. This included; two satisfactory reference checks with previous employers and a Disclosure and Barring Service (DBS) check.

At the previous inspection, improvements had been noted in staffing levels and in the impact of the high use of agency staff on the care provided to people. The service had used regular agency staff to ensure sufficient levels were maintained. At this inspection, we found that there were sufficient numbers of care staff to ensure that people's care needs were met. However, concerns had been highlighted since the last inspection on the provision and numbers of nursing staff. In August 2018, the provider made a decision to reduce the ratio of nurses on duty during the weekday shifts from two nurses to one nurse. Kingsmead Lodge staff team included five permanent registered nurses. There was one registered nurse on duty each shift. Shifts were run from 8am to 8pm and then from 8pm until 8am. Staff informed us that the decision was taken by the provider without any contingency plans being put in place. Staff told us that this staff reduction increased pressures on the sole nurse on duty and had a considerable impact on the completion of duties that nursing staff were undertaking. One staff member told us, "They (the provider) hadn't put anything in place at the time and this put too much strain on the nurse on duty." At this inspection, the manager told us that they felt that there was sufficient clinical cover under the new arrangements. The manager told us that due to the occupancy level at the service and the increased clinical cover now being provided by the deputy manager and by herself as manager, that the single nurse on shift was able to undertake nursing duties by themselves. However, the deputy manager's role had only recently been changed and therefore cover had yet to be implemented or embedded. Also, there was no evidence that the issues of the back log in clinical paperwork and oversight, which had been raised by staff as the result of this reduction, had been alleviated. Further details can be seen in the Well-led section of this report.

At our last inspection, we identified serious risks associated with the management, storage and guidance of thickeners. People were prescribed thickeners. Thickeners are powders which are added to food and liquids to bring them to the correct consistency or texture in order for them to be safely swallowed by people. This is to ensure that people's nutritional and hydration needs are met. We had found risks associated with the lack of specific guidance for people who used thickening powders. This put people at high risk of choking and significant harm because there was a potential for staff to give incorrect amounts. We also had concerns regarding the storage of some thickeners which had been stored in an unlocked cupboard in the dining area and was accessible to people. On 6 February 2015, NHS England issued a patient safety alert on the risk of death by asphyxiation by accidental ingestion of fluid or food thickening powder. It advised the safe storage of thickeners. We had also looked into a safeguarding concern regarding the provision of thickeners that were no longer prescribed to two people. At this inspection we found that improvements had been made to the management of thickeners. Three people at the service were prescribed thickeners. New guidance had been implemented, and was clearly displayed for staff, that explained the required dosage of thickener and level of fluids required for each individual. The guidance included photos of the different consistencies and the texture of fluids. The guidelines were from Sussex Partnership Foundation Trust and were based on the International Dysphagia Diet Standardisation Initiative (IDDSI). Staff told us that all pharmacy labels had been updated to show the correct dosage and fluid requirements. We confirmed that these were now in place. Staff had ensured that tubs of thickeners had been removed from unlocked communal areas and were stored securely in the clinical area. Care staff informed us that guidance now requires them to seek support from a registered nurse when thickeners needed to be mixed.

Inadequate

# Is the service effective?

## Our findings

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 Act 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 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 with appropriate legal authority. 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, and whether any conditions on authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection on 12 and 13 September 2018, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured service users' consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. The provider had not always ensured that all people and their representatives had been involved in the process in their best interests. We also found that conditions within authorised DoLS were not always reflected in people's care plans. Management and staff were not knowledgeable of these conditions and therefore could not ensure that they were being met.

At this inspection we found that there had been no improvements in this area. Conditions associated within people's DoLS continued to be absent from people's care plans while staff were unable to identify these in order to ensure that they were being met. There were concerns that people, and relevant professionals, were not always fully supported or involved in making decisions about their care. Records relating to a decision relating to one person's end of life treatment demonstrated that not all had been reasonably done to support them in making a decision.  Family members had participated in the decision but there was no involvement from the person's social worker or specialist professionals who could have supported the person in their decision. The decision did not contain sufficient information to adequately support how the person conveyed their views, yet the decision had been supported by the deputy manager. These concerns had already been noted by the new manager prior to our inspection and they informed us that a SALT (Speech and Language Therapist) had been contacted, as well as the person's social worker. The manager confirmed that the use of communication aids to support the person had not been considered and could have potentially impacted on the person's ability to convey their decision.

Concerns were also highlighted over the management and oversight of one person's capacity and best interest decision-making process. Records showed that the person's capacity was assessed in 2013 but that it was unclear on whether the person lacked capacity or not. The person was recorded to have both an advocate and a next of kin (NOK), although the 'NOK' was not a family member. Records showed that there was a potential conflict of interest around non-family members within the decision-making process who were also paid professionals supporting that person. This potential conflict had not been historically recognised or acted upon. The manager confirmed that they had identified the issue shortly after her recent appointment to the position of manager in the service. The manager told us that the capacity assessment

process would be comprehensively reviewed for the person and that enquiries would be made with the appropriate legal representatives as there appeared to be no legal trail of the decisions made and no best interests decisions taken.

The above evidence demonstrated that the provider had not ensured service users consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found that there was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not always received appropriate training to enable them to carry out their duties. At this inspection we found that although the provider had taken steps to address concerns over staff management of PEG management, we found that this was still an area that needed improvement. In respect to PEG management, the provider had ensured that only clinical staff were responsible for the management of PEG/PEJ. However, we found that gaps in training remained, while the service, on occasions, did not provide staff with the necessary skills, knowledge and guidance to deliver effective care and support.

At the last inspection, we identified that some people at the service displayed behaviours that challenged. Records and staff feedback had confirmed that on occasions, these behaviours had led to physical aggression towards staff. We had found the lack of training attended in PBS (Positive Behaviour Support) meant there was some risk incidents of a challenging nature would not be managed consistently and with a positive outcome for people. Following the last inspection, the provider had informed us that they would be introducing PBS training across the service in order to address this and had indicated this in their action plan. At the time of this inspection, this programme had yet to be implemented. Records showed there had been no change in the needs of those identified as previously showing physical aggression towards staff, therefore concerns over the effectiveness of staff to manage behaviours that challenge, and the associated risks to people as a result, remained.

At our last inspection, concerns were raised about the skills and competency of staff to effectively manage the PEG/PEJ support people required. The impact of the reduction in nurse support on each shift had meant that there were occasions where a staff member, with no formal training in this area, had supported a person with dressings around their PEJ. At this inspection, the acting manager confirmed that only trained nursing staff would be completing PEG/J support, while the nurse on duty told us that only nurses were allowed to disconnect PEG tubes. The manager informed us that the change in managerial cover meant that the deputy manager, who is also a registered nurse, was now completing the majority of their working hours as clinical support on the floor and would therefore be able to provide support to the nurse on duty. However, training records identified that the deputy manager had not received PEG training as well as another staff member. The acting manager could not provide evidence that the training had been completed and also indicated that there may have been another staff member missing from these records. The incident highlighted within the Safe domain of this report about the mismanagement of PEG/PEJ also raised concerns around the completion of induction for clinical staff. The incident highlighted, and the lack of records confirmed, that not all nursing staff were receiving adequate inductions to ensure they carried out their roles effectively.

Concerns remained regarding staff's knowledge and effective application of correct guidance. During the inspection, we observed one person receiving medical support from emergency health professionals. In order for the emergency personnel to assess the person appropriately and make a correct and safe clinical decision, protocols and formal clinical guidance was requested. The nurse in charge provided the provider's own protocol but failed to give the hospital specialist's protocol. The nurse indicated, when challenged, that

this was not required or relevant information.  We brought this to the attention of the acting manager who made the decision to provide the paramedics with all the guidance for them to assess fully and make an informed clinical decision. These incidents highlighted the shortfalls in the effectiveness of the induction provided to clinical agency staff. They also demonstrated that staff knowledge of information systems and guidance was not always sufficient or adequate to ensure that people received effective and safe support.

The above evidence showed that staff had not always received appropriate training to enable them to carry out their duties as they are employed to perform. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider offered an ongoing an extensive training programme through its academy that included both practical face to face courses as well as online tuition for staff. Staff attended a variety of courses that met the needs of people living at the service including moving and handling, learning disability and epilepsy. Agency staff were used by the provider for both caring and nursing roles. Profiles were provided to the service to show the abilities and training history of the agency member

People were supported to receive ongoing healthcare support. Records showed that staff supported people to access routine and ongoing health appointments. However, the information detailed within the Safe domain with regards to the inconsistency of the application of NEWS (National Early Warning Score) and the failure to sometimes apply this correctly, demonstrated that people were not always supported to access healthcare support in a timely manner.

People's physical, mental and social needs were assessed prior to them moving to the service. Information was used to develop care plans and guidance for each person that detailed their needs and how this care should be provided. However, information and guidance was not always used in how risks were managed safely and effectively. These areas have been highlighted in the Safe section of this report.

People's care needs, in relation to their physical disabilities, had continued for the most part to be promoted through the environment of the service. However, during the inspection issues around the safety and effectiveness of one person's living environment were highlighted when they required emergency medical assistance from paramedics. The person's room contained a single bed situated within a recess, and also an arm chair and a chest of drawers. The impact of the lack of space available was highlighted when we observed emergency personnel struggling to find space for their equipment and to access the person to provide treatment. Their ability to reach the person effectively was impacted by an inability to move their bed so that they could access both sides of the bed to provide treatment.

Many people living at the home required the use of wheelchairs to mobilise around communal areas. Wide corridors and doorways and open plan communal areas allowed people to mobilise safely and freely. Bathrooms and bedrooms were equipped with the appropriate hoists and moving and positioning equipment to ensure that people's needs were met safely.

People nutritional needs were well met and they were supported to have enough food and drink. People were provided with choices about what food they wished to eat. We observed part of the lunchtime experience and people looked happy and content with the food provided. At the last inspection, the chef had demonstrated a good knowledge of people's diets and dietary needs. There had been no concerns raised in this area, or changes in people's needs, since the last inspection.

Inadequate

# Is the service well-led?

## Our findings

At the last inspection on 12 and 13 September 2018 the service did not have a registered manager in place. Since February 2018, the service had been supported by two managers who had subsequently left, and was, at the time of the inspection, being managed on a day-to-day basis by the deputy manager. Since the last inspection in September 2018 another manager had been recruited by the provider but was in post for less than a month. At the time of our site visit, there had been further changes within the management structure. The provider had employed a peripatetic manager who had been in post for a week at the time of our inspection. The manager informed us that they had a very limited handover with the outgoing manager. There had also been changes to the operational oversight of the service with a change to the regional operations manager supporting the service. It is a legal requirement for this service to have a registered manager in place.

The failure to have a registered manager is a breach of section 33 of the Health and Social Care Act 2008.

At the last inspection evidence showed that the systems or processes in place were not consistently effective and the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a failure to assess, monitor and improve the quality and safety of the services provided. There was a failure to maintain an accurate and cotemporaneous record in respect of each service user. At this inspection we found that systems and processes remained ineffective.

Since the last inspection, there had not been sufficient oversight by the provider to ensure that auditing and quality assurance checks were completed. For example, some infection control procedures had been put in place to address the poor PEG/PEJ management observed during the last inspection. However, the manager confirmed that no infection control audits had been undertaken in the three months prior to her recent appointment. The manager confirmed that she had undertaken an audit of infection control management in her first week and had observed and advised a staff member as they were found not using an item of personal protective equipment (PPE) during a procedure. A medication audit had been undertaken by the providers area team, although we did not see consistent systems in place to ensure that oversight of medicines was being undertaken. Due to the failure to ensure that risks could be identified and mitigated, we were not confident that auditing systems and processes were embedded and sustained to ensure and improve the quality and safety of care. The failure to carry out effective auditing had been highlighted to the provider during some inspections of others of their services. This had not led to improvements being made and showed that learning was not being adequately shared across the provider's services.

At the previous inspection we found that some care records failed to demonstrate all care was being provided to people as agreed within care planning. For example, we identified that one person was at high risk of skin damage due to their skin integrity. Their care plan stated that the person should be repositioned once at night time to reduce the risk of damage to their skin. There was no repositioning chart in place. This was brought to the attention of the regional operations director at the time of the last inspection. At this inspection, we found that this issue had still not been addressed and that repositioning charts and guidance

had still not been implemented. A care plan review and quality assurance audit had also failed to identify that these actions hadn't been addressed. This did not provide assurances that repositioning, to prevent pressure damage, had been carried out by staff.

Concerns about repositioning and the recording of it had been highlighted to the provider during some inspections of others of their services. This had not led to improvements being made and showed that learning was not being shared across the provider's services.

At the previous inspection the provider had failed to notify the CQC of incidents which had occurred whilst services were being provided in the carrying on of a regulated activity or as a consequence of this. The provider had not notified the CQC on a large number of DoLS authorisations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. No new DoLS authorisations had occurred in the period since the recent inspection, but we found evidence that the provider had continued to fail to notify the CQC of some incidents. The provider had legal responsibility to complete and send to the Commission statutory notifications. Notifications are changes, events or incidents that the service must inform us about. The provider had failed to inform us of bruising found on one person whose cause was recorded as being unknown. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The failure to notify CQC of incidents had been highlighted to the provider during some inspections of others of their services. This had not led to improvements being made and showed that learning was not being shared across the provider's services.

We previously identified risks associated with the constipation and bowel management of one person. We found that the bowel monitoring chart had been completed incorrectly and that entries had not been made in relation to the Bristol stool chart categories (BSC) which the person's care plan referred to. The BSC is a diagnostic tool designed to classify the form of the human faeces into categories. The risk, which was brought to the attention of the deputy manager and registered nurse, was that inaccurate recordings would not enable nursing staff to accurately monitor whether the person was constipated or not, and that corrective action, such as administering medicines to relieve the constipation, may not be given. At this inspection we found that improvements had not been made since the previous inspection by the management team even though they had been previously alerted to this risk. We reviewed the information and bowel chart which showed gaps and crosses to indicate that the person had not opened their bowels. This continued to demonstrate that accurate, effective monitoring by nursing staff of whether the person was constipated would not be possible. We spoke to the manager who agreed that the current guidance and recording systems were ineffective and confirmed that a new monitoring chart would be devised and implemented.

The failure to monitor people's bowels and constipation risks appropriately had been highlighted to the provider during some inspections of others of their services. This had not led to improvements being made and showed that learning was not being shared across the provider's services.

In August 2018, the provider made a decision to reduce the ratio of nurses on duty during the weekday shifts from two nurses to one nurse. Staff told us that they felt that the provider had made the decision without consultation with staff and without ensuring that the necessary contingency plans were in place. One staff member said, "It was a big mistake. There was too much for one nurse to do." We were informed that under the previous staff structure of two nurses on shift, one nurse was responsible for monitoring people's clinical needs while the second completed clinical paperwork and duties such as care plan reviews. One staff member told us, "We are now catching up. There are gaps in reviews which had not been done in months."

Another staff member told us, "It was done too quickly. There was nothing in place and none of us were warned. They (provider) should have listened to us." We were told that that the impact of this was that reviews and clinical paperwork were not completed and that there were no clear governance arrangements in place to ensure that shortfalls were addressed. The impact of this was that the completion and oversight of care plan reviews and clinical records had not been completed, and that contingencies had not been implemented to ensure that records were maintained safely and effectively.

The provider had not ensured that NEWS systems had been implemented or been used correctly. The provider had introduced the National Early Warning Score (NEWS), across different locations, since November 2017 and at Kingsmead Lodge. This is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. Information and evidence detailed in the Safe domain showed that staff had continued to use the system inconsistently or on occasions, not at all. The provider's quality assurance process had failed to identify shortfalls in the application of the system. The failure to operate NEWS properly had been highlighted to the provider during some inspections of others of their services. This had not led to improvements being made and showed that learning was not being shared across the provider's services.

Auditing systems had failed to identify that one nurse had the appropriate and valid registration to undertake their clinical role. The provider had alerted the CQC to one nurse who had failed to renew their NMC registration following its expiry. There were no systems in place to monitor and check that staff had the appropriate registrations. Nurses are required to maintain their registration with the regulatory body. Records had shown that the nurse had provided clinical care on several occasions over a two-week period while being unregistered. The provider is responsible for ensuring that all relevant employment checks are in place and monitored. Management systems and auditing checks had not identified this lapse in registration and therefore people had received support with their medicines from an unregistered nurse.

The provider had continued to fail to put in place robust measures to drive quality and sustain improvements at the service. The concerns we identified and raised at this inspection were also identified at the last inspection. This had not encouraged the provider to ensure improvements to the quality and safety of care provided to all people living at Kingsmead Lodge had been made. The shortfalls that were found at this inspection had not been identified by the provider prior to the inspection. This demonstrated the provider had not been able to adequately address the concerns that had been raised in the past and take action to ensure they learn from them and people's safety and quality of life is assured.

The above evidence continues to show that the systems or processes in place were not consistently effective. There was a failure to assess and monitor and to improve the quality and safety of the services provided. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People continued to have opportunities to be part of their care plan reviews and attended resident's meetings to share their thoughts and opinions. Relatives were supported to voice their opinions and participate in their family members support. Quality assurance surveys were sent out by the provider to relatives for them to feedback their opinions about the support given.

Records demonstrated that the service worked alongside health professionals and other agencies to provide support for people. We observed links with professionals such as SALT (Speech and Language Therapists and general practitioners. However, the evidence detailed within the Safe domain around the failure to use NEWS highlighted that interventions were not always sought in a timely manner.

Staff spoke encouragingly about the manager who had recently started. One staff member said, "She is very proactive and making changes within the home. Trying her best to improve things." Another staff member told us, "The manager has her finger on the pulse. There is a lot more confidence in her. Over the last month I have seen an improvement. The atmosphere is better." Staff told us that they felt that improvements were being implemented by the acting manager but that the sustainability of the service, as well as ensuring the continued confidence of staff, was dependent on the continuity of the manager's position. Staff indicated that morale had been low over the past year due to the uncertainty over the manager's position, as a number of managers had taken up the position and then left. Staff told us that the different and inconsistent approaches of different managers had been difficult. One staff member told us, "They all have different ideas and expectations and not having consistency has been very unsettling." Another staff member said, "We've had four managers in the past year. They make changes and then go. They're making irrelevant changes. We didn't feel like a team. The changes should be around the people you support not around the manager." Staff expressed a hope that the acting manager would stay at the service. However, the acting manager confirmed to us that they would remain a peripatetic manager and would not be taking up a permanent post. The manager told us that they were committed to addressing the issues around the delivery of care that had been identified on the previous inspection and demonstrated during the inspection that key issues had started to be addressed. Prior to the completion of this report we contacted the provider to get an update on the registered managers position. The acting manager confirmed that the provider had held interviews for the registered managers position. They had also held interviews for the deputy managers position as the existing staff member had recently resigned from their position. The manager informed us that they identified candidates for post posts and were awaiting confirmation of acceptances. The acting manager stated that they would remain at the service to ensure a suitable handover for any prospective registered manager.

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider was not consistently working in accordance with the MCA legislation. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to service users had not always been mitigated to ensure the continued safety of service users. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems or processes in place were not consistently effective. There was a failure to assess and monitor and to improve the quality and safety of the services provided. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not always received appropriate training to enable them to carry out their duties as they are employed to perform. |