Kingswood UK Home Ltd

Kingswood Home

Inspection report

140 Heene Rd
Worthing
West Sussex
BN11 4PJ

Date of inspection visit:
17 February 2020
18 February 2020
19 February 2020

Date of publication:
08 April 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Kingswood Home is a residential care home providing personal care to 20 people at the time of the inspection. People had a range of health and support needs and included people living with dementia. The service can support up to 23 people.

People's experience of using this service and what we found
People were not safe living at Kingswood Home. At the time of the inspection, a team of local authority social care professionals had been brought in to assess people's care and support needs, with a view to moving them into other care homes. People were at risk of receiving unsafe care. Staff had not ensured people had sufficient to eat or drink and their needs were not effectively monitored. Staffing levels were unsafe and meant that people did not have the support or care at the time they needed it. People were not protected from the risk of neglect or abuse. One person who was at risk of choking was given the wrong texture of food which increased their risk of choking. Another person, who was at risk of skin breakdown, was not repositioned regularly according to monitoring records. Medicines were not always managed safely. Stocks of medicines did not tally with records to confirm that people received their medicines as prescribed. There was a strong smell of urine in some parts of the home indicating that cleanliness and hygiene standards were not maintained.

Staff had not completed all the training they needed to ensure people received appropriate care and support. Where training had been completed, staff demonstrated a lack of understanding in key areas, such as safeguarding and types of abuse. People were not always given the correct consistency of food, in line with their assessed risks. Some people presented as being very hungry or thirsty. Drinks were not freely available and people often had to wait for their drinks to be served at set times dictated by staff.

Because of the lack of staff available, people received a poor standard of care. They were not treated with dignity and respect. Care was not personalised to meet people's needs. Care plans were detailed and provided information about people's likes, dislikes and preferences, including their interests. However, there was a lack of activities to provide mental stimulation or to engage people.

The culture of the home was negative and staff were dissatisfied working there; some staff felt the registered manager did not listen to them and was not supportive. The registered manager demonstrated poor oversight and capability in their management of the home and of their legal responsibilities. A system of audits had been implemented but was not effective in identifying all the issues found at the inspection or by external professionals who had intervened at the service.

By the end of the third day of inspection, all service users had been moved from Kingswood Home to alternative care placements.

Due to the nature of this urgent responsive inspection and the enforcement action which proceeded it, we

were not able to fully answer all of Key Lines of Enquiry (KLOEs) in this report. The report has, instead, focussed on the KLOEs of highest significance to people's safety, care and welfare.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement, (report published 24 April 2019).

At this inspection not enough improvement had been made and the overall rating has deteriorated to Inadequate.

Why we inspected
The inspection was prompted due to serious concerns received about people's safety and poor quality of care people had received. In response to these concerns, CQC inspected Kingswood Home as a matter of urgency. Prior to the inspection, we were notified of an incident whereby a person using the service had died. Since the inspection, another person died in hospital. These incidents, as well as concerns about neglect of other Kingswood Home residents, is subject to safeguarding and criminal investigations. As a result, this inspection did not examine the specific circumstances of these incidents. .

Enforcement
We have taken urgent action to safeguard people from the risk of harm. 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. Please see the 'Enforcement Actions' section at the back of this report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Kingswood Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection was undertaken by three inspectors.

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

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

Notice of inspection
This inspection was an unannounced, responsive inspection.

What we did before the inspection
CQC was alerted about serious concerns at the home which occurred over the weekend before the inspection took place. This inspection was brought forward due to information of concern regarding incidents of neglect and serious harm to people that had been raised to CQC by social services, health professionals and police. The information shared with CQC about specific incidents indicated potential concerns about the management of people's nutrition and hydration needs, hygiene and cleanliness, environmental health and management of people's health needs. Information about specific incidents highlighted potential serious concerns about delays in staff recognising an acute deterioration in people's health and seeking timely medical attention. We looked at these concerns in detail during the inspection.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with three people living at the home and one relative about their experience of the care provided. We spent time observing people and how they were supported by staff. We spoke with the provider/nominated individual who was also the registered manager. We spoke with two chefs, two team leaders (one of whom commenced employment on the second day of inspection), two care staff and a number of health and social care professionals who were present at the home during the inspection. We looked at 10 care plans and 'pathway tracked' four people. Pathway tracking is a way of understanding how people are cared for, through observations, looking at their care plans and interviewing staff who support these people and how these processes are joined-up. We looked at daily monitoring charts such as food and fluid intake, continence and repositioning records. We also looked at records in relation to the management of the home. Due to focusing on concerns identified before and at inspection, not all key lines of enquiry (KLOEs) were followed-up at this inspection.

After the inspection
As result of issues identified before the inspection, as well as concerns found during the inspection, we sought assurance from the provider that people were safe living at the home. The provider sent us an action plan which described what steps they would take immediately to ensure people's safety. The provider's action plan failed to accurately reflect how they would immediately act to keep people safe at Kingswood Home. As a result, CQC used its urgent enforcement powers to safeguard people from the risk of harm. Please see the 'Enforcement Actions' section at the back of this report for the full details of our regulatory action.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of neglect, abuse or harm.
- Daily monitoring charts were not effective in ensuring people received safe care and treatment. Prior to this inspection, paramedics visiting the home had identified people who were showing signs of dehydration. Social care professionals had witnessed some people not receiving a drink or food for six hours and who were specifically saying they were hungry or thirsty. Due to the nature of people's support needs, they relied on staff to provide their food and fluids and to prompt them to eat and drink.
- Drinks were not freely available throughout the day. Instead, drinks were offered to people at set times during the day, with a meal, or mid-morning and mid-afternoon. One person, who was cared for in bed, had a jug of juice in their bedroom, but this was placed on a table out of their reach.
- Food monitoring charts recorded the food served to people at breakfast, lunch and supper, but not the amount people had eaten. This put people at risk of malnourishment.
- One chef offered people food they felt they would enjoy without referring to their care plans. They explained, "[Named person] has a soft diet and I do it soft, completely blended down, I've not seen his care plan, but have been spoken to about his diet and he said this is the way he likes it. I've never seen any speech and language guidance, I'm just told by staff. I'm not sure what a speech and language therapist has to do with my job as chef". When asked about thickening liquids in response to people's choking risks, the chef told us, "I never deal with that and I don't know who has thickened drinks. I never use thickener in things such as gravy, that's silly, I would use cornflour. I would make the gravy thicker and cream". The chef said they did not know which people needed to have thickened drinks.
- One person, who was cared for in bed, required to be repositioned every two hours according to their turn charts. This was to prevent the risk of pressure damage. According to turn charts, on three occasions in February the person was not repositioned for three or more hours which placed the person at increased risk of skin breakdown.
- A social care professional told us there were a significant number of safeguarding concerns, including seven people who were found by paramedics to be 'pre-hypothermic' (low body temperature), unexplained bruising for two people, one person not receiving their prescribed medicine, one person for whom there was a delay in seeking emergency medical treatment for an acute health condition, people who did not have adequate bedding and an unexpected death reported to police by paramedics.
- A relative told us that social workers had contacted them about concerns their family member was underweight. They said, "I came straight over, I am really worried. I know something serious must have happened over the weekend, but I'm not sure what it is. I know there is enough concern about him that he is being moved tonight, but I don't know what has happened".
- The provider/registered manager and staff had not identified the neglect or abuse people had experienced, and had failed to mitigate the risk of this happening and to report it. All the issues at

inspection had been found by health and social care professionals who came to the home. Therefore, the provider and staff had failed in their duty to safeguard people.

Systems had not been established to ensure people were protected from the risk of abuse or avoidable harm and this placed people at risk of unsafe care and treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing risk, safety monitoring and management; Using medicines safely

- People's risks had not always been identified and assessed to ensure their safety.
- People had their individual risks assessed, such as their mobility, swallowing and medication. Risk assessments considered people's identified risks and the measures required to minimise any harm. However, people's risk assessments were not routinely accurate or current. Staff were not always aware of people's individual risks, or how they should react when they encountered these risks.
- For example, some people were at risk of falls and paperwork provided conflicting information about people's ability to mobilise safely around the home. One person was assessed as being at high risk of falls, however, their care plan stated they were at medium risk. Incorrect guidance was provided to staff on how to manage this person's mobility safely. One person at high risk of falls was seen to be routinely mobilising around the home without staff supervision and their walking aid was broken. Staff had not identified or acted upon this risk.
- Two people were at risk of sustaining pressure damage. Staff had followed the care plan, recorded these people's skin was damaged and raised it with the registered manager. However, no further action had been taken or recorded, and we could not determine whether people's skin concerns had been acted upon.
- One person's care plan stated they required a soft diet and an assessment completed by staff that they could retain food and fluid in their mouth, so were at risk of choking. No formal assessment had been completed or a referral made to a speech and language therapist or dietician for advice. This person's care plan stated their food should be cut into small pieces. At inspection on 17 February 2020, we saw this person was given a whole banana to eat. The next day at mid-morning, this person was given biscuits to eat with their drink. At lunchtime, they were given a plate of meatballs, mashed potato, cabbage and cucumber. This food had not been cut up for them. This placed the person at risk of choking.
- During the inspection, one person had become extremely poorly. Staff assisted this person, however, they did not notify senior staff of what had happened or that there had been concerns with this person's health. The person's condition worsened considerably, and they required an emergency admission to hospital. The person's deteriorating condition was picked up by visiting care professionals and, without their intervention, staff would not have acted in a timely or appropriate way to keep the person safe.
- We were told by care professionals that when they were called in over the weekend, the home was very cold and people were at risk of developing hypothermia. The external professionals organised for blankets to be brought in, as well as radiators, to warm up the home. When inspectors went in, the home was extremely warm. The registered manager said there had been a problem with the central heating, but this had been sorted.
- Medicines were not always managed safely. A social care professional informed us that on the third day of inspection, one person had become extremely anxious and upset and they began to display challenging behaviour. According to their medication administration record (MAR), they had been prescribed with a particular medicine to help calm them when they became agitated or upset. When a visiting healthcare professional went to find this person's prescribed medicine, they discovered there were none in stock. One staff member told us they always tried to avoid administering medicines to people that had been prescribed to calm their behaviour as they did not agree with this practice. This staff member did not have clinical training to make such a judgement.
- On occasion, people had not always received their prescribed medicines. MARs showed gaps where staff

should have signed to confirm when people received their medicines. Some entries were unclear or conflicting. For example, one person had 28 Lorazepam in stock, but the MAR indicated that 19 of the tablets had either been administered or refused by the person. Another person had 9 tablets of the same medicine in stock, but this medicine had not been recorded on the MAR.

● We checked all the MARs for people living at the home, apart from two, which were checked by visiting healthcare professionals. There were many inaccuracies where stocks of medicines did not tally with the MARs signed by care staff. In most cases, stock levels of medicines were too high, indicating that people did not receive their prescribed medicines on occasion, although care staff had signed the MAR to say they did.

Procedures were not robust to ensure people's safety. Medicines were not always administered as prescribed for people. This placed people at significant risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Only senior staff had been trained to administer medicines.

● One person received their medicines covertly, that is, without their knowledge. A best interests decision had been taken and the person's GP had been consulted appropriately. This person had been assessed as lacking capacity in relation to decision-making about taking their medicines.

Staffing and recruitment

● Staffing levels had not been calculated based on people's needs and assessments. There were insufficient staff on duty to ensure people received the care and support they needed in a timely way.

● At the time of inspection, 20 people were living at the home, two of whom were in hospital. For the remaining 18 people, there were three care staff on duty during the day, when the rota had planned for four. An agency care assistant had left the home during the morning shift, stating they did not feel well. They had been due to work until 8pm that day.

● After the inspection, the provider stated that staff ratios were based on the needs of people living at the home and that new staff were in the process of being recruited.

● A team leader told us there would normally be four care staff on duty between 8am and 2pm, then three care staff from 2pm until 8pm. A relative said, "There is a lack of stimulation and staff say that's because you come in the morning, activities are in the afternoon. But when I come after dinner, three staff are in the dining room doing paperwork and the residents are alone in the lounge".

● We observed periods when people were left alone in the communal areas with no staff presence. People who stayed in their rooms were reliant on staff checking on them. A staff member commented, "I think there should be more staff. We have a couple of people who can use their bells, but I just believe if there was more staff we could give people more. I don't have time to do the paperwork. Care staff also do activities. If we had electronic care plans, it would save time and we wouldn't miss important things. I have asked the manager about having more staff, but he doesn't listen".

● We observed that in addition to their caring responsibilities, care staff also tried to organise activities for people and prepare or heat-up the suppertime meal. One staff member said, "At 4.30pm one staff member will be in the kitchen doing the supper and another staff member will be helping [named person] to eat. I also have to give people their medication. There just aren't enough staff".

● One staff member told us, "Night staff get people up early, about 5 to 6am, so that we don't have to get people up, as it's very busy in the morning. Some people like to go to bed by 8pm and some people earlier than that". There were no records to show that this was in line with people's preferences or with their consent.

Sufficient numbers of staff were not deployed to meet people's needs and ensure their safety. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● Systems for the prevention and control of infection were not effective.

● On entering the home, members of the inspection team noticed a strong odour of urine. Visiting health and social care professionals had also remarked on this unpleasant smell whilst visiting the home.

● We asked staff about cleaning at the home. We were told this was undertaken by night staff as part of their duties. Staff told us that the smell of urine was prevalent because of one person who had urinated on the carpet. We were told that the area would be deep-cleaned by night staff, however, the smell was still strong and evident over the three days of inspection.

● The door to the laundry room should have been locked according to a sign on the door. The door was not locked meaning anyone could have accessed potentially hazardous chemicals. We showed this to the registered manager who immediately locked the door. The door was kept locked during the days of inspection.

● Staff had access to personal protective equipment such as disposable aprons and gloves. We observed staff wearing these when providing personal care or serving food.

Learning lessons when things go wrong

● Systems were in place to record specific details and any follow-up action when incidents or accidents occurred. However, despite these being recorded, people were still at risk of harm. The information recorded had not helped staff to prevent a reoccurrence.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At the last inspection, staff did not receive an induction that included training courses with certificates in specific topics such as safeguarding and mental capacity. Staff did not receive all the training they required to carry out their roles and responsibilities. These were areas that required improvement to ensure all staff had the appropriate knowledge and skills.

At this inspection improvements had not been made. Staff did not receive all the training they needed to carry out their roles and responsibilities.

● Staff did not always receive the training they needed to ensure they had the knowledge they required to look after people safely. Staff demonstrated a lack of understanding when asked about their training.
● We asked staff about the training they had completed during their employment at the home. One member of care staff confirmed they had recently completed training on safeguarding. They told us, "Physical abuse is about when you talk to someone badly. If you don't wear gloves, skin on skin is a type of abuse. You must not touch people when you bath them". We asked this staff member what action they would take if they saw a person with bruises. The staff member said, "I would report it to the team leader straight away. She would have to look into it and probably ask all the staff members about the bruising, if they have seen it or do they know about it? The team leader might do a risk assessment or something. Maybe she would talk to the resident as they might have done it themselves, like on the bed rails, people do that all the time". The staff member had an extremely poor understanding of safeguarding, the types of abuse and how they would protect people from harm.
● The same member of staff confirmed they were studying for their National Vocational Qualification in Health and Social Care, Level 2 and for the Care Certificate, both universally recognised, vocational qualifications for staff new to care. When explaining about their training, the staff member told us, "I have been sent a lot of online training to do by the manager, but I haven't done it yet".
● Documentation showed that staff had received an induction and some training. However, feedback from staff and our observations showed that staff were not trained or equipped to carry out their role effectively. For example, some people were assessed as presenting behaviour that may challenge others. Throughout the inspection, we observed occasions when people presented behaviour that needed a specific response from staff to ensure they and others were kept safe and to reduce their anxiety. Several staff did not recognise these behaviours and did not engage with people when it was required. Without the intervention of visiting care professionals, people would have been placed at risk of harm to themselves and to others, as

staff were not adequately trained to effectively manage people's conditions and keep them safe.
● Other staff commented on the training and support they received. One staff member said, "We get online training, but it's not very good. I can only manage because I'm on the ball and have experience of care from before I worked here. I'm expected to carry out tasks and duties that I've never been trained properly for". Another staff member told us, "You get the online training and I've been on a course that I didn't finish. You're pushed by the manager to do training, but we're not given any support from him to learn though". When asked about their induction, a member of staff said, "New staff do the online training and then just have to get on with it. We have to support them. I give out medication, but I've not had my competency checked for as long as I can remember. I did training around care plans, but I've never done anything with it".

Staff did not receive the training they required to enable them to carry out their roles effectively, which placed people at significant risk. Senior care staff did not demonstrate they were competent or suitable to lead or advise other care staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
● People were not supported to ensure they received sufficient to eat and drink.
● A relative said, "I've never seen [named family member] have a drink in his room. He would need prompting to drink, but there is never drink available and he has to drink in the dining room or lounge. There are lots of empty tumblers in his room, so it looks like he has had a drink, but Dad just collects the empty ones from downstairs and takes them to his room".
● People reported to social care professionals that they were hungry and many were dehydrated. People presented as being extremely thirsty and accepted all the drinks that were offered to them.
● On the first day of inspection at 6.15pm, a social worker asked for sandwiches for one person as they had not been given their tea/supper. People who were able to walk to the dining room had been served with their suppertime meal at 5.30pm. At about 6.45pm, as the inspectors walked past this person's room, they saw the sandwiches and a cold drink had been left on the person's lap table. One inspector knelt next to the person and handed them the sandwich to eat. Since the person was blind, they had not realised the sandwiches had been left for them. The sandwiches had been left for some time as the bread had started to dry out.
● At 6.30pm on the first day of inspection, we observed one person sitting in the lounge; they had not been given their suppertime meal. We asked a member of staff why the person had not eaten and were told it was because they were moving to another home. The inspector informed one of the social care professionals who told us they could not establish whether this person had had lunch, as nothing had been recorded and no-one had observed the person having lunch. The person had sat in the same chair all day in the lounge. The social care professional went to find a member of staff to give the person something to eat.
● At 6.40pm, an inspector went to find a member of staff as the person had still not had anything to eat. The manager went upstairs to look for staff and found them upstairs. We were told that the staff member was far too upset to work. At 7.00pm, we observed the same member of staff sitting in the dining room. Another member of staff said they were upset because they had been asked to get a meal for the person who was moving to another home. The person was eventually given something to eat.
● We saw that people were only offered drinks at certain times during the day, for example, with their meal or at mid-morning or mid-afternoon. Drinks were not freely available or accessible. On the second day of inspection, we observed staff from another home nearby were handing out the mid-morning drinks to people in the lounge. As soon as people had received their drinks, these two staff left. We asked the manager about this and they told us they had rung around other homes in the area to see if staff were available to help serve drinks to people during the morning.

Food and fluid monitoring charts were completed daily for each person at the home. The amount of fluid given to a person was recorded, but not the amount they drank. This put people at risk of dehydration as the staff could not accurately monitor how much the person was drinking. For example, fluid records between 6 and 17 February showed that, on average, one person was offered a total of between 800ml and 900ml of fluids each day. A fluid intake of between 1,800 and 1,200ml per day is the average recommended intake. This person was at high risk of dehydration as there was no evidence to show how much they had drank and they were unable to tell us.

People's nutritional and hydrational needs were not met, putting people at risk of malnourishment or dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed some people having their lunch or suppertime meal in the dining room. People appeared to enjoy what was offered to them and they had a choice of what they wanted to eat and drink.

Adapting service, design, decoration to meet people's needs
● The home had not been specifically adapted to meet people's needs.
● Many people at the home were living with dementia. There was little in the way of signage or the use of colour schemes and décor to help people navigate around the home. The numbers on bedroom doors were not in a logical sequence and some bedrooms did not have numbers at all. Social care professionals had stuck pieces of paper on some bedroom doors to help them identify which room was which.
● Bedrooms were basically furnished and some parts of the home were in need of refurbishment or redecoration. In a bathroom on the middle floor, there was no hot water. The original Edwardian sink was badly cracked and the surface on the bath was worn, making it difficult for cleaning to be effective.

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 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 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 asked one staff member whether they had received training on the MCA or DoLS.
● This staff member demonstrated a poor understanding of this topic. They told us, "I think I might have done that, but I'm not sure. It means mental stuff, if people have mental capacity. It's about if people refuse something or they don't want it". When asked about DoLS and why the front door was locked, the staff member said, "Well we need to lock the door because people try and open the door and escape, so we have to lock them in".

Supporting people to live healthier lives, access healthcare services and support
● We did not gather sufficient information to come to a complete judgement on this key question. However, when one person became extremely unwell, district nurses called in the paramedics, because staff had failed to do so.
● There was evidence that a dentist visited the home and that some people had a recent check-up. Some

people had been prescribed with a special fluoride toothpaste.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care was not planned and delivered in line with people's needs or national care standards. This has been explored in further detail in other parts of this report.

Staff working with other agencies to provide consistent, effective, timely care

- Due to the nature of concerns raised before and during the inspection, this key question was not inspected and has not been covered in this report.

Inadequate

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 the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated with dignity and respect.
- We saw one person was wearing hospital issue pyjama bottoms, although they had not been in hospital lately. Staff told us the person preferred to wear these because the legs were wide and more comfortable. The person had a quantity of hospital tops and gowns in their wardrobe and some other ordinary clothes which were screwed up on the bottom shelf. On the second day of inspection, the person was wearing their own clothes.
- A relative told us about their family member. They said, "Every time we come we have to check that he is wearing his glasses. We have to ask staff and they find the wrong ones in the office and give him those. It's always the same. Making sure someone has their own glasses is not much to ask, but they can't even get that right".
- The sheets on one person's bed were old and of poor quality and had worn thin. The blanket had holes in it. The bed linen looked unclean and the person's bed was still unmade at 3pm when we had observed them in the dining room or lounge area all day.
- The same person was seen to wear a clothes protector the entire day, whether they were eating/drinking or not. At 6.50pm we saw the person was in bed, wearing their fleece and the clothes protector.
- People were not always treated well or cared for by staff.
- As a result of incidents that had occurred at the home, and care professionals who were assessing people or undertaking the inspection, staff had become anxious and stressed.
- One senior member of staff kept threatening to walk out. Another member of staff distanced themselves from people and was observed sitting alone. This meant that there were frequent occasions when people were ignored and some basic needs like eating and drinking were neglected.
- One person who stayed in their room all day with their bedroom door open had little engagement with staff. From what we observed, staff went in to provide personal care or food and drinks. No staff member took the time to sit with the person. The person was rubbing their head a lot and chewing their hands, a potential indicator that the person was in distress or discomfort. This had not been recognised by staff or action taken to address the person's potential upset

People were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to express their views and be involved in making decisions about their care

- From our observations at inspection, people were not included in discussions with the provider or care staff or informed about what was happening at the home.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

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

- People did not receive personalised care.
- A relative told us, "It's just task orientated here, it's very sad and upsetting. Dad worked hard and this is how his pension is being spent. The whole place needs a revamp and more staff."".
- Individual person-centred care plans had been developed, designed to enable staff to support people in a personalised way that was specific to their needs and preferences. For example, what they enjoyed doing during the day, about their clothes and personal grooming.
- However, care was not routinely personalised to the person, and we saw several examples of people's preferences not being met. We saw people not being supported to get up when they wished to, and not being provided with their preferences in relation to food and what they did during the day.
- Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together, where possible, by the person, their family and staff. However, care plans were not effectively reviewed, containing contradictory and out of date information. Plans did not provide staff with the required knowledge or understanding of people, their interests and preferences, to enable them to engage effectively and provide meaningful, person-centred care.
- We asked one staff member if they had seen people's care plans. They told us, "You have to read the care plans and sign them when you first start. If you want to go back and read them, you can".

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 living at the home were at risk of social isolation. There was little mental stimulation or activities for people to engage with.
- A staff member told us activities were provided occasionally by external entertainers, but the majority of the time, staff were expected to provide activities for people.
- Staffing levels at the home meant there was little time for staff to organise activities and, when these did occur, there was no evidence how they were planned based on people's interests and choices.
- One staff member told us that people rarely went out into the community, but people could go out into the garden if there was a staff member available to accompany them.

People did not receive personalised care according to their preferences and choices. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Relatives and friends could visit the home any time they wished.

Improving care quality in response to complaints or concerns

● Due to other concerns and issues that took priority at this inspection, we did fully evaluate how complaints were recorded or managed.

● A relative said, "Mum has had a moan, but it falls on deaf ears".

End of life care and support

● Due to other concerns and issues that took priority at this inspection, we did not look at end of life care and support in detail.

● However, the inspection was prompted in part due to an alert raised by paramedics who had visited the home the weekend before the inspection and raised concerns about staff not seeking timely medical attention for people whose health had deteriorated. In addition, paramedics had reported an unexpected death to the police for further investigation. According to the paramedics' account, staff at Kingswood Home had not identified that the person was deceased until the paramedics had examined them.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Due to the nature of concerns raised before and during the inspection, this key question was not inspected and has not been covered in this report.

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 the last inspection this key question was rated as Requires Improvement. At this inspection 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection, systems and arrangements were not always used to monitor and improve the quality and safety of the service. This included care plans being updated following changes to people's needs. Medication audits were not regularly undertaken in line with the provider's policy. There were gaps in staff training. Communication relating to daily handovers was not effective. Cleanliness of the home was not monitored as there were no cleaning schedules or audits.

At this inspection, we found that the provider had continued to fail in their responsibilities for effective oversight and leadership. At this inspection, these failures had a significant impact on the lives and welfare of people living at Kingswood Home.

- The provider undertook a range of quality assurance audits designed to check quality standards. Audits included medicines, care planning and accidents and incidents. Audits were analysed to determine trends and introduce preventative measures. However, these systems of quality assurance had failed to ensure that people received a consistent and good quality service that met their individual needs. The audits had not identified the significant shortfalls found at this inspection and had failed to escalate serious concerns about staff competencies, people's safety and the basic care and welfare of people living at Kingswood Home.
- There were errors and stock concerns in respect to medicines. Care plans did not routinely reflect people's needs and contained errors and omissions and the competency of staff in respect to the care given was not kept under review.
- The provider told us that management oversight in relation to the competency and care delivery of staff and the recording of people's care would be put in place. However, we received no assurance as to how, or who, would implement this practice.
- During the inspection, the provider commissioned the use of a care specialist consultant to develop an action plan to rectify the issues at the home and drive improvement. This action plan proved to be aspirational and could not practically improve the service and care received by people in a reasonable and timely manner. For example, the action plan stated that senior and trained staff would be used on each shift to ensure that staff were supported, and people's needs met. However, these staff had yet to be recruited to work at the home and no plans had been implemented at the time of inspection to provide an adequate interim arrangement.

● The provider had stated that a 'crisis management professional' would be consulted to manage the day to day running of the home and support staff. This proved not to be the case and no arrangement had been made for ongoing quality improvement and senior support to staff. There CQC was not assured that people's immediate safety and welfare would be prioritised and improvements delivered.

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

● People did not receive a high standard of care that was personalised to meet their needs.

● We asked staff about the culture of the service, how they communicated and worked together as a team, and whether they felt supported in their roles. The feedback we received was not good. One member of staff told us, "We support each other because we have to. If we raise any problems with the manager, we are either ignored or told it will be sorted out, but it never is. He just sits in his office". Another member of staff added, "I want to give good care to the residents, but I can't. There's not enough of us and we're expected to do so much, but without the right training and support to do it".

● Further feedback from staff reflected such a level of dissatisfaction with working at the home that we could not be assured appropriate numbers of staff would arrive at work as planned, or that staff would leave the service and not return.

● The culture of a home directly affected the quality of life and safety of people who lived there. The lack of a fully supportive, positive culture and general dissatisfaction of staff had impacted on their ability to deliver a good standard of care.

● After the inspection, the provider stated that all staff were 'very happy and content working at Kingswood Home and that was evidenced in their supervision'. The provider added that in the last survey, staff felt the manager was very supportive.

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

● We talked with the provider/registered manager about the concerns and issues found pre-inspection and on the days inspectors visited the home. We asked the registered manager whether he had told staff what was happening when a range of care professionals came into the home and started completing assessments for people. The registered manager said that social workers had briefed relatives and anyone visiting the home. He added that he had talked about what had occurred at the home over the weekend with day and night staff and that an action plan was, 'in progress'.

● We asked the provider/registered manager what he had said to relatives. He said, "Yes, we had some issues from Saturday and there will be a safeguarding from the weekend. Relatives have asked if their family members were involved and I said 'No'. I will be writing to them about what we are doing and how the issues are to be addressed".

● We talked about staffing with the registered manager. He said he would be at the home and if necessary would get agency staff to come in during the afternoon. We asked who would be working and whether the registered manager could be assured everyone would turn up. He told us that he had a new member of staff who had been appointed as a senior who would start immediately. The registered manager told us, "[Named person] will be a senior member of staff. She is aware of what has happened and is still willing to come".

● We asked the registered manager whether he felt people received good care. He said, "I delegate to the team leader and I oversee things. I make sure they have the support required. Last Saturday I don't know what staff said as the record has been taken by police. There is a team leader on every shift and there was one on Saturday. Now I realise she can't be a team leader anymore; I will review that". The registered manager added that he would bring in new staff and discipline anyone who was not competent. He explained, "I will give it my best shot and I am worried about the residents too. I need to do things as it is my

livelihood. If I need to sack staff I will, through disciplinary procedures. There will be a different type of leadership shown on the floor".

● Although the registered manager had employed the services of a consultant to draw up an action plan in response to concerns and issues found, it was clear he had little understanding of what had occurred at the home and how staffing levels, staff knowledge and training, and poor leadership, had impacted on the care people received. The registered manager's lack of oversight, and his readiness to condemn care staff for the situation, was indicative of a 'blame culture'. The provider/registered manager was reluctant to take responsibility for everything that had happened at the home, despite the fact it was his legal responsibility to do so.

● We asked staff what the provider/registered manager had told them about what had happened at the home in the days leading up to the inspection and why the home was being inspected. One staff member said, "The manager told us it's just procedure. They [care professionals] are doing their checks because one person died and the other is in hospital. I think this is part of the inspection. People are being moved out because they have high support needs." It was clear that the provide/registered manager did not fully appreciate the gravity of concerns that were found by external professionals, emergency services and CQC and therefore was not able to clearly communicate to staff what was happening.

People received inadequate care and were placed at significant risk as the provider had failed to implement effective systems to monitor and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Due to the nature of concerns raised before and during the inspection, these key questions were not inspected and have not been covered in this report.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care according to their preferences and choices.

The enforcement action we took:

Urgent cancellation of provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

Urgent cancellation of provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Procedures were not robust to ensure people's safety. Medicines were not always administered as prescribed for people. This placed people at significant risk of harm.

The enforcement action we took:

Urgent cancellation of provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been established to ensure people were protected from the risk of abuse or avoidable harm and this placed people at risk of unsafe care and treatment.

The enforcement action we took:

Urgent cancellation of provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydrational needs were not met, putting people at risk of malnourishment or dehydration.

The enforcement action we took:

Urgent cancellation of provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People received inadequate care and were placed at significant risk as the provider had failed to implement effective systems to monitor and improve the service.

The enforcement action we took:

Urgent cancellation of provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed to meet people's needs and ensure their safety. Staff did not receive the training they required to enable them to carry out their roles effectively, which placed people at significant risk. Senior care staff did not demonstrate they were competent or suitable to lead or advise other care staff.

The enforcement action we took:

Urgent cancellation of provider's registration.