

Kingsthorpe View Care Home Limited

Kingsthorpe View Care Home

Inspection report

Kingsthorpe View
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Nottingham
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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Kingsthorpe View is a care home providing personal and nursing care for up to 50 people. The service provides support to people living with a mental health diagnoses, dementia, physical disability or sensory impairment. The service accommodated 30 people at the time of our inspection in one adapted building, set out over two floors.

People's experience of using this service and what we found

People living in the service were not safe and were placed at risk of harm. The environment, poor infection control processes, medication management and lack of consideration of fire safety measures at the service put people at risk.

The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. The provider had not ensured that their systems and processes were effective in enabling staff to provide safe and effective care for people. Lessons were not learned, and improvements were not made when things went wrong.

Records relating to people's care did not always contain information and guidance to enable staff to provide the safe care and support people required. Risk management was not in place for some people who were at a high risk of falls and people who may present a risk to others from their behaviour.

Medicines were not managed and administered safely. People's skin management and risk of falls or choking was not effectively managed.

Not all staff received training in areas relevant to people's healthcare needs and completed an induction when they started work at the service. People were left at risk of being supported by insufficient numbers of staff without the skills and knowledge to support their identified needs.

We received mixed feedback from both people and their relatives regarding their opinions of the quality of the care and support they received. We observed positive interactions between staff and people using the service during the inspection.

Relatives and people told us that staff were kind, caring and they liked the staff who supported them.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

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 the service under the previous provider was Requires Improvement, published on 12 January 2022.

Why we inspected

The inspection was prompted in part due to concerns received about poor management of people's end of life care needs, safeguarding, consent, tissue viability and falls management. The decision was made for us to inspect and examine those risks under safe, responsive and well led. We inspected and found there were concerns with multiple areas of the service, so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of caring and effective.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. The provider sent us evidence to show what action they had taken to the concerns we raised with them as part of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kingsthorpe View Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safe care and treatment, staff being deployed to safely meet people's needs, safeguarding, person-centred care, consent to care and how well the service assesses and manages risks and improves the quality and safety of care at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Kingsthorpe View Care Home

Detailed findings

Background to this inspection

The inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

This inspection was carried out by two inspectors.

An Expert by Experience carried out telephone calls to relatives of people using the service to obtain their opinion of the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Kingsthorpe View is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Kingsthorpe View is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the

quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for three months and had submitted an application to register. We are currently assessing this application.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 8 November 2022 and ended on 10 November 2022.

What we did before the inspection

We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We contacted Healthwatch for information they held about the service on their records. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection

We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service. We spoke with 3 people who used the service and 8 relatives of people who use the service. We spoke with the Manager, the Regional Manager, the Compliance Manager, Nurses, senior staff, care staff, the cook and members of the domestic team. We reviewed a range of records. This included relevant parts of 6 people's care records and multiple medicine records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

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

This is the first inspection of this service under the new provider. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks associated with people's health and care needs were not always clearly assessed. This meant staff were not always aware of how to minimise known risks to people or identify incidents which placed people at risk of harm. For example, we saw people who had experienced falls had not been provided with appropriate equipment or guidance for staff to reduce the risk to them.
- The manager advised the inspection team at the beginning of the inspection that, "Risk assessments aren't 100% for everyone." They advised the service was currently updating from paper plans to an electronic system. We found the care plans and risk assessments we reviewed lacked clear guidance for staff on how to support people effectively.
- People were not always supervised. We observed 1 person who required supervision at all times in communal areas due to their risk of falls did not receive this level of support. We discussed staffing of communal areas with a member of staff who told us, "I have concerns about leaving the lounge unattended because 4 people need hoisting on this floor and we only have 2 care staff. So, we are often leaving people alone. We can call the nurse or activities co-ordinator to sit with people, but they are often too busy." This left people at risk of harm.
- Staff did not always follow risk assessments. For example, 1 person required support for their skin management. This person's care plan and risk assessment were incomplete and described the person as requiring repositioning by staff every 3 hours. We saw they had not been regularly moved by staff as required to prevent further damage to their skin. This left the person at risk of harm.
- Risk assessments were not always reviewed or updated. Some people had modified diets recommended by a speech and language therapist (SLT) but associated care plans, risk assessments and dietary notifications had not been updated to reflect the change in need. We saw 1 person had conflicting information about their modified diet recommendations. This increased the risk of people being given the incorrect diet which could increase the risk of choking. We brought this to the attention of the manager, who responded to this following the first day of our inspection. We will review this at our next inspection.
- Risk assessments relating to the environment were not robust enough to mitigate risks for people. They did not include Personal Emergency Evacuation Plans (PEEP's) for use in case of an emergency. Some of the staff we spoke with did not have an understanding of the equipment in the service used to evacuate people in the event of a fire or emergency. One staff member told us, "I don't know how to evacuate people from upstairs at the moment."
- We raised our concerns in relation to fire safety with Nottinghamshire Fire & Rescue Service, who visited on the 14 November 2022 following our inspection. The Manager responded to this immediately during and after our inspection to ensure these concerns were addressed.
- Relatives we spoke with provided positive feedback in regard to the support staff offered to people to keep their loved ones' safe. One relative said, "My relative is safe, they cannot walk so staff transfer them with a

hoist and they use a wheelchair. They have fallen out of bed but the service have lowered the bed and they have a mattress next to the bed in case they fall out again."

Using medicines safely

- Medicines were not administered and disposed of safely. Staff involved in handling medicines had not all received recent competency checks around medicines. This meant people were at risk of not receiving their medication in a safe way.
- The service had recently experienced the failure of the service lift. This meant the member of staff dispensing medication was required to use the stairs to dispense medication to people. Staff did not have sight of the medicine administration record (MAR) at the time of administration for people. This increased the risk of medication errors and was not safe practice. After the inspection, the provider sought alternative medicine dispensation provision for people and ensured the appropriate staff were assessed as competent to support people with their medicines. We will review this at our next inspection.
- Prescribed creams for people were left in communal bathrooms. The labels were not readable and the risk of these being applied to the wrong people or a person ingesting these was high. We asked the manager for these to be removed after the first day of inspection. We checked this had been completed when we returned on day 2.
- Covert medicine management documentation was not always in place for people. We identified that some decisions to administer covert medicines were not in place where people were receiving their medication in this way. Covert medicines are given hidden in food, drink or given through a feeding tube without the knowledge or consent of the person receiving them. The nurse responded to this immediately during and after our inspection to ensure these were processed with the relevant authority.

Preventing and controlling infection

- We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection. The arrangements for reducing the risk for people in regard to cohorting were not robust. The Manager could not describe how this would be implemented for mobile people who live with cognitive impairment.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found areas of the service which were not cleaned to a sufficient standard. Some of the equipment used to support people was not cleaned effectively. Cleaning records were not being audited by the provider to identify these shortfalls.
- We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We found a lack of care planning in place to support robust outbreak management for people.

We found no evidence that people had been harmed however, systems were not effectively established to assess monitor and manage risk; ensure medicines were administered safely and ensure infection prevention and control measures were in place. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection. They confirmed risk assessments were in place, medicines management and staff competency had been reviewed. The provider supplied a service improvement plan they were working on to show how they planned to address concerns in regard to infection control.

- We were assured that the provider was preventing visitors from catching and spreading infections. The

provider was following current Government guidance in relation to infection prevention and control.

- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely. One relative told us, "Yes I see the staff attending to the other people and they always put on aprons and gloves."
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach. This included sharing our findings with the local Infection Prevention and Control Team.

Visiting in care homes

- The service was following current Government guidance in relation to visiting in care homes. All of the relatives we spoke to gave positive feedback about their experience of visiting the service. One relative told us, "The staff were good during COVID-19, the visitors had to gown up and the staff gave me a box of Lateral Flow Tests for when I visited."

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from the risk of abuse. The manager had not investigated incidents to ensure abuse was identified, or measures to reduce risks had been taken. Analysis of incidents to identify themes and trends in relation to falls, tissue viability, palliative care requirements, equipment needs and verbal and physical altercations between people did not take place. This meant people were exposed to the risk of avoidable harm.
- Not all staff had received safeguarding adult's training. This left people at risk of being supported by staff who did not understand how to ensure people were protected from the risk of abuse or harm. At the time of the inspection there were some ongoing safeguarding investigations being conducted by the local authority and the manager was assisting with those enquiries.

The provider had failed to ensure that systems and processes were operated effectively to safeguard people from the risk of abuse. This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider and manager to ensure all staff attended training to protect people from the risk of abuse. The provider responded to this immediately during and after our inspection. We will review this at our next inspection.

Staffing and recruitment

- There were not enough staff deployed across the service to support people safely.
- Staffing levels compromised people's health and safety. A reoccurring concern raised by staff was staffing levels. Nursing and senior care staff in particular had insufficient time to fulfil their duties. They were required to provide direct care, manage the care team, liaise with healthcare professionals onsite, respond to incidents, monitor people's care needs and update associated care records.
- The daily records we reviewed showed evidence of this lack of time available for staff to complete documentation effectively. One staff member told us, "We reposition people but don't have time to record it properly."
- The provider's dependency tool had not fully considered the amount of people who required 2 staff at times to meet their care needs, people who were cared for in bed and how bedrooms were laid out over the 3 units within the building; when calculating staffing levels required.
- We observed during inspection and staff told us, "It is dangerous staffing levels. There just isn't enough of

us to be safe." We witnessed incidents where people were displaying behaviours towards each other, and staff had to intervene. This left other people unattended whilst staff attended these incidents. This left people at risk of harm; as the Manager was not analysing incidents effectively, this risk was not being captured.

- People and their relatives told us staff were kind and caring towards them. Relatives described staff as 'obliging' and 'efficient'. Although one relative told us in relation to staffing levels, "They do the best they can with the amount of staff there."

The provider had failed to ensure people received safe care by deploying sufficient staff to meet their needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

- We found staff had been safely recruited with appropriate references and disclosure and barring service (DBS) checks in place prior to their appointment. This means that the manager could be assured that people were protected from the risk of potential abuse from unsafe staff. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong

- Systems and processes to review incidents and analyse these to reduce further re-occurrence was ineffective, this meant the service did not learn from events and take action to improve safety. For example, there was no evidence of analysis of falls or incidents between people using the service to reduce further harm.

This lack of learning meant people were at risk of avoidable harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

We found the service was not working within the principles of the MCA and if needed, appropriate legal authorisations were not in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were not being met.' We have reported on this further under the Effective section of this report.

- For example, there were no risk assessments for one person's cognition. This person lived with a range of conditions which had not been recently reviewed or assessed. Their care plan contained no Mental Capacity Assessment (MCA) assessments, to describe this person being resistant to personal care. There were descriptions of this person being 'aggressive' and 'naughty', both of which are inappropriate terms to describe a person. There was no clear risk assessment or positive behavioural support plan for staff to follow to support this person. The service had not considered the use of Antecedent, Behaviour and Consequence charts for people who have mental health needs. These are used to record and analyse the behaviours that

people are communicating in order to provide appropriate risk management and support for them.

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.

This is the first inspection of this service under the new provider. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's care plans lacked detail for staff to follow and were not reflective of people's current level of need. This left people at risk of harm by not being provided with the appropriate level of support required.
- Care plans lacked review and had not been updated when people's needs had changed, or a significant event had occurred. For example, where people had experienced falls, we found their risk assessments had not been updated following an incident. This meant staff did not always have up to date information about a person's needs.
- One staff member told us in relation to providing quality care, "There's always another task to do, like lunch, then change someone, then respond to a behaviour. We are chasing round, and records don't get done. We don't have time to just chat to people or hold their hands; because there is another task to do."

Staff support: induction, training, skills and experience

- Supervisions had not been completed regularly with staff. Supervision provides staff members with an opportunity to reflect and learn from their practice, check competence and identify training needs. The supervisions had not identified gaps in staff knowledge or improvements required to staff practice. For example; supervisions did not highlight staff were not repositioning people in line with care plans or that staff lacked understanding of the fire evacuation process in the service. This meant opportunities for staff to develop and improve were missed.
- Not all staff were trained. We viewed records which demonstrated core training such as, tissue viability, equality and diversity and safeguarding had not been completed by all staff. Specific health training on diabetes and supporting distressed behaviours had not been completed by all staff despite the service providing care and support to people living with those needs. This left people at risk of being supported by staff without the skills to meet their needs effectively.

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

- Daily records of people's food and fluid intake were poorly documented. We reviewed records and found there was not sufficient information recorded to allow staff to monitor people who required monitoring for food and fluid intake or risk of skin damage. Staff told us the confusion of recording information on several differing documents was challenging. One staff member said, "Records are repetitive, like recording drinks in three different places. It takes so much time up." This meant there was a risk people could be exposed to harm and deteriorating health.
- People's weights were monitored. Staff looked for indicators of weight loss and actions were taken where there were concerns identified about people's weight. For example, timely referrals to the GP or Dietician

were made. Information around weight loss however; was not used to inform people's care in other areas, for example skin management. We found a person's weight was not reflected in mattress settings which would ensure risks to people's skin deteriorating was safely monitored. We shared this with the provider who responded to this immediately during and after our inspection. We will review this at our next inspection.

- We observed a positive dining experience on both days of inspection. People who required support with their meals were supported in a caring and dignified way by staff.

Adapting service, design, decoration to meet people's needs

- The service had not considered a design to help people who lacked capacity to orientate. The signage for specific areas of the service which the provider was developing was not in place, so this did not link up with the details in care plans for people. For example, people were described as living in 'St Ann's Valley' but there was no signage to describe where this was within the building.
- People lacked regular access to the outdoor space. The garden was notably unsuitable for people with mobility needs. The driveway up to the service was dark and overgrown, and staff told us they were anxious when walking home at night. One relative told us, "The lighting in the car park and the lane leading to the home is unlit and could be dangerous. The staff mentioned it's been like this for a couple of years. But the provider is looking at quotes for getting this fixed." This meant people could not freely access the garden independently.
- People had chosen how their personal space was furnished. For example we saw bedrooms were decorated in a way that people chose with their own personal items in place to personalise their space.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

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

- MCA assessments were not always completed. We found some people who appeared to have issues with their capacity to make certain decisions, did not have appropriately completed assessments in place. This meant we were not always assured people were not having their liberty unlawfully deprived.
- Best Interests decisions were not always completed. Best Interest decisions are made for and on behalf of a person who lacks capacity to make their own decision. We found 1 person who lacked capacity to consent to wound care management did not have a best interest decision in place to manage how their care was delivered. This placed the person at risk of infection, skin breakdown and falls as they would not wear footwear around the service.

The provider had failed to ensure care and treatment was provided with the consent of the relevant person.

This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

We recommended the provider completed MCA assessments and best interest decisions to ensure decisions are made that do not deprive a person's liberty unlawfully.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Staff worked closely with other professionals who were involved with people's care. For example, social workers, occupational therapists, speech and language therapists were involved in peoples' care to maintain good health. However, we found evidence people had not always been promptly referred to other professionals when their needs had changed, and they required equipment or review of their mental health.
- Relatives felt staff worked well with health care professionals. Most relatives told us staff worked with local health teams to ensure their loved ones received appropriate support. One relative told us, "Yes [Name] had the chiropodist recently and staff communicate well with other health teams."

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.

This is the first inspection of this service under the new provider. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- There were no regular surveys or meetings carried out to engage people and their relatives in understanding their views in shaping the future of the service.
- Staff responded in a compassionate and appropriate way when people were exhibiting emotional distress. We were concerned the lack of robust recording of these events left people at risk.
- One staff member, who we observed calmly preventing an incident between 2 people which was at risk of escalating in the dining room told us, "We have a real challenge at this time of day, people tend to have a dip after tea and there are not enough staff to support people properly. It also depends who is on shift and what their skills are."
- People and their relatives were not always involved in planning their care. We found some people had moved bedrooms due to the lift being out of order, but there was a lack of documentation in place to reflect the discussions or decisions that had been made in relation to this. We were not assured people and their relatives had been consulted before decisions to move them had been made.

Respecting and promoting people's privacy, dignity and independence

- Information was not always kept securely. We found a large open box of personal files which were due to be archived kept in an office. There was a folder of a person who was deceased that was found in the cabinet along with the care plans of current service users. This information was accessible by other people living at and visiting the service.
- Staff were aware of people's right to privacy. We observed staff knocking on bedroom doors prior to entering and addressing people by their preferred name.
- People's relatives told us they were made to feel welcome and able to visit under the current Government Covid-19 visiting guidelines.

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

- People were supported by staff who knew them well and understood their individual support needs and routines.
- People and relatives spoke highly of the caring nature and kindness of the staff. One relative told us, "Staff are nice, kind and caring and they look after [person's name] well."
- One relative told us, although there were often 'different faces' among the staff team, "They know and understand [person's name] condition. I feel they [Staff] are always attentive. They are caring and compassionate."
- We observed staff speaking with people kindly. Staff we spoke with understood people and their needs,

although they felt the documentation could be improved to support them with this. One member of staff told us, "Records are repetitive, like recording peoples' drink intake in 3 different places. It takes so much time up."

Is the service responsive?

Our findings

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

This is the first inspection of this service under the new provider. This key question has been rated Requires Improvement. This meant people's needs were not always met.

End of life care and support

- Care plans were in place for end of life care and included details on funeral arrangements. However, some care plans did not contain detailed information about how to support people as they wished at the end of their lives. Advanced decisions were not clearly documented for people. This meant staff did not have all relevant information to ensure people's last wishes were upheld.
- Relatives we spoke with told us they had not been involved in discussions around end of life care planning with their relatives.
- Not all staff were aware of people's Do Not Attempt Resuscitation (DNAR) decisions. The service had marked people's bedroom doors with a butterfly to indicate if people had a DNAR decision in place. Not all of the staff we spoke to however understood the meaning of these signs. The service did not have this information updated correctly for emergency services to access. This left people at risk of receiving inappropriate intervention.
- Not all staff had received recent training on death, dying and bereavement. This left people at risk of being supported by staff without the correct skills and knowledge.

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

- People did not always receive person-centred care. For example, the service had moved people into different rooms temporarily due to the lift being out of order. This was not documented within their care plans. We could not be assured that people's preferences had been fully considered.
- People and their relatives had not been involved in reviews of their care. We saw care plans and decisions for people which required updating and review. This left people at risk of harm.
- People's care plans included their personal history, individual preferences and interests. We saw examples of people being offered a choice of food and drinks. Staff we spoke with understood people well and knew how to support people at mealtimes in their preferred way.

Meeting people's communication needs

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

- People's communication needs were not always considered. We did not find evidence that people were supported to tell staff about their wishes and views; care plans lacked information about how people

communicated.

- The manager struggled to explain their responsibility to follow the AIS. We did not find the service had accessed information in different formats to meet individual needs. For example, easy read, large print or another language.
- One person using the service did not have English as a first language, and some staff greeted them in their own language. We saw this information was poorly documented in their care plan. The Manager had not attempted to learn any of these words to enable them to communicate effectively with this person.

The provider had failed to ensure people received care that was appropriate, met their needs and reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

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

- Activities were not readily available. People, relatives and staff told us there were not enough activities offered to engage people in an active life at Kingsthorpe View. Of the relatives we spoke with, few reported that their relatives were involved in the activities.
- One person told us they had attended a Jubilee party, played dominoes, bingo and did baking. However, there was no evidence of people visiting the community or of community groups coming into the service. One relative told us, "I am not sure why people do not go out on trips or into the community."
- The service employed an activities coordinator who supported people to take part in activities. This staff member was observed to be working with small groups of people in the downstairs lounge. We found the activity board with information on what was available was not up to date for people.

Improving care quality in response to complaints or concerns

- Complaints and concerns were not always responded to. We received a mixed response from people and relatives regarding the response to concerns they had raised. One relative had raised a concern about their loved one who had experienced falls and a medicine error which had not been addressed. We shared this with the Local Authority Safeguarding Team.
- Other people told us they would be confident raising concerns with the nurse in charge, or the manager if anything arose. One relative told us, "They are straight onto it if there are any issues."

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.

This is the first inspection of this service under the new provider. This key question has been rated 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Governance in the service was not always reliable and effective. Audits had not identified or addressed some of the issues we found during inspection. For example, fire safety, infection prevention and control, falls management and staff training.
- The provider had failed to meet their responsibility to report all significant events to CQC in a timely manner. At this inspection, we reviewed incidents which CQC had not been informed about; for example, when 1 person had been injured following a fall. It is important that CQC has a clear overview of all incidents at the service, so they can check the provider has taken appropriate action. We discussed these with the provider and manager in correspondence prior to the inspection and requested CQC were notified of the incidents. We will monitor the quality of the information received in statutory notifications and review this at our next inspection.
- Systems and processes to assess and monitor the service were not always effective. For example, there was no effective system in place to ensure the repositioning of people or the use of equipment to reduce the risk of falls was taking place.
- The manager lacked a clear oversight on what was happening in the service. We spoke to the manager about the provider's service improvement plan. This document detailed what actions the provider and manager had identified to make improvements to the service. We discussed which actions had been addressed; with the exception of some people's care and support plans which had been updated onto the electronic system, we found other areas of required action had not been addressed.
- The systems and processes to monitor quality and safety were not fully effective in protecting people from the potential risk of harm. The provider had not identified all the shortfalls in the expected care standards found during this inspection.
- Staff deployment had not been effectively assessed and planned for. This meant people were not sufficiently and continually cared for safely. This exposed people to the risk of harm.
- Audits and checks on health and safety and the environment were not effective. Audits completed had failed to identify poor standards of hygiene and cleanliness, which exposed people to increased risk. A communal bathroom was found to have chipped woodwork and contain soiled manual handling equipment. These issues had not been identified in audits and consequently they had not been addressed.

Continuous learning and improving care

- The manager had not analysed the call bell system to ensure people were protected from the risk of

further harm. The manager advised 'Staff normally attend quickly.' This left people at risk of harm. The manager agreed this was difficult to assess the effectiveness without automated system analysis. The manager was unable to tell the inspection team if there was a set time for staff to respond to people in the provider policy.

Working in partnership with others

- The provider had not made timely referrals for people or worked closely with other professionals to achieve the best outcomes for people. We found people had not been promptly referred when a change in their health or social care needs had been identified. For example, in regard to skin breakdown, choking risks, falls management equipment or mental health support.

Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The previous registered manager had recently left. The nominated individual was providing support until the newly recruited manager was registered with the Care Quality Commission. A registered manager is a person who has 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.

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

- We saw from records, and most relatives told us, that the manager had responded to previous complaints appropriately. All of the relatives we spoke with felt the changes in management had impacted on the quality of information they received from the service and they would benefit from more regular meetings. One relative told us, "I did not know they had them." Whilst another relative did say, "We had a meeting about [Name's] health recently."
- Staff told us they knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to, or their concerns had not been acted upon.

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 saw that the manager had understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.
- The majority of relatives told us the service were forthcoming in relation to requests for information or updating them on changes with their family members.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had failed to ensure people received care that was appropriate, met their needs and reflected their preferences.

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
Treatment of disease, disorder or injury	The provider had failed to ensure that systems and processes were operated effectively to safeguard people from the risk of abuse.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had failed to ensure care and treatment was provided with the consent of the relevant person.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems were not effectively established to assess monitor and manage risk; ensure medicines were administered safely and ensure infection prevention and control measures were in place. This placed people at risk of harm.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems in place to assess, monitor and improve the quality of the service were not used effectively to ensure the health, safety and welfare of people using the service.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had failed to ensure people received safe care by deploying sufficient staff to meet their needs.

The enforcement action we took:

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