Kingsway (Clayton House)

Kingsway Clayton House Residential Care Home

Inspection report

Clayton House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Kingsway Clayton House Residential Care home is a residential care home providing personal and nursing care. At the time of the inspection ten people with learning difficulties and autism were being supported at the service. The service can support up to 16 people.

People's experience of using this service and what we found
The systems and processes in place did not always protect people from the risk of abuse. Risks to people's safety were not always well managed.

Lessons from incidents and events had not been learnt to mitigate ongoing risk. Staff recruitment processes were not robust.

There was a lack of formal oversight from the provider and quality monitoring processes were either not in place or were not effective in identifying risks or improving care.

There was a lack of reporting events and this had resulted in poor practices developing among staff leading to punitive approaches to people's behaviours.

There were enough staff to support people, medicines were managed safely, and infection and prevention practices were in place.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture.

Due to the lack of oversight and learning from events there had been a development of a closed culture at the service. Following our inspection, the registered manager took steps to address the areas of concern we raised to them.

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

Rating at last inspection
The last rating for this service was Good (published 20 December 2019).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding concerns. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

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

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, management of risk, staffing and governance of the service at this inspection.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Kingsway Clayton House Residential 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 Care Act 2014.

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 three inspectors. Two inspectors carried out a site visit and a third inspector spoke with relatives and staff by telephone and reviewed documentation off site.

Kingsway Clayton 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 service had a manager registered with the Care Quality Commission. This means that they and the provider 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 unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four members of staff including the registered manager, senior care workers, and care workers. We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two 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 registered manager to validate evidence found. We looked at training data and quality assurance records. We spoke with five relatives and four members of staff by telephone.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse. The systems and processes in place to manage people's finances were not robust. The provider's policy for managing people's finances was not being followed and this left people open to financial abuse.
- Peoples behaviours were not always managed in the least restrictive way. On occasion physical restraint was used when a less restrictive approach could have been used.
- Staff told us they had been supported with safeguarding training. However, entries in people's care records showed there were times when punitive approaches to people's behaviour were used unnecessarily. For example, locking people out of their rooms. These incidents had not been reported to the local authority safeguarding adult's team for investigation and no internal investigations had been undertaken.
- Sufficient action had not been taken to safeguard people from staff who may pose a risk to them. The registered manager had failed to effectively assess and mitigate risks posed by a staff member. This failure meant people were exposed to the risk of financial abuse.

Failure to protect people from abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the person acting for the provider took steps to address these concerns. They ensured the policy for managing people's finances was reviewed, reinstated and all staff were aware of their responsibilities when managing people's finances.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The risks to people's safety were not always well managed. Staff and the registered manager did not have a clear understanding of what constituted an incident and consequently incidents were not properly recorded or reviewed and there was no evidence of learning from them.
- One person who had a risk assessment in place for falls had sustained bruising to their foot, staff had recorded the person stated they had fallen down the last few stairs of a staircase at the service. This was not documented on an accident or incident form and their risk assessment had not been updated following this incident to mitigate risks associated with stairs.
- People were not consistently protected from risks associated with their health needs. Two people had a long term potentially serious health condition. There were no care plans or risk assessments in place in relation to this serious condition. These people had known behaviour patterns that could impact on this health condition. Their care plans and risk assessments had no information or guidance in place in relation to these behaviours or what staff should do to reduce or respond to these behaviours.

The failure to review and learn from incidents exposes people to the risk of reoccurrence and consequent of harm. This was a breach of Regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People were supported by sufficient numbers of staff. People's relatives told us they felt there was enough staff to support their family members and people were able to go out into the community when they wished.

● Safe recruitment practices were not always in place. The registered manager had not ensured that all staff disclosed their reason for leaving previous positions and some references were incomplete. This meant we were not assured people were protected from the risk of being supported by unsuitable staff.

Using medicines safely

● Medicines administration was safe. People had clear information in the medicines administration records (MARs). When people needed medicines to be given at a particular time these were given. As required medicines had guidance in place for staff so people were given these medicines when needed. Medicines were stored safely.

● The registered manager and her team undertook regular audits of medicines to ensure any concerns or errors were identified and addressed.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 Good. At this inspection this key question has now 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.

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

- There was not always an empowering person-centred positive culture at the service. A punitive approach to managing people's behaviours had been allowed to develop at the service. There were times when staff withheld items or activities to control people's behaviours. For example, one person was told they could not watch a favourite television programme if they did not modify their behaviours.
- Further examples of demeaning and derogatory treatment to people included staff not allowing a person access to their own bedroom unless they disclosed information of the whereabouts of an object. Furthermore, a person was subjected to their personal belongings being taken away from them unless they gave staff information.
- All of the aforementioned events meant people were at high risk of abuse which could have had a negative impact upon their safety and wellbeing. This indicated a culture of staff having power over service users. These practices had been allowed to develop due to the registered manager failing to monitor and manage staff practices.

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

- There was a lack of governance at the service from both provider and registered manager level. The home was being run by the registered manager. There was an absence of any formal provider level leadership and governance to ensure the safety of people at the service. There were no formal systems in place to quality assure the safety and quality of the care people received.
- Risks to the health and safety of people had not been identified or addressed. They were not protected from financial abuse, safeguarding and safety incidents had not been responded to appropriately and there were indicators of a closed culture where staff had power over people. These issues had not been identified or addressed prior to our inspection.
- There were no effective audits of the management of people's finances, consequently, issues which exposed people to financial abuse had not been identified or addressed prior to our inspection. The provider's finance policy had not been followed. Specifically, transactions had not been witnessed by two staff and receipts of expenditure had not been kept. This failure to follow policy exposed people to the risk of financial abuse.
- There was a lack of systems to review and learn from adverse incidents, including behaviours. There was no system in place to identify and record incidents. This led to the registered manager not always being made aware of safeguarding incidents and poor practice. Trends had not been identified and addressed.

This lack of oversight had negatively impacted on people's care as staff practices had not been monitored and there had been no learning from events.

● There was no written contingency plan in place to show how the service would be managed in the event of the absence of the registered manager. Given the absence of any formal oversight from the registered provider, it was of serious concern this issue had not been considered to protect people living at the service.

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

● Although relatives told us the registered manager was open and honest with them around events at the service. There had been a lack of recognition of events which should have been reported to CQC. The records we viewed had entries showing people's behaviours and staff's reactions to them. The incidents should have been reported to us via the statutory notification process and this had not been recognised by the registered manager. This lack of understanding had led to a development of a closed culture that affected the way people were supported.

● We found concerns regarding the restrictive practices used in the service and evidence demonstrated these were used in a demeaning way. This has not been identified in any audits so consequently not addressed. Deprivation of Liberty Safeguards (DoLS) had not been applied for in relation to any of the restrictions and the registered manager did not demonstrate a good understanding of the Mental Capacity Act (MCA) or the process of applying for DoLS.

● The provider had failed to monitor the performance of the registered manager. This was evidenced by the failings we found at the inspection not having been identified prior to our visit. This failure of oversight and governance created additional risks to the safety and effectiveness of service provision.

The above issues are 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

● There was a lack of support and supervision for the registered manager. They had not received any formal supervision from the provider since prior to the COVID-19 pandemic. Staff told us they had regular supervisions and felt supported by the registered manager.

● Relatives and staff told us there were regular meetings with people at the service to gain their opinions of the different activities they would like to undertake. Staff ensured people could access the community to undertake activities of their choice. One member of staff told us since the COVID-19 restrictions had been lifted people were able to go out into the community more. They gave examples of the different activities people had enjoyed such as shopping or going to hairdressers.

Working in partnership with others

● Staff worked with health professionals to ensure people's health needs were well managed. People were supported to attend healthcare appointments should they require these.