El Shaddai Homes Limited

Kingsway Care Home

Inspection report

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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:
Kingsway Care Home provides accommodation for up to eleven people who need help with their personal care. The home supports people who live with a learning disability and other complex support needs. At the time of the inspection eleven people lived in the home. The home has a combined communal lounge and dining area, a second quiet lounge for people to share and a back garden for people to enjoy.

People's experience of using this service:
The overall rating for this service is 'inadequate' so therefore the service is in special measures. This was because the service was found to be in breach of Regulations 9, 11, 12, 17 and 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no adequate or effective systems and processes in place to monitor the quality and safety of the service. This resulted in people being exposed to ongoing risks with regards to their care.

The provider's fire safety arrangements were unsafe. There was no evidence that any staff had practiced how to evacuate people from the home in an emergency for over two years. People who lived in the home also did not have personal emergency evacuation plans in place. This meant should an emergency arise, emergency personnel would not have important information about people's needs and support requirements in an emergency situation.

People's needs and risks were not properly assessed or managed. Where people had health conditions, their care plans did not always contain sufficient information about these conditions and the support they required.

Records showed that the support some people received was inconsistent and unreliable. People's care was not personalised to their needs as staff lacked adequate information on what these were in order for them to do so.

People's support was not always appropriate. CCTV was used to monitor people's movements in communal areas without their consent and the language used in some care records was not very respectful.

Where people's capacity to consent to decisions about their care was in question, the provider had not always followed the Mental Capacity Act 2005 to ensure that any decisions made on people's behalf were legally consented to and in the people's best interests.

The management of medication was not safe and the manager failed to demonstrate that they understood safe medication practices within the home.

The provider's complaints procedure did not meet the Accessible information standard and did not provide relevant information to people on how to complain to in the most suitable way for them to understand.

There was little evidence that information about the service such as accident and incident information, safeguarding and resident meetings were used to learn from and improve the service.

Information in respect of people's eating and drink needs was limited and the preparation of one person's special diet did not follow recommended advice. People told us they were happy at the home and said they got enough to eat and drink. During our inspection, we saw that staff members treated people kindly and with respect.

People had the support of other health and social care professionals. For example, dentists, opticians, GP's as well as specialist medication teams for any medical conditions.

Staff told us they felt supported by the manager and records showed staff received supervision in their job role. Staff received training and training was up to date.

Regular meetings took place with people who lived at the home and their views and opinions on the activities they would like to become involved in sought. We saw that people enjoyed a range of social and recreational activities. For example, knitting, horse riding, barbecues and college.

The atmosphere at the home was warm and homely.

You can see what action we told the provider to take at the back of the full version of the report.

Rating at last inspection and why we inspected: This was the first inspection of the service since it registered as a regulated provider with CQC as El Shaddai Limited. It was previously registered under a different name.

Follow up: Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

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

Kingsway Care Home

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: This inspection was undertaken by two adult social care inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Service and service type: Kingsway Care Home is a care home. People in care homes receive accommodation and personal care. 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. The registered manager was also the registered provider who is 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:

- We reviewed information we had received about the service since the service was registered. We also contacted the local authority for their feedback. We used all this information to plan our inspection.
- We talked with seven people who lived at the home and a relative about the service.
- We spoke with the registered manager (who was also the provider), the deputy manager and two care staff.
- We looked at four people's care records and a sample of medication records.
- We viewed three staff recruitment files and other records relating to staff support and the management of the service.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

- The fire safety arrangements in the home were not safe. The provider's fire risk assessment was dated 2017. There was no evidence it had been reviewed since this date. There was no evidence to show that staff had practiced how to evacuate people from the home in an emergency since 2016.
- People did not have personal evacuation plans (PEEPs) in place. PEEPs provide emergency service personnel with information about a person's needs and risks during an emergency. This helps them identify those most at risk and the best method to secure their safe evacuation.
- People's needs and risks had not been properly assessed or described and staff had little guidance on how to support people appropriately and keep them safe. This placed people at risk of unsafe care and treatment.
- For example, one person lived with a medical condition that required specific monitoring. Despite this, staff had limited guidance on what support the person required or the action to take in the event of ill-health. The person's records showed that their support was inconsistent and unreliable which placed the person at risk of physical harm.
- Another person lived with a medical condition that placed them at serious risk of harm. Despite this staff had little information on this condition or the action to take mitigate the immediate risks to their health, safety and welfare when they became unwell.
- One person needed a special diet as they had difficulty swallowing. This meant they were at risk of choking or aspiration pneumonia. Aspiration is when food or drink passes into the lungs instead of the stomach. It can cause chest infection type symptoms. Despite this staff had no information on the level or risk or the action to take should a choking or aspiration incident occur.

Using medicines safely

- Medication management was unsafe. Accurate and complete records had not been maintained with regards to people's medicines. This meant it was difficult to determine if people's medicines were given safely and if they had received the medication they needed to keep them well.
- People had 'PRN' plans in place for 'as and when' required medications such as painkillers or anxiety medication. We found that these PRN plans were poorly detailed and in some instances were incorrect.
- For example, one person had a PRN plan in place for the wrong pain relief medication. Another person's PRN plan incorrectly advised staff to give double the dose of medication that had been prescribed for them in any 24 hour period. This placed the person at the risk of unwanted side effects.
- Some people's care files indicated that they had a medication allergy. We found their medication administration records had not been updated with this information. This meant there was a risk that the person would be prescribed a medication unsuitable or unsafe for them to take by the pharmacy.

Learning lessons when things go wrong

● Accident and incidents were documented with the action taken by staff to support the person's wellbeing at the time the accident or incident occurred.

● There was little evidence to show that the manager had reviewed the accident and incident records or that this information was used in any meaningful way to learn from how accident and incidents occurred so that preventative action could be taken.

The above evidence demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's care was not always safe.

Staffing and recruitment

● Staffing levels had not been determined based upon an assessment of people's needs. Night time staffing levels were insufficient to meet people's needs and keep them safe.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the number of staff on duty was not sufficient at all times.

● Overall people and the relative we spoke with felt there were enough staff on duty during the day.

● One relative said "Mostly there are enough staff, though sometimes I'm sure there could be more, for example when they're a driver short and an activity is cancelled for some of the residents".

● Pre-employment checks were carried out prior to employment to ensure staff members were safe and suitable to work with vulnerable people. For example, a criminal conviction check, previous employer references and proof of identification were all sought prior to employment.

Systems and processes to safeguard people from the risk of abuse

● Staff had received safeguarding training. This meant they had received training in how to identify and respond to incidents of potential abuse.

● Staff members spoken with were knowledgeable about types of abuse, They knew what action to take to protect people from the risk of abuse.

Preventing and controlling infection

● We looked around the home and saw that it was clean and tidy. Standards of infection control were satisfactory.

● Staff had received training in infection control and had access to personal and protective equipment such as disposable gloves when providing personal care.

● There were arrangements in place to monitor the risk of Legionella bacteria developing in the home's water system.

Requires Improvement

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that this legislation had not been followed to protect people's legal right to consent to their care.

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

- Deprivation liberty safeguards (DoLS) had been put into place for some people without a mental capacity assessment being undertaken by the manager or provider to determine if this was legally justified.
- There was also little evidence that the manager had discussed the DoLS arrangements to be put in place with the person and other relevant persons place to ensure these safeguards were in the person's best interests.
- One person's DoLS had expired and had not been renewed. The manager confirmed that the person was unsafe to go out into the community on their own and would be prevented from doing so by staff for their own safety. Despite this, the manager had not taken any action to ensure the person's DoLs was renewed in accordance with the MCA to ensure any deprivation of this person's liberty was legal.
- CCTV was used in communal areas in the home without people's consent being obtained in accordance with the MCA. There was no evidence that people had been consulted with about its use or that they were aware that they were being recorded.

This demonstrates a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's consent was not always legally obtained.

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

- Staff had limited information on people's choices and needs. It was difficult to tell how staff were delivering care in line with standards, guidance and the law without this information.

Staff support: induction, training, skills and experience

● Staff had received an induction into their job role when they first started working at the home and training to do their job.

● Staff training included medication administration, health & safety, safeguarding, moving and handling, fire safety, food hygiene, infection control as well as specialist topics such as diabetes and epilepsy awareness. This training was sufficient.

● Staff had access to supervision with their line manager and told us that they felt supported in their job role.

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

● People did not have adequate eating and drinking plans in place to advise staff of their needs and risks. Some people who lived at the home required a special diet. Information about people's special requirements was not always clear or sufficient.

● For example, one person had a medical condition that meant that they had to limit their intake of sugar and carbohydrates. There was no adequate guidance on what this meant in terms of their day to day diet or how staff were to ensure these dietary requirements were met.

● Another person was assessed by the speech and language therapy team (SALT). The SALT team had given staff advice on how to prepare this person's meals so that they looked and tasted appetising. On the day of the inspection we saw that their meal was not prepared in accordance with this advice. This was not good practice.

● People told us they had a choice of what to eat and drink and that the food was good. One person said "The food is nice" and another told us "I love the dinners here".

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

● The building was suitable for the people who lived there. There were eleven single occupancy bedrooms and suitable communal space for people to share.

● The back garden was well maintained with summer houses for people to relax in and a small spa/Jacuzzi bath in another. A person we spoke with said "We've got a summer house and we have a party when it's our birthday".

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

●We saw that people had support from a range of professionals in support of their needs. For example, local GPs, dentists, opticians, district nurse as well as specialist teams such as neurology, dieticians and speech and language therapists.

● A relative we spoke with said 'If they [the person] are poorly they call the doctor. They went onto say "When they [the person] has appointments at the doctors or hospital a carer goes with them which helps me to feel their safe in their care".

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.
People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

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

- CCTV was used in the home in communal areas. CCTV should only be used where there is an identified and justifiable need to do so. This should be appropriately assessed and documented. There was no evidence that this had been done.
- Most uses of CCTV are covered by the Data Protection Act (DPA). The DPA sets rules which CCTV operators must follow when they gather, store and release CCTV images of individuals. The Information Commissioner's Office (ICO) must also be notified when CCTV is used.
- There was no evidence that the ICO had been notified or that the DPA had been considered with regards to its use. We spoke with the manager about this and advised them of their duty to do so.
- Some of the language used in people's care files was not always appropriate. For example one person's daily routines referred to "[Name of person} feeding needs" as opposed to referring to the support the person needed to eat and drink. The use of the term 'feeding' de-personalised the person.
- One person's care review records referred to them as "playing up". This type of language was not very respectful. Furthermore it did not show that staff members had tried to understand what the person was trying communicating by their actions so that support could be adapted accordingly.
- People's daily records did not demonstrate that people received the care they needed to keep them safe and well at all times. This did not show that the service cared that people were well treated and supported.
- We saw that staff members were kind and caring in all of their interactions with people. One person told us 'The staff are wonderful, they look after me really well' and another said 'I love living here".

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

- Service user meetings took place to enable people to express their views on the service.
- The meetings focused primarily on asking people about the activities they would like to do and whether they were happy with the service. The minutes showed people were happy 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

People's needs were not always met. Regulations may or may not have been met.

Improving care quality in response to complaints or concerns

- The provider's complaints procedure was displayed in the entrance area of the home. It was displayed above eye level and was in small print. It did not comply with the Accessible Information Standard.
- The Accessible Information Standard is a legal requirement. It outlines what services must do to ensure that information is shared in a range of different formats to meet the diverse communication needs of people using services who live with a disability, impairment or sensory loss.
- The procedure did not provide the names and address for the manager or proprietor to whom complaints should be addressed. This meant there was a risk that people would not know who to send their complaint to in the first instance.
- CQC was referred to as the authority for people to send their unresolved complaints to. This was incorrect. CQC do not hold any statutory powers to investigate people's complaints.
- Organisations responsible for investigating complaints about adult social care services include the Local Authority complaints department and/or the Local Government Ombudsman. Details of these organisations, were not provided.
- The complaints procedure displayed therefore did not provide people living at the home with relevant information about how to make a complaint in the most suitable way for them to understand.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager told us no formal complaints had been received since the last inspection.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- People care plans did not contain sufficient information about their needs, risks and preferences to enable staff to provide, safe, effective and responsive care.
- Information about people's mobility, nutrition, personal hygiene, finances and communication was poor.
- Where people had specific health conditions, there was a lack of adequate information on what these conditions were and what they meant for the person in terms of their health, wellbeing and day to day living.

- The support people needed was not clearly identified. This meant staff lacked guidance on how to meet people's needs in a person centred way.
- Generic statements such as "Support [Name of person] to maintain a safe environment in compliance with health and safety procedures" and "Staff will give [Name of person} full support with all aspects" in people's care plans did not advise staff on the person's individual requirements.

● For example, one person's care plan indicated that they were at risk of pressure sores developing. Despite this there was no risk management or care plan in place to advise staff what support the person required to prevent a pressure sore from occurring.
● There were no advanced care plans in any of the care files plans we looked at to evidence that people's end of life choices had been discussed with them and planned for in relation to their future care.
●Care records looked at during the inspection did not show that people were in receipt of consistent or responsive support that met their individual needs

This evidence indicates a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's care was planned in a person centred way.

● People had access to a range of activities to meet their social and recreational interests. One person said "There's always plenty to do here, I'm going horse riding soon, we do exercises every Tuesday to music and I won the bingo £1.50".
● Another person told us "I am better when I'm busy, the staff give me lots to do, we go out too and I walk around the garden".
● A third person said "In the good weather we have barbecues, the staff cook for us". On the day of the inspection a staff member took one person out for the morning. The went on the tram to the shop as the person wanted to buy some trousers and some cakes for an activity they were attending the following week.
● We saw that people were encouraged to maintain their independence with day to day living activities if they wanted. One person told us "I've got a shower and a sink and a toilet, I keep them all nice, look. I clean my shower after I use it and get dressed myself and I set the table for breakfast every morning".

Inadequate

Is the service well-led?

Our findings

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- There were no effective systems in place to monitor the quality and safety of the service.
- There was a lack of adequate fire safety arrangements, the delivery of care was not safe or person centred, night time staffing levels were insufficient and the provider had failed to adhere to MCA legislation designed to protect people's human rights.
- During discussions with the manager, they did not demonstrate an awareness of the serious concerns we identified during the inspection.
- There were no audits in place to check the quality and accuracy of people's assessments and care plans. We found that people's assessments and care plans were inadequate.
- There were no audits in place to monitor medication management and during our inspection we identified serious shortfalls with the system in place.
- There were no adequate governance arrangements in place to ensure fire evacuation practice was undertaken.
- The manager was aware of their responsibility to ensure each person who lived at the home had a personal emergency evacuation plan in place yet despite this they had not taken any action to ensure these were completed.
- There were no governance arrangements to ensure the Mental Capacity Act legislation was adhered to.
- There was also no effective management of the submission and renewal of people's deprivation of liberty safeguards (DoLS) to keep them safe.
- It was clear from our discussions with the manager and the records we looked at, that they did not have an adequate knowledge and understanding of the health and social care regulations that they were legally responsible for complying with. This was concerning and after our inspection we took immediate action to ensure people were protected from serious risk.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care;

- There was no adequate assessment or planning of person centred care.
- There was no evidence that the manager and provider used information in the day to day delivery of the service such as care plan reviews, resident meetings, safeguarding incidents, accident and incident data to learn from and improve the care provided to people.

The above issues demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not well managed or well led.

- From our observations it was obvious that staff and the people who lived in the home were comfortable

with each other. Staff told us they worked together as a team to support people.
●The atmosphere at the home was homely and people told us they were happy living at the home.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People had access to a range of other health and social care professionals such as dentists, opticians, doctors and social workers who worked with staff at the home to meet their needs.
● People who lived in the home had access to a range of social and recreational pursuits in the community with a variety of outside organisations that contributed to their emotional well-being.

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 People's needs were not properly assessed or planned for so that person centred care could be provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to the care they received had not always been obtained in accordance with the Mental Capacity Act 2005.

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 12 HSCA RA Regulations 2014 Safe care and treatment The fire safety arrangements in the home were inadequate. People's health conditions were not properly assessed or described. People's risks were not properly assessed or managed. Medication management was unsafe.

The enforcement action we took:

We issued an urgent notice of decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no adequate or effective governance systems in place to mitigate risks to people's health, safety and welfare.

The enforcement action we took:

We issued an urgent notice of decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The fire safety arrangements in the home were inadequate. People's health conditions were not properly assessed or described. People's risks were not properly assessed or managed. Medication management was unsafe.

The enforcement action we took:

We issued an urgent notice of decision to impose conditions on the provider's registration.