

Kingsley Care Homes Limited

Downham Grange

Inspection report

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

Downham Grange is a nursing home providing accommodation and personal care to up to 62 people. At the time of our inspection there were 56 people using the service. The service is purpose built and set over two floors with lift access. There are several communal areas, including gardens. The service accommodates people who require nursing or residential care and for people living with dementia.

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

People were not receiving good quality standards of safe care. Areas of the care environment were visibly unclean and increased the risk of the spread of infection. People, including those living with dementia were at risk of consuming items such as denture cleaning tablets, personal care products and prescribed creams as these were not being stored securely.

People with risks of developing pressure sores, the management of choking risks, as well as ensuring their fluid and nutritional intake was well monitored were poorly managed. This did not protect people from the risk of harm. Diabetes care needed improvements to ensure people's long-term healthcare needs were well managed.

People were not receiving their medicines safely, with medicines running out, and not being re-ordered to ensure they were available to people. Unsecured creams increased the risk of people accessing items that could cause them harm. We found issues with record keeping in relation to the application of creams, and rotation of medicines given in a patch form.

Changes to levels of staffing, particularly at night time were needed to ensure people's needs were met safely and in a timely way. Increased levels of governance and oversight of the service were required to ensure people's basic standards of care were being met, such as personal cleanliness and appearance, as quality checks and audits of care records were not identifying gaps in the completion of care tasks.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported 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

The last rating for this service was requires improvement (published 26 September 2022). The service has been rated requires improvement for the last 2 consecutive inspections and has not held a compliant rating since 2019.

Why we inspected

This focussed inspection was prompted by a review of the information we held about this service. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Downham Grange on our website at www.cqc.org.uk.

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.

Enforcement and Recommendations

We have identified breaches of the regulations in relation to safe care and treatment, staffing and good governance 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.

Follow up

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?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service well-led?

The service was not well-led

Details are in the well-led findings below.

Inadequate ●

Downham Grange

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

Day 1 consisted of 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day 2 consisted of 1 specialist medicine inspector.

Service and service type

Downham Grange 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. Downham Grange 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 manager who had previously been registered, had returned to working at the service and was present for the inspection. For the purposes of this report, they will be referred to as the manager.

Notice of inspection

This inspection was unannounced on day 1, announced on day 2.

What we did before the inspection

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 sought feedback from the local authority professionals who work with the service. We reviewed information we held about the service. We used all this information to plan our inspection.

During the inspection

We spoke with members of staff including the service manager, quality director, deputy manager, 6 members of nursing and care staff, a member of kitchen staff and a member of housekeeping. We spoke and interacted with 7 people living at the service and observed care provided in communal areas. We spoke with 4 people's relatives about the care provided.

We reviewed a range of records, including 10 people's care records and 10 medicines records. We looked at 3 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.

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.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Management of choking risks was poor. We identified examples of where people's dietary requirements were not being followed, resulting in them being given food of the wrong consistency increasing their risk of choking. This did not demonstrate staff were following medical guidance provided.
- People were not protected from risk of harm. People, including those living with dementia were able to have unsupervised access to items such as denture cleaning tablets, drink thickener, razors and personal care products were not stored securely to protect them from harm. One person's bedroom and communal areas of the service contained ants. No risk assessment had been completed prior to the decision to use powdered chemicals in the person's bedroom. The risk of harm relating to the use of chemicals in the person's bedroom had not been considered.
- People were at risk of developing pressure sores. Where people had been assessed as needing regular repositioning at specified time intervals, care records contained gaps and did not confirm this was being completed.
- People's basic care needs were not met. We observed people with unclean finger nails, and a lack of records to show their nails or teeth were being regularly cleaned. This placed people at risk of harm, as the provider was not supporting people to maintain their basic standards of hygiene and prevent the risk of the spread of infection.
- People's food and fluid levels were not well monitored. Records contained multiple gaps which did not show people had received regular food or drink. Where people were asleep at meal times, from reviewing the corresponding records these did not demonstrate further attempts being made to ensure they ate when ready. This was of particular risk for those people living with diabetes who needed to eat and drink regularly to maintain their health condition.
- The service was not clean in certain areas. Some people's bedrooms had malodour, which was not ensuring the environment was clean and comfortable. We found food debris in kitchenettes, attracting ants, and poor standards of cleanliness. People were reliant on staff to maintain a safe and clean environment.
- People were not protected from the risk of infection. Items of equipment needed cleaning. Crash mats, wheelchairs and bed rail covers were found ingrained with visible dirt.

The provider did not mitigate risks to people receiving care. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Regular checks of fire safety equipment, and legionella water safety checks were being completed.
- Following the inspection, we received written confirmation the use of ant powder had ceased.

Using medicines safely

- People did not always receive their medicines as prescribed. We identified times where medicines had not been available as they were out of stock. Where people were offered medicine and this was not given, for example, if the person was asleep, records did not show if later attempts were made to give the person their medicines. This did not ensure people were receiving their medicines as prescribed.
- People were not supported to manage their pain levels. Where people were given medicine on a when required basis (PRN) there was a lack of guidance in place when people were prescribed multiple forms of pain relief for PRN use to ensure effective management was in place.
- Errors and issues with medicines were not being correctly reported. Staff were not following the provider's error reporting procedures. Discrepancies found during this inspection had not been identified by the service's own checks.
- Risk assessments were not in place where a person managed their own medicines. This did not ensure staff had assessed the person's ability to safely manage their own medicines, or that this decision was being kept under regular review in case their abilities changed.
- There was a risk that people did not receive topical medicines safely and as prescribed. Staff were not consistently completing paperwork to show if people's creams had been applied. Topical medication records contained gaps. We also identified some creams were found to be out of date but remained in use. People's records did not consistently contain body maps to give information to staff, so it was unclear where to apply cream on a person's body.
- Topical medicines were not being stored securely. Creams and emollients were not always being kept securely to ensure people could not access them and put themselves at risk of accidental harm.

Risks relating to the management of people's medicines were identified. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- As an outcome of our inspection findings, the provider has now put required risk assessments in place to ensure the person managing their own medicines does so safely.

Staffing and recruitment

- People did not always receive care from enough staff to keep them safe. From reviewing staffing rotas against the number of staff we were told were required on each shift, we found the service was regularly working below the assessed number of staff. This was of particular concern at night time. Care records showed some people living with dementia required oversight and supervision at night time. Not having enough staff on shift impacted on their ability to oversee people's safety at night time.
- There were not always enough nurses on shift maintain people's safety. Rotas showed there was regularly only 1 nurse on shift overnight when we were told the service had assessed the need for 2. Some of the people living at the service had complex medical support needs and required regular oversight at night time to maintain their safety.
- People did not always receive support from suitably trained staff. New staff were not receiving thorough inductions and support. For example, the supervision records identified 3 newly appointed staff had not received supervision in over 3 months of starting with the service to ensure they were meeting the requirements of their induction and probationary period. Staff meeting minutes identified the need for improvements to be made to the standards of induction provided to ensure new staff had the required level of support and oversight from the management team that they were meeting the requirements of their role and responsibilities. From reviewing staff files, action was still required to address this shortfall.
- We asked the provider to look into findings from our inspection. Feedback from the provider identified the need for further staff training and to address areas needing to be improved.

Sufficient levels of suitably trained, competent staff were not in place to keep people safe, in line with the

service's own assessed staffing numbers. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People were not always being protected from risk of harm or abuse. Safeguarding processes were not always followed. We identified safeguarding incidents that had not been reported to the local authority or to CQC to protect people from the risk of harm.
- Staff completed safeguarding training. Staff were clear of the escalation process if they identified safeguarding concerns.
- People and their relatives told us they felt safe living at the service. We observed staff to be responsive to people for example if they were upset or needing reassurance.

Learning lessons when things go wrong

- The provider did not act on audit findings to learn and improve. We were not assured that the provider recognised the risks being identified through their own audits and checks, as some areas of concern and risks identified during this inspection had been identified by the provider's own audits but had not been acted on to keep people safe.
- Feedback was not consistently acted on. For example on day 1 of the inspection, we asked the provider to ensure risk items such as prescribed creams were stored securely. On day 2 of inspection, this risk remained unresolved.

Visiting in care homes

- People spent time with relatives and friends inside and outside of the service, as well as accessing the local community. Policies were in place for the management of visiting the service in the event of an outbreak such as COVID-19, to prevent people being at risk of social isolation.

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 working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was a lack of provider level oversight of the service. In the absence of a registered manager, the provider was legally responsible for the safety of the service. Inspection findings identified poor management of risks for people and the condition of the care environment. The quality of individualised care needed greater levels of oversight by the provider to ensure people's basic care needs and quality of living environment were consistently maintained.
- Notifiable incidents were not consistently reported to CQC and the local authority. Greater provider level oversight was required to ensure notifications were being submitted to CQC and the local authority in line with their regulatory responsibilities. Findings did not demonstrate an open and transparent approach.
- The provider did not have sufficient oversight of the service to keep people safe. Checks of electric beds, window restrictors and the completion of cleaning tasks were not being signed off by a manager to confirm they had been completed to required standards. This did not safeguard those staff completing the checks on the manager's behalf.
- Cleaning schedules did not include items of equipment. For example crash mats were not on the schedule to ensure these were regularly checked and cleaned by staff.
 - The service has not been compliant with the regulations since 2019. A continued lack of improvement has seen the service remain rated requires improvement at the last 2 inspections, with further deterioration and breaches of the regulations as an outcome of this inspection.
 - The provider's own meeting minutes, audits and training records highlighted individual staff members not performing in line with their expected standards, but their performance was not being addressed to drive safety and improvement. The provider's own audits had not identified issues found during this inspection.

The systems and processes to assess, monitor and improve the quality and safety of the service were not established or operated effectively to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider was not promoting an open and supportive culture within the service. Staff meeting minutes did not demonstrate leadership and accountability by managers to support staff to make necessary changes to their ways of working to make improvements to standards of care.

- We observed use of reflective practice by the nurses where incidents occurred. This supported the staff member to review what they would do differently in the future. This is a recognised approach by the Nursing and Midwifery Council.
- Staff and members of the provider team were observed to be familiar with people and their relatives and be proactively engaging with them when they visited to ensure good lines of communication were maintained. This also reduced the likelihood of complaints, as any concerns were addressed in a timely way.

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

- People and relatives told us they felt comfortable raising concerns or complaints with staff, and these would be responded to appropriately. One person told us, "I raised a concern, it was dealt with swiftly and to my satisfaction."
- People and relatives were involved in the development of their care records. Records contained details of feedback sourced from people and their relatives, including discussions by email and telephone to enable relatives not living locally to remain fully involved in the planning of people's care.
- The service held meetings with people to source their feedback. Meetings offered an opportunity to give feedback on areas of care including food quality, level of activities, and areas people felt needed to be improved.
- Relatives told us the staff also offered them support. One relative discussed the welfare checks made by staff to ensure they felt well supported when their loved one was unwell. The relative was appreciative of the holistic approach taken by the staff team.

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 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	<p>The care provider was not ensuring there were sufficient numbers of suitably trained and competent staff on shift to meet people's assessed needs and risks. There were areas of training and development identified as an outcome of this inspection. Induction and support for new staff needed further development.</p> <p>This was a breach of regulation 18 (1)</p>

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
Treatment of disease, disorder or injury	The care provider was not ensuring people received safe care and support. Concerns were found in relation to the condition and cleanliness of the care environment, management of people's medicines and individual risks. This was a breach of regulation 12 (1).

The enforcement action we took:

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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	The care provider did not have good governance systems and processes in place to drive performance and improvement, as well as to ensure quality of service provision. This was a breach of regulation 17 (1).

The enforcement action we took:

Warning Notice