Harbour Healthcare 1 Ltd

Kingswood Mount

Inspection report

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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
Kingswood Mount is a care home providing accommodation, personal and nursing care for up to 45 people; some of whom lived with dementia and physical disabilities. At the time of our inspection 36 people were living at the service.

People's experience of using this service and what we found
The home's environment was unclean and unsafe. Infection prevention and control practices were inadequate and did not protect people from the risk of infections.

Relatives told us that staff members had a kind and caring approach towards their family members; but described the staff team as overstretched and under stress.

Records used to monitor, and review people's care were not fully completed and kept up to date. We found many examples where sections of care records were incomplete and where people's care plans had not been updated to reflect changes in their needs.

There were systematic and widespread failings in the way the service was led and managed. The systems in place for monitoring the quality and safety of the service were not used effectively. They failed to identify and mitigate risk and bring about improvements to the service people received. Daily checks of the environment, aspects of people's care and staffing had not taken place as required.

Medicines were administered safely and there were enough staff who knew people well to provide support.

People were supported to access healthcare services, staff recognised changes in people's health, and sought professional advice appropriately. Staff were confident about how to raise concerns to safeguard people.

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

Rating at last inspection
The last rating for this service was good (published 08 February 2019)

Why we inspected
The inspection was prompted in part due to concerns received about the safe care and treatment of people. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. Please see full details in the individual sections of this full report.

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.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. For more details, please see the full report which is on the CQC 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 safe care and treatment, infection prevention and control and good governance at this inspection.

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

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Kingswood Mount

Detailed findings

Background to this inspection

Background
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
The first day of the inspection was carried out by two inspectors and an expert by experience. The second day was carried out by one inspector.

Service and service type
Kingswood Mount 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.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was no registered manager in post.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We gathered feedback from the local authority and other professionals who have visited the home since our last 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. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and twelve family members about their experience of the care provided. We spoke with nine members of staff including the deputy manager, care, nursing and ancillary staff, area managers and other senior managers within the organisation.

We reviewed a range of records. This included five people's care records and four people's medication records. We looked at recruitment records for two staff members employed since the last inspection.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance, training records, rotas, COVID-19 testing records and maintenance records.

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 our last inspection we rated this key question good.

At the last inspection this key question was rated as good. At this inspection this key question has changed 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.

Preventing and controlling infection

- We were not assured that people were fully protected against the risk of the spread of infection including those related to COVID-19. Infection prevention and control practices were inadequate and did not protect people from the risk of infections.
- We could not be assured PPE was being effectively used. On one occasion maintenance staff were asked to put on a face mask and on other occasions maintenance staff removed or wore face masks incorrectly.
- People were placed at risk of increased transmission of COVID-19 due to shared equipment and communal areas not being thoroughly cleaned following each use.
- Equipment in use to support people was unclean and unhygienic. Wheelchairs, walking aids and pressure relieving cushions were stained with spillages, bodily fluids and food debris.

The provider failed to assess the risk of, and prevent and control the spread of infections. 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 was aware of the concerns highlighted and took action following our inspection to make improvements.

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

- There was an inconsistent approach to managing some of the risks to people's health and wellbeing.
- Peoples support needs were not always monitored accurately. For instance, some people's daily care notes were not updated accurately. There were gaps in ongoing monitoring from the previous 12 months throughout care and monitoring records.
- The provider had not ensured people lived in a safe environment. Risks associated with the premises and equipment were not managed through regular safety checks and maintenance at the service.
- People's bedrooms were in a poor condition with wallpaper peeling off walls and fixtures and fittings poorly maintained.
- Fire safety was not robust. There was low compliance in basic fire safety training (69%) and moving and handling training (33%) for staff .

The provider had failed to appropriately assess, monitor and manage risks to people's health and safety. This was breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was aware of the concerns highlighted and took action following our inspection to make improvements.

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.
● Mental capacity assessments were undertaken where it was believed people lacked capacity to make informed decisions regarding their safety.

Staffing and recruitment
● People had mixed views on staffing numbers at the home. Some people told us there were times when there were not enough staff. Comments included, "Last two years been challenging, found it hard and recruitment has been a challenge" and "I worry that staffing level is too low."
● Recruitment systems were not always robust. In the recruitment files there was gaps with some references not received or induction not recorded. The provider had completed a recent audit and was aware of the issues we identified and was taking action.
● The provider carried out DBS checks. 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.
● Throughout the day, we observed staff providing the assistance people needed including attending to people's personal care needs.
● The provider evidenced they were actively recruiting additional permanent and agency staff.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The were effective systems to safeguard people from the risk of abuse.
● Staff had access to the providers safeguarding policies and procedures and guidance which detailed what they must do if they suspected abuse was taking place. Staff were aware of how to raise concerns.
● Staff followed the accident and incident process and management oversight was recorded. People's care plans showed updates and review of risk assessments following incidents including falls.

Using medicines safely
● Medicines were safely managed.
● The medicines support people needed was detailed in their care plans. People's medicines were regularly reviewed to monitor the effects on their health.
● Medicine administration records (MARs) showed people had received their medicines as prescribed.

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 our last inspection we rated this key question good. 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

- The service was not managed effectively. The service had a registered manager. However, they were absent from work and the regional manager and deputy manager facilitated this inspection.
- There had been lack of accountability, responsibility and scrutiny at all levels which impacted on people's safety and the quality of service.
- The systems for assessing, monitoring and improving the quality and safety of the service were ineffective as they failed to identify and bring about improvements to the service people received.
- Until recently the provider had failed to ensure adequate oversight of the service. They had not completed quality assurance audits in line with their own policy and there was little evidence to show they had visited the service as part of their oversight.
- Records used to assess, monitor and review risks to people were not fully complete and kept up to date.

The provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider was aware of the concerns highlighted and was taking action following our inspection to make improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People, relatives and staff were not fully engaged in the running of the service.
- There was no evidence to show relatives had the opportunity to suggest improvements to the service. One relative told us, "The people above the manager do not contact us and when we have raised concerns with them [provider] we never hear anything back."
- Relatives said they were generally kept informed about any changes to their relative's care or health needs. However, whilst care plan reviews were recorded there was little evidence people or their relatives had been involved in these reviews.
- Some staff were longstanding members of the team and were dedicated to providing people with good quality care. However, staff morale had been affected with ongoing management changes and uncertainty.
- Staff, service user and relatives meetings were irregular therefore they had little opportunity to provide

feedback or make suggestions on areas the service could improve. The provider had recognised this recently and arranged regular meetings to discuss how the service can improve.

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; Working in partnership with others

- The provider understood and acted on the duty of candour. They shared the findings of our inspection with relevant others.
- Staff had engaged with healthcare professionals when changes were made to meet people's needs.
- The provider was working with other agencies to make improvements, such as the local infection prevention and control 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people received consistent safe care and treatment because they did not always ensure the environment was clean, hygienic or suitably maintained. The provider exposed people to the risk of transmitting infectious disease.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective governance of the service.