Harbour Healthcare 1 Ltd

Kingswood Manor

Inspection report

Woolton Road
Woolton
Liverpool
Merseyside
L25 7UW

Tel: 01514279419
Website: www.harbourhealthcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Kingswood Manor is a residential care home providing personal and nursing care to up to 44 people. The service provides support to older people, some who live with dementia. At the time of our inspection there were 36 people using the service.

People's experience of using this service and what we found
The provider failed to ensure people were consistently protected from avoidable harm. Areas of the environment were unhygienic and had not been suitably maintained. We found shortfalls in the management of food hygiene standards, fire safety and the emergency call bell system.

Staff did not always ensure people received their medicines as prescribed. The provider failed to effectively quality assure how medicines were managed and this meant people were exposed to the risk of harm. For example, time specific medicines were not always given as prescribed and we could not be sure people received their creams and ointments.

Staff did not always follow safe infection prevention and control processes. People were exposed to the risk of transmitting infectious disease, including COVID-19.

The provider and manager failed to identify the shortfalls found at this inspection. Quality assurances systems were not effective and the home was not well-led.

The provider and manager did not always ensure people received person-centred care and treatment. We found people did not always receive their medicines in a person-centred way and decisions made were not always carried out in liaison with the person or their representative.

The provider did not always keep a record of agency worker induction. Shift leaders told us agency workers were inducted and shown emergency procedures however, they had failed to keep a record. The provider did ensure new applicants were screened for good character before they were recruited.

People and their representatives told us they felt safe and well cared for. We observed people had built trusting relationships with staff. People had access to stimulating activities and encouraged to maintain contact with friends and family.

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 31 October 2019).
At our last inspection we recommended the provider look at improved ways to manage the deployment of staff and medicines. At this inspection we found the provider had acted on the staff deployment

recommendations and improvements had been made. However, the provider had not made sufficient progress in safe management of people's medicines.

Why we inspected
We received concerns in relation to the management of medicines, accident and incidents and person-centred care. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. 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 good to inadequate based on the findings of this inspection.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

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

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

We have identified breaches in relation to safe care and treatment, person-centred care, medicines management, environment safety, infection control and governance at this inspection. Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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 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**

Kingswood Manor

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 included checking the provider was meeting COVID-19 vaccination requirements. 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 inspection was carried out by two inspectors, a medicines specialist 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.

Service and service type
Kingswood Manor 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. Kingswood Manor is a care home with nursing 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. 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who lived at the service and seven relatives. In addition, we spoke with 12 members of staff including; the registered manager, the assistant manager, a regional manager, registered nurses, support workers, two directors, the cook, a kitchen assistant, the maintenance person and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at nine people's medicine records, 5 people's care records, two staff recruitment files and a number of records in relation to the running of the service.

After the inspection
We looked at evidence submitted by the registered manager and continued discussions remotely with the senior management team.

Inadequate

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 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

- The provider failed to consistently ensure people were protected from the risk of avoidable harm. We found environmental risk including fire safety standards, emergency call bells and building security had been compromised because of a failure to ensure proper quality assurance processes.
- People's care records were not always updated when things changed. For example, three people had moved bedrooms due to a faulted call bell system, staff did not record how this was risk assessed or monitored. Important emergency evacuation information was not updated to reflect the room change and people's care and medicine records still showed their original bedroom which placed them at risk of avoidable harm.

Systems had not been suitably carried out to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed shortfalls from the fire risk assessment were now completed or work was scheduled, suitable checks of the environment were in place and people's records showed accurate information.

Using medicines safely

- Medicines management processes were not safe.
- The room where medicines were stored was noticeably unhygienic and storage cupboards were not secure. We observed reusable medicine pots being washed in an area designated for hand washing which increased the risk of cross-infection.
- People did not always receive their medicines in a person-centred way. For example, people did not always receive their medicines at the time directed on the prescription. We found safe time gaps between medicines including paracetamol were not always adhered to by staff responsible for the administration of medicines.
- Safety standards for the use and storage of prescribed thickening agents to prevent people from aspirating on fluids were not always followed.
- Prescribed creams and ointments were not managed in a safe and effective way.

Systems were not effective to ensure safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed immediate work was undertaken to clean the medicine room and improve safety standards. The provider told us they welcomed support from the local medicine optimisation team to drive improvement.

Preventing and controlling infection
● The provider failed to ensure safe infection prevention and control.
● Kitchens were unhygienic and food safety standards were compromised. We made an immediate referral to the Food Standards Agency.
● The environment throughout showed substandard hygiene standards. For example; sinks and taps had significant build-up of mildew, the equipment in communal bathrooms and toilets were heavily rusted which impinged on the effectiveness of cleaning.
● Staff failed to consistently follow safe practices when handling clinical waste or soiled linen.
● The provider did not ensure effective governance of COVID-19 screening. Temperature checks for service users, staff and visitors were not in place and a record of COVID-19 testing was not maintained.

Systems were not effective to ensure the prevention and control of infection. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed immediate work was undertaken to clean the areas identified as unhygienic and a comprehensive audit had been completed by the director of estates to ensure immediate remedial work was scheduled to improve the quality of equipment and environment.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. The provider failed to consistently maintain a record of visiting professionals vaccination status.

We identified a breach of Regulation 12(3), but the Government has announced its intention to change the legal requirement for vaccination in care homes.

Staffing and recruitment
● The provider did not always keep a record of agency worker induction. Shift leaders told us agency workers were inducted and shown emergency procedures however, they had failed to keep a record.
● The provider ensured perspective staff were screened for good character before recruited. Disclosure and Barring Service (DBS) checks were made which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● People and their representatives told us sufficient numbers of staff were deployed. During the inspection we observed staff responded to people's requests for support in a timely way.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Staff demonstrated good understanding of safeguarding processes and we saw alerts were submitted to the local safeguarding authority when needed.
● We found one person had unexplained bruising that had not been fully investigated. We discussed this with the senior management team who agreed to investigate and make a safeguarding alert.
● 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.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive person centred care and treatment.
- Staff did not always ensure people's care records were updated when things changed. For example, three people had moved bedrooms due to a faulted call bell system, staff did not record how this was discussed, risk assessed or monitored.
- Staff did not always ensure people received their prescribed medicines in a person-centred way, we also found people's care records did not always show person-centred assessment in relation to pain management and emotional distress.

The provider failed to ensure people consistently received person-centred care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and their relatives told us they were supported to maintain their hobbies, interests and relationships. Comments included; "There is clearly a lovely relationship between residents and carers," "The activities co-ordinator tries but mum doesn't want to participate, she does enjoy the activities going on around her" and "Regular emails are sent updating us on what is happening at the home."
- Throughout the COVID-19 pandemic staff supported people to maintain contact with their family and friends by use of video call, pod visits and visits in person, when safe to do so.

Improving care quality in response to complaints or concerns

- We received mixed feedback from people's representatives about the way their complaints and concerns were dealt with. Comments included; "It is a welcoming environment, from the core staff to nurses, they are approachable and helpful," "Management and staff are approachable, including the domestic staff", "We have had issues but always addressed, they are very good at that, " "The managers do not listen when I tell them my concerns, they are defensive" and "It depends on who we tell about our concerns, the nurses are good at listening but the managers are not always willing to listen."
- The registered manager did not always maintain robust records in relation to complaint management.

Meeting people's communication needs

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

relation to communication.

● Staff assessed people's communication needs and preferences. We saw people were supported to wear their communication aids including glasses and hearing aids.

● Staff understood the needs and preferences of people they supported. During our observations we saw staff respectfully engaging with people who had impaired communication and encouraged them to feel involved and informed of their surroundings.

● People with impaired cognition or visual impairment could access important information including the complaints procedure in a format which best suited their needs.

End of life care and support

● Staff supported people to plan their end of life care, support needs and wishes. Staff made clear records of discussions with people and their representatives.

● Staff told us they were confident supporting people with end of life care and nurses had necessary training to ensure people were supported in an effective and person-centred way.

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.

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

- The provider and manager failed to ensure the service was consistently well-led. There was a lack of effective quality assurance therefore, shortfalls found at this inspection were not already known or suitably acted on.
- The provider and manager failed to ensure compliance with regulatory standards including fire safety, food hygiene, medicines management, the emergency call system and infection control processes therefore, people had been exposed to the risk of avoidable harm.

Systems were not effective to ensure good governance of the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed immediate work was undertaken to ensure improved quality assurance of the service.

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

- The provider and manager did not ensure good oversight of quality assurance processes. This meant a positive and person-centred culture was not consistently maintained. For example, when the emergency call bell system failed decisions made to move people to alternative bedrooms were not carried out in an inclusive or effective way.
- The provider and manager did not ensure continuous learning because their quality assurances processes were ineffective.

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

- An external social care professional told us the manager was not always open to the support and learning opportunities on offer.
- The majority of people and their representatives told us they felt there was a pleasant atmosphere and the service was well-led. Comments included; "It is a welcoming environment, from the core staff to Nurses, they are approachable and helpful" and "Good atmosphere in the home, I would recommend it."

● Staff ensured people were referred to and reviewed by external health and social care professionals. Care records detailed information about recommendations made by professionals involved in people's care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider failed to ensure people consistently received person-centred care and treatment.

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 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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to ensure effective governance of the service.

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 provider failed to ensure people received their medicines in a safe and effective way.

The enforcement action we took:

We served a warning notice