Care Quality Commission

Kingsley Care Homes Limited

Lynfield

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Lynfield is a residential care home providing personal care for up to nine people with complex needs, including physical and learning disability. At the time of our inspection nine people were resident. The service is one of a small number of specialist care services operated by the provider, Kingsley Healthcare Limited. People who use the service share some communal spaces, including a hydrotherapy suite, and each has their own bedroom.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

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

Right support:
The model of care was designed to maximise people's independence. The provider had negotiated additional hours to help people who used the service access and be part of their local community. During lockdown this access had understandably decreased. Daily care records showed in-house activities were not always offered as a substitute. Staff told us they wanted to do more to promote people's independence.

Right care and right culture:
Care interactions we observed were kind and focussed on each person's needs. Care aimed to promote people's dignity, privacy and human rights. However, judged that the culture of the service was to occasionally treat the people who used the service as if they were young children rather than adults. This is something we have asked the provider to review and work on before we carry out our next comprehensive inspection. This culture did not appear to impact negatively on the people we saw, and staff were clearly very caring in their interactions. However, treating people in a way which is not appropriate to their age can be demeaning and impact on their dignity.

Oversight and monitoring of the safety and quality of the service needed to improve. Both the registered manager and the provider needed to have more effective systems in place to ensure safe recruitment of staff.

Risks to people's health, safety and welfare had not always been robustly assessed and mitigated. This could have placed them at increased risk of harm. Care plans were detailed and provided staff with clear guidance to help them support people's distressed reactions. We were not fully assured that staff always followed all this guidance.

We have made a recommendation about reviewing incident and accident records to ensure care plans had been followed.

Records were not always accurate and some concerns we identified may have been recording issues rather care issues. Electronic care plans were very detailed and contained a lot of guidance but one record had been replicated from a previous year which could have been very confusing for staff.

Medicines were well managed and medicines to help people with their distress and anxiety were closely monitored and given appropriately.

Staff were clear about how to recognise and report signs of abuse and had received training about this. The provider was clear about their safeguarding responsibilities and worked in co-operation with the local authority safeguarding team to investigate issues.

There were usually enough staff for them to carry out their roles, although sometimes numbers dipped below the provider's assessed levels.

Risks relating to Covid-19 had been assessed and actions to mitigate these risks were recorded. Infection control procedures were mostly good, and staff promoted this well with the people who used the service. Some small improvements were needed to further reduce risks.

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 29 November 2017.)

Why we inspected
We received concerns in relation to poor staffing practices and an overuse of medicines to manage people's distress reactions. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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 a breach of regulation 19 relating to the recruitment of staff. 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? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Care Quality Commission

Lynfield

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors. Two inspectors carried out the inspection visit and the lead inspector co-ordinated the inspection remotely.

Service and service type
Lynfield is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection, including notifications which the service is required to send us by law to alert us to significant incidents.

We used all of this information to plan our inspection.

During the inspection
The people who used the service were not easily able to talk to us about their care. We observed staff providing care and support and spoke with three relatives about the care provided. We also spoke with four staff, including two senior staff members, the registered manager, the regional manager and the director of compliance. We spoke with members from the local authority safeguarding team and an assessor working with the local authority Deprivation of Liberty Safeguards (DoLS) team.

We reviewed a range of records. This included three people's care records and five people's medication records. We looked at three staff files in relation to recruitment and at other records relating to the quality and safety of the business.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, further rotas, staffing hours and quality assurance 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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
●This inspection was prompted, in part, by some information we received which alleged poor safeguarding practices. Our inspection failed to identify any elements of a closed culture or of poor practice by staff supporting people who used the service.
●However, we did identify that some staff used language which would be more appropriately used when working with very small children. This kind of language can impact negatively on people's dignity.
●Care records also suggested that some staff might not be following the care plan when dealing with people's distressed reactions., For example, one person's care plan suggested several steps to remove unnecessary distractions from them when they were very upset. This is to help them focus and calm down. However, care records recorded removing distractions as if this were a form of punishment. One record stated for example, '[Toy] taken off [person]….I told [person] very firmly that [they] have now agitated other residents, so if [their] behaviour continues [they] will lose something else.'
●We discussed how incidents of distress and physical behaviours are managed with the registered manager, staff and relatives. We have judged that the provider needs to review the language used in care records and to monitor incidents closely. We did not find evidence of abusive practice. The registered manager agreed to keep this matter under review and discuss the recording and management of incidents with staff.
●Where safeguarding concerns have been raised with the local authority, CQC have also been kept informed and staff have received appropriate safeguarding training.

Assessing risk, safety monitoring and management
●People who used the service had assessments in place which aimed to reduce any known risks. However, some environmental risks had not been fully considered and mitigated. For example, one window restrictor was not a standard type and was easily overridden by our inspectors. We also found a wardrobe needed to be fully secured to the wall to prevent potential injury, a showerhead in need of repair and some hot water pipes needed to be fully covered to reduce the risk of scalding.
●People coming into contact with these potential hazards were not themselves at risk but others could potentially access these areas and hurt themselves. In addition, one person had an internal 'safe space' within their bedroom. This had recently become damaged and there was a risk the person was not fully protected. The provider told us they were in the process of negotiating additional funding to supply this equipment. Following our inspection they informed us that they has managed to secure this funding and would now be able to ensure this person was safe when in their bedroom.
●The provider began to address these issues whilst we were still onsite and we were assured by their actions.
●We identified from care plans that the service advocated the use of a choking aid device. However, the risks

associated with using such a device had not been fully considered and assessed. We asked for urgent review of the use of this device and the provider took prompt action and removed the device from the service.
●Care plans relating to how to support and manage people's behaviours and reactions when they were distressed or upset were detailed and contained clear guidance for staff. Care records documented, however, that sometimes staff were not following all aspects of these detailed plans. Instead they were moving through the various de-escalation stages too quickly. We discussed this with the registered manager who assured us they would review the care plans and discuss with staff, where necessary. Staff also gave us some reassurance on this, with some telling us they felt the recording was poor rather than the care. They were able to tell us, in detail. how they would support people who became anxious or upset safely. Staff were clear about the risks people presented to themselves and others.

Staffing and recruitment
●Staff were not always safely recruited. Staff recruitment records did not always show a complete employment history and, in two records, contained very few details about the person. Interview notes were incomplete and did not demonstrate how the provider had reached the decision that a person, especially if they were new to the care role, had been judged to have appropriate skills and qualities for the post.

Recruitment procedures were not sufficiently robust. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●New staff received a Disclosure and Barring Service (DBS) check which aimed to ensure they were safe to take on this kind of role.
●Staff received a comprehensive and very detailed induction which was designed to give them the skills they needed. New staff told us they were not rushed into taking on roles and responsibilities they were not ready for. Some key training had been delayed recently due to the Covid-19 pandemic but was rescheduled for January 2021. One relative told us, "I take my hat off to the staff. They are all specialist staff"

●Staffing levels included a considerable number of one to one hours for people who used the service. These were deployed flexibly and rotas did not make clear how each person's one to one hours were being used, although the registered manager explained that staffing hours were in excess of the safe level for the service.
●There were times when staffing hours were reduced. The registered manager assured us these were quieter times of the day. Aside from staff sickness absence at short notice, vacant staff hours were able to be covered with existing staff including the registered manager. We have asked the provider to ensure that any hours covered by the registered manager are monitored so that they do not impact on their management role.
●Staff and relatives all told us that they felt staffing was adequate, even during lockdown when everybody was home. One relative commented, "[The staffing enables my relative] to go out and about for walks around the village and drives out. [Staffing levels] keep [my relative] safe."

Using medicines safely
●Before we inspected the service, concerns had been raised with us about the overuse of some medicines to manage people's behaviour when they became distressed and upset. The suggestion was that staff were using medicines as a first resort rather than using other distraction and calming techniques first. We found no evidence to support the allegations and found these kinds of medicines were used appropriately and were well monitored.
●Other medicines were administered safely. Staff received the appropriate training and supervision which aimed to ensure people received their medicines as prescribed.

Preventing and controlling infection

- We were assured that the provider promoted safety through the layout and hygiene practices of the premises. We found some incomplete cleaning records but this has been addressed by the provider since our inspection visit.
- People who used the service were having their oxygen levels routinely monitored in order to alert staff of any potential Covid-19 symptoms. We observed staff encouraging people who used the service to wash their hands. There was good signage for people who used the service and visitors and relatives told us measures to protect them and their families had been in place from the earliest concerns.
- We were assured that the provider was meeting shielding and social distancing rules, using personal protective equipment (PPE) effectively and safely and was accessing testing for people using the service, staff and relatives.
- We were assured that the provider's infection prevention and control policy was up to date and staff had received appropriate infection control training.

Learning lessons when things go wrong

- Although staff filled out accident and incident forms when things went wrong, these were not always sufficiently detailed. Accident and incident records, although signed off by senior staff, did not always lead to robust analysis to see if lessons could be learned to make improvements and reduce future risk.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
●Staff and relatives were positive about the open and inclusive way the registered manager was trying to take the service forward. They commented on the fact they felt their voices were heard and they had influence over how the service was run. The registered manager told us people who used the service were involved in decisions about their care and support as much as they were able to be.
●Relatives were kept informed and given opportunities to meet with the registered manager if they wished to. One relative commented that should they raise any issues, the registered manager could be relied on to look into them and address them if needed. They told us, "I have confidence in [the registered manager]."
●Staff demonstrated an understanding of how to involve people who used the service in decisions about their daily care and support. Experienced staff told us that it took a long time to get to know people's complex needs and new staff were supported to understand people's routines, communication needs and priorities for their care.
●Although staff demonstrated this in-depth knowledge, we also found that further work was needed to ensure staff always treated people who used the service in an age appropriate 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
● The registered manager understood their responsibilities regarding duty of candour and relatives had been appropriately informed when incidents occurred.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
●There was a registered manager in post and they demonstrated an understanding of regulatory requirements. They were relatively new to the role and the provider continued to support them to develop their skills and knowledge. Staff were positive about the registered manager and felt they were beginning to make a positive impact on the service. One staff member said, "[The registered manager] takes the job very seriously and is very professional….Things are definitely much better here than when I started. They are better than they ever were."
●There was a system of audits and checks in place which was designed to monitor the quality and safety of the service. These checks were not fully effective and some improved oversight was needed in some areas.

For example, recruitment procedures were not robust and audits had not identified that the provider's own policies and procedures had not been followed in all cases.
●Where checks and audits were in place these were not always detailed enough and sometimes did not identify actions to address concerns raised. For example, we saw incident records which had been signed off by the registered manager, but some information was missing which had not been followed up. One incident record suggested that a person's care plan had not been followed when dealing with their distressed behaviour. This record had been signed off without further investigation.
●Oversight from the provider at a more senior level had not identified all of the issues we found and needed to be more robust. For example, where people were placed on fluid charts to ensure they had enough to drink, low amounts of fluids had not been identified and investigation undertaken to ensure risks to the person were identified and reduced.

We recommend the provider reviews accident and incident records more robustly to ensure that reports are fully completed and demonstrate that staff have been following the detailed care plans in all cases.

●The provider's electronic recording system was very detailed and contained lots of helpful guidance for staff. However, we identified a glitch in the system where it replicated a record from 2019 about a head injury. It was not clear why the provider had not identified this for themselves, although this issue has now been resolved.
●There was a service improvement plan in operation, and this was regularly reviewed and updated. The provider undertook out of hours spot checks and we saw that those carried out most recently were more in depth than previous checks. Checks included talking to staff and assessing their health and safety knowledge and understanding of safeguarding procedures.

Working in partnership with others
●The service worked well in partnership with many other health and social care professionals. People who used the service had multiple complex needs and care records demonstrated close working with a variety of specialist health professionals including psychiatrists, psychologists, speech and language therapists and physiotherapists.
●One social care professional gave us very positive feedback about the service and the registered manager. They told us, " [They] have always been quite sound and have always been able to care for people at this level. I applaud their ability to support people with such complex needs to lead a decent life".

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to operate an effective recruitment procedure. Regulation 19 (1) (2) (3) (a).