West Sussex Safeguarding Adults Board

Organisational Learning Review in respect of Kingswood

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Date: 24/03/2021

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1. Foreword

1.1 This report is regarding an Organisational Learning Review, arranged by the West Sussex Safeguarding Adults Board. Its focus is on the circumstances surrounding the necessary closure of Kingswood Care Home in West Sussex.

1.2 The events that led to the closure occurred following a visit to Kingswood by the Ambulance Service. During this visit, ambulance crew found that two residents had died and that several others were mildly to moderately hypothermic, many showing signs of dehydration. Neglect was evident both in relation to care needs and the environment.

1.3 Following the Ambulance Service's visit, several agencies were involved to coordinate an immediate response to ensure the safety and wellbeing of residents at Kingswood. The concerns were of a level that necessitated the cancellation of the Care Homes registration with CQC.

1.4 The Board has been very keen to understand and learn of the circumstances at Kingswood to mitigate against similar future risk.

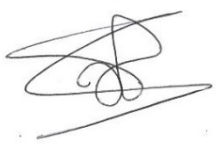
1.5 The Board wants to wholly extend our sincere condolences to the families and friends of the residents who died and fully acknowledge the impact for residents, families, and friends of the conditions at the home and evident neglect.

1.6 The purpose of this Review was not to reinvestigate or to apportion blame but to establish where, and how, lessons can be learned and how services can be improved for all those who use them and for their families and carers.

1.7 The Review provides seven recommendations for the Board to take forward to seek assurance. In summary these are: developing multi-agency understanding, professional curiosity, partnership working, information sharing, promotion of whistleblowing and raising safeguarding concerns, working with private and voluntary sector and, increasing family members' understanding of quality and safeguarding.

1.8 The Board will, without delay, establish a multi-agency action plan in response to the findings of the report so that assurance is provided that all changes required are implemented.

1.9 The Board will monitor progress of this action plan and will ensure that the learning from this review is widely disseminated to support minimising risk of similar concerns reoccurring in the future.



Annie Callanan, Independent Chair

2. Introduction

2.1 The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when certain criteria are met. These are:

- When an adult has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, whether known or suspected; and
- There is a concern that partner agencies could have worked more effectively to protect the adult.

2.2 If the criteria appear to be met, Safeguarding Adults Boards may agree to proceed with an alternative and more appropriate Review. These Reviews remain statutory Reviews.

2.3 It was determined for Kingswood that an Organisational Learning Review would be most appropriate and the most effective method to consider the systemic factors and processes, which may have impacted on the circumstances at Kingswood.

2.4 An Organisational Learning Review promotes effective learning, improvement actions and recommendations, which contribute to the improved safety and wellbeing of adults with care and support needs, therefore, reducing the risks of future deaths or serious harm occurring again.

2.5 As with a SAR, Organisational Learning Reviews are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

2.6 Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances and, a shared action plan to implement these recommendations. It was not the purpose of the Review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

2.7 The Review has followed due process, which has involved: the Independent Reviewer chairing an initial panel meeting to agree the Review terms of reference; conducting research by critically analysing Individual Management Reports, chronologies and relevant records held by involved agencies; interviewing representatives of agencies; holding a subsequent Organisational Learning Review panel meeting and presentation to the West Sussex Safeguarding Adults Board.

3. Overview of the case and circumstances leading to the review

3.1 On 15/02/2020, the South East Coast Ambulance Service attended Kingswood Home in Worthing in response to a 111 call about a resident. In the process, the crew found that another resident had died unexpectedly and became so concerned about the care provided that they telephoned the police.

3.2 Subsequently, further ambulance crews were called back to Kingswood Home in the early hours of 16/02/2020 and remained until the mid-morning. During this time, the crews identified that 7 of 19 residents were mildly to moderately hypothermic and several showed signs of dehydration and neglect. With the assistance of West Sussex Fire and Rescue, blankets and portable heaters were supplied. Further assistance was provided by the Hazardous Area Response Team, an Out of Hours GP and Responsive Services. A safeguarding concern was raised with West Sussex County Council.

3.3 On 17/02/2020, the Care Quality Commission began an inspection at Kingswood Home which lasted until 19/02/20. The inspection identified the following:

3.4 **Safety and staffing levels**

- People were not safe and were at risk of receiving unsafe care. People were not protected from the risk of neglect or abuse.
- Staffing levels were unsafe and meant that people did not have the support or care at the time they needed it. Because of the lack of staff available, people received a poor standard of care.

3.5 **Hydration, nutrition, and the risk of choking**

- Staff had not ensured people had sufficient to eat or drink and their needs were not effectively monitored. Some people presented as being very hungry or thirsty. Drinks were not freely available, and people often had to wait for their drinks to be served at set times dictated by staff.
- One person who was at risk of choking was given the wrong texture of food which increased their risk of choking. People were not always given the correct consistency of food, in line with their assessed risks.
- One resident, who was cared for in bed, had a jug of juice in her room, but it was placed out of her reach.
- Checking of records found that between 06/02/20 and 17/02/20 on average one resident was offered between 800 and 900ml of water per day, well below the recommended intake of fluids. Only how much was offered was recorded, not what was drunk. This resident was in serious risk of dehydration.
- Residents reported to social care professionals that they were hungry and thirsty. Residents presented as being extremely thirsty and consumed all the drinks offered to them.
- A blind resident was unaware food had been left for them in their room.

3.6 **Pressure care**

- A person, who was at risk of skin breakdown, was not repositioned regularly according to monitoring records.

3.7 **Medicine management**

- Medicines were not always managed safely. Stocks of medicines did not tally with records to confirm that people received their medicines as prescribed.

3.8 **Hygiene and cleanliness**

- There was a strong smell of urine in some parts of the home indicating that cleanliness and hygiene standards were not maintained.

3.9 **Training, care standards, planning and management**

- Staff had not completed all the training they needed to ensure people received appropriate care and support. Where training had been completed, staff demonstrated a lack of understanding in key areas, such as safeguarding and types of abuse.
- People were not treated with dignity and respect. Care was not personalised to meet people's needs. Care plans were detailed and provided information about people's likes, dislikes and preferences, including their interests. However, there was a lack of activities to provide mental stimulation or to engage people.
- The culture of the home was negative, and staff were dissatisfied working there; some staff felt the registered manager did not listen to them and was not supportive. The registered manager demonstrated poor oversight and capability in their management of the home and of their legal responsibilities. A system of audits had been implemented but was not effective in identifying all the issues found at the inspection or by external professionals who had intervened at the service.

3.10 As a result, Kingswood Home UK Limited's registration was cancelled on 19/02/20.

3.11 The West Sussex Safeguarding Adults Board commissioned an Organisational Learning Review to identify if anything might have predicted the rapid closure of Kingswood Home and if there are any lessons to be applied in the future to predict and prevent situations like this reoccurring.

3.12 Representatives of agencies contributing to the review through meetings with the Independent Reviewer are listed below (titles are those which applied during the reporting period):

- West Sussex County Council (WSCC)
- Clinical Commissioning Group (CCG)
- Sussex Community NHS Foundation Trust (SCFT)
- Sussex Partnership Foundation Trust (SPFT)
- Sussex Police

- South East Coast Ambulance SECAmb
- Care Quality Commission (CQC)

4. Literature Review referencing Local and National learning

There were few formal concerns about Kingswood Home and no ongoing monitoring or service failure process was in place prior to the events on 15-16/02/20. The literature review therefore involved a search for previous Safeguarding Adults Reviews (SARs) that featured the sudden closure of care homes, and especially those where there had been few previous concerns about quality. A number of these were found in the Social Care Institute for Excellence (SCIE) Safeguarding Adults Review database, which contained (as of 23/03/21) the following which matched the criteria.

- Kirklees, The Closure of Oxford Grange 2015 (SCIE database number 06)
- Nottingham City, Autumn Grange 2016 (SCIE database number 28)
- Dorset, Autumn Grange 2016 (SCIE database number 66)
- Somerset County, Mendip House 2018 (SCIE database number 76)
- Doncaster City, Care Homes Governance Arrangements 2018 (SCIE database number 122)

4.1 Of these the most relevant to the concerns about Kingswood Home appeared to be the Dorset review of the closure of Highcliffe Nursing Home 2016, since this was a home where few or no previous concerns had been reported.

4.2 This review identified that it was, "…important to recognise that Care Homes are part of a wider system of health and care services for an individual, with a range of organisations working in partnership in delivery". There was a need to see care home staff as colleagues and to work together where there were issues and concerns. Care services should be linked into service improvement initiatives. The Dorset review described that Care Homes were often seen as completely separate entities, conceived either as 'a money-making business' or as a 'provider of care' and that, "…partnership was not always strong in that some practitioners tended to see all concerns as training issues internal to the Home rather than difficulties in a shared system of care". There was sometimes a gap in partnership working and the, "…system requires development in true partnership with Care Homes if proactive, personalised care is be provided to manage effectively the needs of people living in them".

4.3 Since the SCIE SAR library does not appear to have been updated since 15/02/18, a further search was made using Google. One review, not found in the SCIE library, was that of the closure of the two nursing homes, Grantley Court and Merok Park and a residential care home, Faygate. This was a Learning Together Review facilitated by SCIE and commissioned by Sutton Safeguarding Adults Board. Even though there had been previous safeguarding concerns at two of the nursing homes and a process was in place to lead and monitor progress, the relevance of this review was that a lack of heating featured prominently as a warning sign of wider concerns about the quality of care. This review also considered why the relatives of residents in care settings

may not always recognise or report concerns: "For complex reasons, not all families in Sutton, Surrey and Kingston are well-placed to provide professionals with early warning of worsening standards in care homes, with the consequence that local systems need to operate without making assumptions about relatives' ability to do this, and to compensate for it".

5. Key Themes/questions identified for this review

5.1 The literature review was used to identify key themes or questions for this organisational learning review as follows:

1) Did the quality of care rapidly decline at Kingswood Home, or were there warning signs?
2) Did Kingswood Home try to obscure the poor quality of care?
3) Is there a need for curiosity or inquisitiveness when visiting residents in care homes (or in their own homes) to not only focus on the purpose of the visit but to consider the environment?
4) Is there a need to work with relatives to increase their awareness of quality and "what good looks like" in care homes?

6. Pen picture of Individuals living at Kingswood

6.1 In February 2020 there were 20 people living at the Kingswood Home. They had a range of care and support needs, and some were living with dementia.

7. Engagement with families/representatives

7.1 Letters were sent to relatives of residents living at Kingswood Home in February 2020 inviting them to participate in this Organisational Learning Review. The outcome was that one family member agreed to speak to the Reviewer. This interview has been included within the findings and analysis.

8. Summarised Chronology

8.1 The multi-agency chronology between 03/03/19 and 20/03/20 prepared for this organisational learning review included 220 entries by the following organisations:

- Sussex Community NHS Foundation Trust, 114 entries, 99 prior to 15/02/20
- West Sussex County Council, 31 entries, 15 prior to 15/02/20
- General Practice, 22 entries, 13 prior to 15/02/20
- South East Coast Ambulance Service, 21 entries, 20 prior to 15/02/20
- Sussex Partnership NHS Foundation Trust, 19 entries, 12 prior to 15/02/20
- The Care Quality Commission, 11 entries, 9 prior to 15/02/20
- Police, 2 entries, 1 prior to 15/02/2020

8.2 The majority of contacts by all agencies were recorded prior to 15/02/20. Contacts after this date concerned response to the events at Kingswood Home following the concerns raised there by the South East Coast Ambulance Service.

8.3 Despite the concerns identified by the Care Quality Commission during its inspection between 17/02/20 and 19/02/20, the majority of the entries in the chronology were positive about Kingswood Home and the quality of care provided there. Statements made by both health and social care professionals included for example, one resident, "…being more settled at Kingswood compared to when she was last assessed and felt that the home was a very 'good fit' for (them)" (30/10/19) and "(a resident's) relative was reported as being positive about the care provided by staff at the home" (06/09/19) and "Kingswood is doing a great job at meeting (a resident's) needs. His health and wellbeing have improved since living there and this is evidenced by his weight loss, improved mobility and more cheerful demeanour" (01/11/19).

8.4 Between 29/01/20 and 14/02/20, there were eight direct contacts with six residents by Sussex Community Foundation Trust staff and by a General Practitioner. None of these contacts, which took place at Kingswood Home, resulted in any concerns being recorded.

8.5 Despite this, in the process of conducting this review, a number of persistent concerns about quality and three safeguarding concerns about Kingswood Home did emerge, which will be considered in the findings section of this report.

8.6 At 15:06 on 15/02/20, the South East Coast Ambulance Service attended Kingswood Home in Worthing in response to a 111 call that a resident (for the purpose of this Review, referred to as K1) was unconscious and was not breathing. In the process the crew were asked by a member of staff to see another resident (for the purpose of this Review, referred to as K2) who was ill. The crew discovered this resident to have died and became concerned because of the discrepancy between the care home staff's claim to have checked them one hour ago and their own judgement that K2 had been dead for considerably longer than this.

8.7 The ambulance crew were further concerned about the care of K2 and called the police since there had been an unexpected death. The police completed an investigation and concluded that evidentially the criminal threshold was not reached and took no further action with regard to any safeguarding concern or death at the home.

8.8 Further ambulance crews were called back in the early hours of 16/2/20 as there was a concern that a resident (for the purpose of this Review, referred to K3) had been left without heating and fluids.

8.9 By 05:30 the three ambulance crews on the scene had identified that 7 of 19 residents were mildly to moderately hypothermic. Additionally, several residents were presenting with signs of dehydration and neglect. The decision was made for one crew to contact the Clinical Commissioning Group and to manage the interactions with partner agencies, whilst the other two crews assessed and cared for the residents. Several conference calls were held with partner agencies. A safeguarding concern was raised by the first attending crew.

8.10 The Hazardous Area Response Team (HART) attended the scene at 08:22 to deliver extra supplies of blankets and 'warming' blankets for hypothermic patients.

8.11 At 09:30 only one resident remained hypothermic and was being warmed in a room with a heater.

8.12 At 10:30, the Out of Hours GP from Integrated Care 24 (IC24) arrived, as did Responsive Services (a multi-disciplinary team providing short term services to help people recover). The remaining ambulance crew prepared to withdraw and handover the scene to community services, led by the GP from IC24.

8.13 At 11:38 a resident was taken to Worthing Hospital. The Care Quality Commission highlighted in its inspection report that the staff at Kingswood Home were very slow to respond and the intervention of visiting care professionals was required to alert them to the need to seek medical attention.

8.14 The Head of Safeguarding and Quality at West Sussex County Council contacted the Care Quality Commission early on the morning of 17/02/20. CQC convened an immediate internal management review meeting and a team of inspectors arrived on site by that afternoon.

8.15 The inspection was conducted over three days and resulted in the CQC using urgent enforcement powers under Section 30 of the Health and Social Care Act 2008 to cancel the provider's registration, which was granted at Brighton Magistrates Court on 19/02/20. Subsequently all residents were moved to alternative accommodation.

9. Key Findings

9.1 The combined chronology and submissions from partner organisations were analysed and a practitioner learning session was held to explore what had happened and the four key themes. The following findings emerged.

9.2 There were persistent concerns about the care at Kingswood Home. The concerns consisted of the following areas:

Service quality

9.3 A previous Care Quality Commission inspection on 11/03/19 had given Kingswood a rating of "requires improvement". The areas for improvement were: "…induction, training, ensuring staff updated care plans when changes occurred, medication audits, oversight of staff training, daily handovers, cleaning schedules and audits, and information for people was not comprehensive and up to date".

9.4 A number of these areas, for example, training, care planning, medication management, cleanliness and hygiene and auditing were identified in the

inspection between 17/02/20 and 19/02/20. It is apparent that there had been a deterioration between the inspections (on the basis that Kingswood required improvement in 2019 but required closing in 2020) and that consequently the required improvements had not been made.

Care and responsiveness

9.5 On the 11/09/19 Police were called by the ambulance service because of the unexpected death of a resident, following an unwitnessed fall. Staff at Kingswood Home advised that they had seen the resident 10-15 minutes before the fall. The staff had not responded to the fall and had not attempted or offered first aid.

9.6 On 19/10/19 SCFT (Sussex Community Foundation Trust staff, a provider of community nursing and other services) tended to a wound on a resident's hand. This was not a new wound but had not previously been known to community nurses.

9.7 On 26/11/19 a social worker notified an advocate from Powher (an advocacy service that provides Independent Mental Capacity Advocacy) that Deprivation of Liberty (DoLS) conditions were not being met for a resident as follows:

- Recording of objections: not keeping separate logs so information is getting lost.
- Facilitating outings: no recordings that the home has been offering trips out.
- Care plan needed updating as it was not clear.

9.8 On 28/11/19 SCFT noted that a resident had lost 5kg in a month and that the GP had been asked to visit. The resident died unexpectedly on 12/12/19.

9.9 Resident K2 was attended by SCFT staff over the period 12/10/19 to 28/1/20 (3 and a half months) for five separate injuries / skin tears. K2's age made him more at risk of skin tears, but it is unclear what Kingswood Home did to reduce their likelihood. K2 was found deceased by paramedics on 15/2/20. Despite claims by a Kingswood staff member that K2 had been "fine an hour ago", the ambulance crew's judgement was that he had been dead for longer than this. The crew also report that there was a lack of documentation in K2's care folder to show any care had taken place since the previous day, including lack of turning in bed, hydration and nutrition. These reports suggest that low quality care might have been provided to K2 for an extended period of time.

Robust internal oversight at Kingswood Home.

9.10 The CQC inspection on 11/03/19 identified that the registered manager of Kingswood Home was also the "nominated individual". Kingswood Home lacked a level of internal scrutiny common in other registered homes where there are often others involved in senior leadership oversight such as a board of directors, separate registered managers or other internal quality assurance teams.

Staffing levels and staff morale

9.11 On 08/08/19 an anonymous whistle blower concern was received by the Care Quality Commission regarding short staffing, bullying and lack of training for new staff at Kingswood Home. The report was considered but not taken any further and the residents at Kingswood Home were not considered to be at immediate risk. During the course of the review, the CQC explained that it monitors and makes decisions on anonymous concerns but that these can be difficult to manage since the anonymous referrer left no contact details for additional information. At the time the concern was received it was vague and there was no suggestion of any harm or abuse. On entering Kingswood Home after the closure, concerns about low staffing levels, competency of staff, and the environment were identified which had not been made clear in the anonymous concern.

9.12 West Sussex County Council explained that if it had received the anonymous whistle blower concern from the CQC then it is likely that reviews of individuals living at Kingswood Home would have been brought forward (i.e. would have taken place sooner). This may, however, not have highlighted any further concerns since reviews had already been undertaken during 2019-20. If further reviews had taken place and had identified concerns, then West Sussex County Council would have used its Quality Pathway and the concerns would have been discussed at the Quality Safeguarding and Information Group (QSIG). This soft intelligence forum would have been an opportunity to discuss quality and/or low-level concerns to agree how to respond to them.

9.13 All of the allegations made by the anonymous whistle blower reflected on the registered manager's running and oversight of Kingswood Home. Even if residents were not considered to be at immediate risk of harm, given the lack of the layer of internal scrutiny identified by the CQC in its inspection on 11/03/19, this anonymous whistleblowing may have been a missed opportunity for sharing intelligence with other agencies and taking steps to monitor Kingswood Home more closely.

9.14 On 07/01/20 West Sussex County Council noted that in December 2018 there had been an alert from an ex-member of staff at Kingswood Home regarding unwitnessed falls at Kingswood Home due to low staffing levels, which had not been reported to West Sussex County Council, and a report of fracture to a resident's lower arm which had also not been reported to West Sussex County Council until several days later. These concerns were investigated and formed part of an Overarching Enquiry. This enquiry does not appear to have raised any further concerns about Kingswood Home. On reflection, as part of this review, West Sussex Council staff realised that they had noticed that there appeared to have been a dominance of one member of staff at the care home and that other staff members seemed fearful of them.

9.15 On 27/01/20 a member of staff at SCFT was notified by another care home that there may have been a mass walkout of Kingswood staff due to conditions at the home. This information was sent the West Sussex County Council contracts

team's shared inbox. This address receives a lot of emails. The email was not noticed, and the Community Social Care Teams were not notified.

9.16 On 01/02/20 SCFT recorded that there had been a "Clinical incident raised on internal system re adult safeguarding concern" for a resident K1. There is no note next to the entry to say what happened and if this was followed up and action taken.

Lack of reporting from Kingswood Home.

9.17 Between March 2019 and February 2020, the CQC had received no safeguarding concerns about Kingswood Home. This may be a risk indicator of a potentially closed culture and/or a failure to notify the CQC of incidents and allegations. However, a review of the CQC's internal intelligence reports for this period indicated that Kingswood Home was not an outlier for the high- or low-level reporting of specific events, including safeguarding concerns. Given that no concerns had been received from Kingswood Home, it is unclear exactly what it would take to be an outlier. The CQC is, at time of writing, trying to understand what the benchmark indictors should be for services of a similar size to Kingswood Home.

9.18 Whilst none of these concerns on their own predicted what would be found at Kingswood Home on 15-16/02/20 and subsequently during the CQC inspection, they do suggest an accumulation of problems that might have warranted further multi-agency attention and intervention.

In addition, drawing from previous Safeguarding Adults Reviews, the following were also identified.

The concerns were not always followed up and no pattern was identified and responded to.

9.19 Prior to this Review, there does not appear to have been any systematic compilation of concerns at Kingswood Home in order to build up a picture of the quality of care and management there.

Family members appear to have been unaware of concerns at Kingswood Home.

9.20 The interview with a relative of one of the residents who died revealed that there had been no concerns about quality of care, staffing levels or instability of staffing. There had been no change in, or concerns about, the manager or their behaviour and that the relationship between the relative and the manager had been friendly and supportive. The relative had last visited two weeks before 15/02/20 and their conclusion was the decline in the quality of care had been rapid and had taken place on 15/02/20. No other relatives took part in this review.

9.21 There were also examples of good practice:

What worked well

9.22 The agencies and services that went into Kingswood Home on 15/2/20 appear to have done an excellent job in responding quickly and appropriately to the seriousness of the developing situation there. The ambulance service staff were hands on in identifying serious concerns for resident's health, safety and welfare on the weekend of 15-16/02/20, for assessing and caring for residents, and for notifying the CCG on call. The Hazardous Area Response Team (HART) delivered a supply of blankets and West Sussex Fire and Rescue delivered portable heaters. The call out and attendance of the out of hours GP and community services over the weekend helped to ensure that residents were properly cared for.

9.23 Had the condition of residents otherwise gone unchecked over that weekend in February 2020, the lives of residents would have continued to be at serious risk, for example, from hypothermia. The swift action taken by services may have saved the lives of a number of residents.

9.24 CQC's responsive inspection which started on the afternoon of Monday 17/2/20 led to enforcement action being taken and the cancellation of the provider's registration on 19/2/20.

10. Analysis of findings

Did the quality of care rapidly decline at Kingswood Home, or was were there warning signs?

10.1 A question that emerged during this review was whether the standard of care at Kingswood Home deteriorated very rapidly, such that there were no warning signs or whether it was already, and had been for some time, poor.

10.2 The reports of agency contact with Kingswood Home during the review period frequently make positive statements about the quality of care at Kingswood Home and on 14/02/20, the day before the incidents that ultimately led to the closure of Kingswood Home, no concerns were raised during a visit at which a MUST (Malnutrition Universal Screening Tool) assessment was made. Whilst MUST focuses on food intake, the guidance also references "eating and drinking". As already described in this report both the ambulance service and the CQC identified that many residents were dehydrated.

10.3 However, as shown in the findings section above there were persistent concerns about:

- Management and management practices, including bullying and lack of scrutiny.
- Staffing, including staffing levels, training, attentiveness to residents and morale.

- No reporting of safeguarding concerns and falls.
- Individual care including weight loss, medication administration and pressure care.

10.4 Consequently, even if the quality of care had decreased rapidly between the last visit by a professional on 14/02/20 and 15.06 on 15/02/20 when the ambulance crew arrived at Kingswood Home, there had been warning signs that the service was not always providing the quality of care that it should have provided.

Did Kingswood Home try to obscure the poor quality of care?

10.5 A further question was to what extent was poor care covered up by Kingswood Home so that visiting professionals could not identify it?

10.6 During this review, practitioners reflected that when they visited to see their clients or patients, the doors to other residents' rooms were kept closed, so they could not assess the general environment of the home. Notes were locked in the staffroom; care home staff were reluctant to talk without the care home manager present. Nurse practitioners reflected that there were concerns about staff levels, training and care notes. Nurses entering Kingwood said that they had challenged the provider at times and had asked to view communal areas and see entertainment programmes. They were always told that entertainment had just finished or was coming later in the day.

10.7 West Sussex County Council staff also noted that their routine visits happened at certain times of the day and that they did not go to Kingswood Home at the weekend or out of hours unless there were any previously highlighted concerns.

10.8 Despite this the CQC inspection on 11/3/19, just under a year previously, was unannounced and resulted in a rating of "Requires Improvement", citing the need for improvement in induction, training and record keeping amongst other areas. This suggests that the care home was not "staging" or giving a false impression of the level of care provided at the time. If there were efforts at Kingswood Home to cover up the quality of care, these had not distracted the Care Quality Commission inspector.

Is there a need for curiosity or inquisitiveness when visiting residents in care homes (or in their own homes) to not only focus on the purpose of the visit to but to consider the environment?

10.9 Professionals concluded on reflection that the home manager was very good at instilling confidence and would often send through information and paperwork to show progress, although it may be that not enough was done to seek assurance that the actions had been completed. When professionals know what to say and do to provide reassurance, it can be difficult for other professionals such as social workers to challenge them. SCFT stated that its staff may only see patients in their rooms and therefore may not consider the wider service or environment. Nurses noted that the Kingswood was on their radar because

there were concerns about staffing, lack of training, and lack of/insufficient care paperwork. However, they were taken by care home staff directly to individuals' rooms and often all other residents' doors were shut. The owner was reported to have blocked visiting professionals from having contact with the staff and paperwork would often be locked in the office. It was felt that visitors only saw what the Care Home Manager wanted them to see. Concerns were raised internally within SCFT but did not prompt a multi-agency intervention.

10.10 This could be a case of disguised compliance, in that Kingswood Home gave professionals the indication that it was running well, gave the necessary assurances to be convincing and the impression that change would be made, yet did not then make any changes.

10.11 In hindsight these factors might have alerted professionals and organisations to the presence of problems at Kingswood Home, but they did not necessarily predict the level of neglect that became uncovered on 15/2/20 and over the following few days. Isolated, relatively low-level events may not have warranted any further scrutiny on their own but taken together they may have suggested that all was not as well as it seemed at Kingswood Home. It appears that opportunities to share intelligence were missed. If these issues had been shared between the agencies it might have prompted:

- a multi-agency response involving greater scrutiny and monitoring,
- the creation and implementation of a multi-agency improvement plan to tackle the problems at an early stage before they developed into major failure of care and neglect.

10.12 The CQC noted that prior to 15/2/20 it was having regular contact with West Sussex County Council about providers of concern, but that Kingswood Home was not a particular provider of concern. The CQC recognised, with the benefit of hindsight, that the lack of information it had from the home, paired with the inherent risk of having the Registered Manager and Nominated Individual being the same person and the prior "requires improvement" rating, could have been an opportunity to trigger more curiosity and scrutiny about Kingswood home.

Is there a need to work with relatives to increase their awareness of quality and "what good look like" in care homes?

10.13 There has been mixed feedback from relatives about the quality of care at Kingswood Home, for example:

- During the CQC inspection on 11/3/19 relatives gave positive feedback about the home.
- The Reviewer had a conversation with a relative who also gave good feedback about the management, staff and the quality of care.
- On 16/2/20 resident (for the purpose of this Review, referred to as K4) was admitted to hospital with a variable heart rate, swelling of the leg and possible urinary tract infection (UTI). There was a note that on 18/2/20, K4's sister was not surprised about the UTI since in four weeks she has not once noticed water in K4's bedroom.

- Subsequently, relatives revealed some concerns to CQC's inspectors during the inspection of the home over the period 17 to 19 February 2020.

10.14 Family members might be expected to form part of the overall quality monitoring of care services but, as was found in the Sutton Learning Together Review, they are not always aware of the standards and quality requirements that should be met. Relatives might also be unwilling to complain since they fear the consequences of doing so. These include fear of loss of the service and of their loved one moving to a new service which might be no better or perhaps worse than the current one. There is also a naturally optimistic tendency to hope and expect services to improve, which influences both professionals and relatives' judgements and decision making.

Summary

10.15 Prior to 15/2/20 there were warning signs about the quality of care in Kingswood Home. These do not seem to have been recognised at a multi-agency level and were not always shared between the agencies involved. As a result, there may have been opportunities to intervene to support Kingswood Home to improve.

10.16 There appears to have been a very considerable decline in the quality of care between the CQC inspections in March 2019 and in February 2020. Whilst none of the concerns identified during this period revealed the extent of this decline or predicted what would happen, there are some similarities between them.

10.17 There are a number of actions for the West Sussex Safeguarding Adults Board to consider based on the findings of the organisational review. These might improve the identification and sharing of concerns about the quality of services and interventions to resolve them.

11. Recommendations

The West Sussex Safeguarding Adults Board should work with partner organisations to:

1) Increase partnership working with private and voluntary sector providers so that they are part of a "system of care" and to engage with them as a partner in this. This includes supporting homes where there are quality concerns to make the necessary improvements rather than simply identifying the problems and expecting the homes to resolve them.

2) Develop the multi-agency understanding of regulatory requirements, contractual requirements, service quality, safeguarding and health and safety and the different approaches that can be used and the different legal frameworks and responsibilities that apply. This is so that there is a clearer understanding of what action is required, when and by whom when there are persistent concerns about services.

3) Increase the curiosity and inquisitiveness of staff when visiting residents in care homes (or in their own homes) to not only focus on the purpose of the visit to but to consider the environment, the culture and the practice of the service they are visiting. This should include developing strategies for overcoming the closed nature of the homes and recognising the limitations of overly optimistic approaches to service improvement.

4) Further explore how partners can work together to use their different legal powers and responsibilities to improve quality and safeguarding in services. This should be aimed at overcoming any reticence by individual agencies and workers, based on their previous negative experiences, about being more assertive with care providers on standards and expectations.

5) Develop ways of identifying and sharing information on unusually low (or high) levels of reporting of accidents/incidents, safeguarding concerns etc. This should include agreeing what unusually low or high means.

6) Promote, support and sustain whistleblowing and the raising of safeguarding concerns in services. Partners need to find ways for whistle-blowers to be protected so that they do not face discrimination and disadvantage during and after whistleblowing. This may need reinforcing through both regulatory and contractual expectations and requirements.

7) Increase family members' understanding of quality and "what good look like" in care homes. This needs to take into account the reasons why relatives may not complain or raise concerns and should include ways of overcoming these.