SHC Clemsfold Group Limited

Kingsmead Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:

Kingsmead Lodge is a residential care service that is registered to provide accommodation, nursing and personal care for up to 20 people with the following support needs; learning disabilities or autistic spectrum disorder, physical disabilities, younger adults.

At the time of this inspection Kingsmead Lodge was providing support for 10 people. At the end of the first day, one person moved out as planned to another service. On the second day of the inspection, the service was providing support for 9 people.

Kingsmead Lodge is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. This does not include Kingsmead Lodge but the investigation is on-going and no conclusions have yet been reached.

Kingsmead Lodge had been built and registered before the CQC policy for providers of learning disability or autism services 'Registering the Right Support' (RRS) had been published. The guidance and values included in the RRS policy advocate choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen.

Kingsmead Lodge requires further development to be able to deliver support for people that is consistent with the values that underpin RRS. For example, care planning processes did not always consider people's personal information and how these informed their individual support needs and wishes. People did not always agree, identify, review or develop individual support outcomes and aspirations or take part in meaningful activities. People's communication needs were not fully supported to enable them to have maximum control of their lives.

People's experience of using this service:

Risks to people were not always assessed, monitored and managed safely. This included risks associated with people's behaviours that may challenge, skin integrity, postural, mobility, choking and health monitoring support needs.

Information about people's care and treatment was not always made available in the most accessible way for people.

Medicines were not always managed safely.

There were not always enough suitably qualified, competent, skilled and experienced staff deployed to meet people's needs.

Lessons were not always learned and improvements made when things had gone wrong at the service.

People's needs and choices were not always assessed effectively so staff did not always know or understand how to support people to achieve their preferred outcomes.

People were not always receiving respectful or dignified support and staff did not always promote people's independence.

People did not always receive personalised care that was responsive to their individual needs, including support to follow their interests and access meaningful social activities.

Quality assurance and governance systems were not operating effectively.

Staff and management were not supported to understand or fulfil their responsibilities and ensure that regulatory and contractual requirements were met and quality performance and risks were understood and managed.

There were safe recruitment practices.

People and those acting lawfully on their behalf had been consulted and given consent before people were being provided with support.

Conditions on authorisations to deprive a person of their liberty were being met appropriately.

The service was clean and hygienic. The design, decoration and adaptation of the premises met people's individual needs.

This inspection identified repeat breaches of Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection identified a further breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Rating at last inspection:

We last inspected Kingsmead Lodge on 28 January 2019 and the final report was published on 30 April 2019. The service was rated Inadequate.

Kingsmead Lodge has been rated overall Inadequate in the two previous inspections that had taken place at the service between September and December 2018.

At each of these three previous consecutive inspections between September 2018 and January 2019 there have been multiple and repeated breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Kingsmead Lodge has been placed in Special Measures since October 2018. In the case of Kingsmead Lodge

the service was rated Inadequate in October 2018 and at each subsequent inspection, so has not been removed from Special Measures. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. Services in Special Measures will be kept under review and, if needed could be escalated to urgent enforcement action.

Why we inspected: This inspection took place on 22 and 23 May 2019. This inspection was scheduled and planned based on the previous rating to explore if the provider had acted to significantly improve the service to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enforcement: On 23 March 2020, we imposed conditions on the provider's registration telling them that they could not admit any service users into the service without the prior agreement of the Care Quality Commission. We also imposed a condition which requires the provider to tell us how they will address clinical oversight at the service, management of epilepsy and how they are responding to people's deteriorating health. The condition requires the provider to submit a monthly report to the Commission on their actions to improve in these areas

We imposed conditions on the provider's registration, due to repeated and significant concerns about the quality and safety of care at several services they operate. The conditions are therefore imposed at each service operated by the provider, including Kingsmead Lodge.

The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Follow up: The overall rating for this service is 'Inadequate' and the service remains in Special Measures. Services in special measures will be closely monitored and are expected to make significant improvements to ensure their rating is at least good. Where necessary, another inspection will be conducted within or before a further six months. If there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling or varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always Effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always Caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not Well-Led.

Details are in our Well-Led findings below.

Kingsmead Lodge

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

This inspection took place over two days on 22 and 23 May 2019.

The inspection team on 22 May consisted of two inspectors and a nurse specialist advisor.

The inspection team on 23 May consisted of two inspectors.

Service and service type:

Kingsmead Lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

The service should have a manager registered with the CQC. 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.

The service had not had a manager registered with the CQC since February 2018. In the period between February 2018 and the current inspection, the provider had recruited several managers to the registered manager post at the service. Applications to the CQC to formally register had been submitted by successive managers who had been recruited over a period between March and April 2018.

However, as these managers had left after only a short time in post, their registrations were not completed.

Following this, later managers responsible for overseeing the service had not submitted applications to register with the CQC until the provider recruited a manager to the registered manager's post who started in April 2019. At the time of the inspection, the manager was in the process of formally registering with the Care Quality Commission (CQC).

Notice of inspection:

This inspection was unannounced.

What we did:

Before the inspection we reviewed information we held about the service. We considered the information which had been shared with us by the provider as well as the local authority, other agencies and health and social care professionals.

We looked at any safeguarding alerts which had been made and notifications which had been submitted by the provider. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

During the inspection we spoke with four care staff, two registered nurses, the chef, a peripatetic manager, the deputy manager, the manager and the regional operations manager.

We 'pathway tracked' 4 people using the service. This is where we looked at people's care documentation in depth and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care.

We spoke with people using the service and observed people's support across all areas of the service.

We reviewed staff training and supervision records, staff recruitment records, medicines records, care plans, risk assessments, and accidents and incident records.

We also reviewed quality audits, policies and procedures, staff rotas and information about activities people were supported with and provided by the service.

The manager was on planned leave for the afternoon of 22 May and on 23 May. Due to this, we arranged to speak with them via telephone after the inspection site visits had taken place and they had returned from leave and did this on 31 May.

For this inspection we did not request a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm.

Some regulations were not met.

Assessing risk, safety monitoring and management, learning lessons when things go wrong, systems and processes to safeguard people from the risk of abuse, using medicines safely

●At the last inspection the provider was not doing all that was reasonably practicable to mitigate risks related to people's epilepsy, hydration, constipation and choking support needs. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we looked to see if the provider had made necessary improvements since the last inspection and if this breach of regulations had been met and found that it had not.

●People had risk assessments in place that identified any potential hazards to their well-being, including risks related to their epilepsy and choking support needs. Some people had several different risk assessments containing different information and levels of guidance about how to manage risks safely. Staff had not always received training to enable them to use equipment or know how to safely support people with identified risks. Monitoring records did not always show that people had been supported to manage risks safely. We observed that staff were not always following guidance in people's risks assessments. Recommendations from healthcare professionals about how to help manage risks to people were not always followed up quickly.

●For example, most of the 10 people living at Kingsmead Lodge were at risk of choking or aspiration when eating or drinking. There was a lack of guidance about actions staff should take in the event of people choking. Healthcare assistants (HCAs) and registered nurses (RGNs) had not always received training to use necessary equipment to support people when choking. HCAs and RGNs we spoke with were not always knowledgeable or confident about what to do in the event of a choking incident occurring.

●Some people living at Kingsmead Lodge had been identified as being at risk of aspiration (choking) when receiving their PEG feed. PEG is an abbreviation for percutaneous endoscopic gastrostomy (PEG) tube. This is a tube that is inserted into a person's abdomen, so they can receive liquid food, fluids and/or medicines directly to their stomach. Staff we spoke with told us they were aware of how to support people to receive their PEG food and fluids safely. However, people's PEG care plans and risks assessments contained different guidance and amounts of detail about how to support them to safely manage risk of aspiration. Food and fluid records monitoring the risk of aspiration for people with PEG support needs did not show that people had been consistently receiving their PEG feed in a safe way.

●For example, PEG care plans did not always identify when people needed to be at a safe angle when

receiving their feed, or when feed should be paused if people needed to move and it was not recorded that this was being done. We observed that people appeared to be at a safe angle when being fed via PEG but that staff were guessing the correct elevation, rather than accurately confirming this. Staff were not always recording that they were cleaning or rotating people's PEG's as directed, to manage the risks of inflammation and infection.

●Risks associated with choking and aspiration have been highlighted in inspection reports about a number of the provider's other services. This information had not led to similar risks to people at Kingsmead Lodge being properly reduced.

● People's epilepsy protocols and risk assessments had been regularly reviewed. However, some people's risk assessments and protocols for administering rescue medicines in the event of a prolonged seizure continued to contain minimal, incorrect or contradictory and conflicting information. Recent monitoring records showed that staff had not followed the guidance in their epilepsy risks assessments when supporting people during a seizure. Recommendations following referrals to healthcare specialists such as neurologists regarding managing epilepsy risks had not always been recorded or acted on within timeframes suggested by the specialists.

●Some people living at Kingsmead Lodge needed support to manage risks associated with their skin integrity, postural support and mobility support needs. Guidance and direction available for staff to manage these risks was not always documented. People's postural, mobility and skin integrity support needs included the use of specialist equipment including pressure relieving mattresses and mobility aids such as wheelchairs, hoists, slings and slide sheets. For some people, there was no record of regular checks being made of their equipment to confirm that it was safe enough to use. Staff had not always known how to use people's pressure care equipment. We observed one person's postural support equipment not being used as required. Recommendations about using specific mobility equipment made by healthcare professionals had not always been followed up within timeframes suggested by the specialists.

● To help monitor and manage risks associated with people's urgent healthcare needs, staff used a standardised system for recording and assessing baseline observations of people's health indicators. This included temperature, pulse, blood pressure and respiratory rates. The system was called National Early Warning Score (NEWS). NEWS was designed to ensure that people's health needs were effectively monitored and, if necessary, people could be supported to receive or access healthcare support and services quickly. Staff were expected to complete NEWS as and when required if noticing a person appeared or was unwell.

● RGNs were responsible for completing NEWS but not all RGNs working at the service had received the necessary training to know how to use the NEWS systems. NEWS charts were not always being completed as and when required. There were examples of where staff had not contacted emergency medical services when scoring on a persons' NEWS indicated that this was necessary. People were at risk that their healthcare needs may not be monitored or escalated appropriately.

●There were systems in place for staff and management to report, review and investigate safety and safeguarding incidents. However, these systems were not always effective. Safety incidents had not always been reported internally. Where incidents had been reported they had not always been reviewed, investigated and acted on to prevent a recurrence. For example, we saw incidents relating to missed medicines and unexplained bruises had been reported in April and May 2019. The peripatetic manager and manager confirmed they had not been aware of and had not reviewed these incidents. They confirmed that the nature of these incidents required further investigation and response to ensure people were being

supported to be as safe as possible and help avoid them happening again.

●Safety incidents had not always been reported externally to appropriate agencies, such as the local authority or NHS clinical commissioning groups. This meant that any further necessary review and input was not obtained regarding reasonable actions to keep people safe, ensuring lessons were learned and any necessary improvements were made.

● Staff had received training and support to help them to be able to recognise safeguarding concerns and know how to use the forms and report incidents. However, not all staff understood their responsibilities to report incidents or make sure that if an incident occurred this was reported as soon as possible.
Not reporting incidents or delays in reporting meant that the manager would not always know or be able to act as quickly as possible to help ensure people were kept safe.

● The service was currently using a mixture of permanent and agency staff to meet people's needs as necessary. There had been a decrease overall in use of agency staff since the last inspection, although at the time of the inspection, while they recruited to staff vacancies, all nurses on day shifts were from an agency. Although all formal inductions had been completed for agency RGNs and HCAs working at the service, not all agency RGNs we spoke with had been able to access and discuss information about how to support people's individual needs safely, before leading the shift. As a comprehensive handover had not taken place,
The RGNs said they were relying exclusively on speaking with other staff or locating documents themselves if needing information on an 'as and when' basis should this become necessary during the shift. This could increase the risk of a delay in providing people with support they needed to keep them safe.

●Systems and processes were failing to ensure medicines were consistently being managed safely. Staff completed stock control sheets after administering medicines to keep a total of how much medicine people had. However, stock counts of medicines had not always been consistently completed. Stock counts did not confirm running balances of stock carried forward or returned. Stock counts could not be checked against Medication Administration Records (MAR's) to see if they corresponded with medicines that had been given. Where completed, stock counts showed excess or missing medicines were unaccounted for. Levels of stock recorded on stock control sheets did not always correspond with balances found in stock. It was not known if these medicines had gone missing, been stolen or had not been given to people.

● People had their own MAR's. Some people's MAR's were not clear and accurate and required more detail about how their medicines were taken or used. For example, the time and route of administration was not included on MAR's for people who required their medicines via certain routes. MAR's had not always been completed accurately to record when medicines had or had not been administered. For example, there were gaps in administration records where staff had not signed so it was not known if people had received their medicines as prescribed.

●People did not always have accurate, up to date or detailed protocols for when to offer and administer any prescribed 'as and when required' (PRN) medicines. Medication Administration Records (MAR) had not always been completed to record when PRN medicines had been given and the reasons why. This increased the risk that people may have too much or too little PRN medicines, or that they may be administered when it was not necessary.

● Audits to check that medicine systems and staff practice were operating safely were not taking place as per the provider's expectations - once weekly and once monthly. Where they had taken place, management

audits had not always identified issues. Where issues had been identified there was not always actions to investigate and address these. For example, repeat medicine errors had occurred at Kingsmead Lodge in recent months concerning people missing medicines used to treat conditions associated with individual's specific health conditions. There were multiple gaps in MAR's, repeat stock discrepancies, including reported excess medicines and controlled drugs indicating medicines had possibly not been given.

●The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, deploy suitably experienced and knowledgeable staff, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Risks to people associated with their constipation and hydration needs were being monitored and managed safely. Staff completed monitoring charts for people with bowel care support needs who were at risk of constipation. If charts indicated that further support was needed to keep people safe, such as accessing further medicines or healthcare services in the event of becoming constipated, this had been done. Staff were aware of people's fluid recommended daily amounts (RDA) and completed monitoring charts so they could see that RDAs were achieved reducing the risk of people becoming dehydrated.

Staffing and recruitment

●To help address the risk that shifts may not contain the right mix of experienced and knowledgeable staff, the provider had recently introduced a more comprehensive agency staff induction process. This covered safety related environmental, accident and incident and emergency recording and reporting systems, processes and practices. Wherever possible, the same agency staff were booked for continuity.

●Rotas had been written to allocate staff, based on the provider's calculations of the levels of support people needed. People did not raise any concerns about staffing levels. All staff we spoke with told us there were enough staff. One staff said, "Staffing levels are good." The peripatetic manager explained that the provider had purposefully not reduced staffing levels, although several people had left the service over the last 12 months, to ensure that there was less pressure on staff and to help improve the service.

● All staff working at the service had undertaken a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Permanent staff submitted applications, references and passed a competency-based interview prior to being offered a position.

● All nurses working at the service had a valid registration pin number with the Nursing and Midwifery Council (NMC). The NMC regulates nurses and midwives in the UK against their set standards of education, training, conduct and performance. A valid NMC registration helps ensure nurses have mandatory nursing knowledge, training and skills and uphold expected professional standards.

Preventing and controlling infection

● The service was clean and hygienic. The provider employed cleaning staff who carried out daily cleaning of all areas and equipment in use at the service. Plastic gloves and aprons where available and staff used these when supporting people with their personal care. Hazardous waste was managed appropriately.

There were separate catering staff and both they and support workers received food hygiene training to help ensure food was handled and prepared safely.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law, staff support: induction, training, skills and experience, staff working with other agencies to provide consistent, effective, timely care

● An assessment of people's needs was carried out before they started using the service. If appropriate, family members and health and social care professionals were also consulted. However, the assessment process focused heavily on people's clinical health needs and diagnosis and did not always consider their social needs. There was a lack of information and detail about the specifics of the support people needed in all areas of their lives and why this was important.

●People's assessments also lacked detail about how best practice guidance informed the support people needed, or what people wanted from their support. It was not always evident that people's differences had been considered or respected during the assessment process, to ensure they had been protected from any direct or indirect discrimination relating to their support needs or decisions. This increased the risk that people would not achieve their preferred support outcomes.

● The failure to ensure care and treatment is designed to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●At the last inspection the provider was not ensuring that staff had always received appropriate training to be able to meet people's needs. A specific concern was identified regarding staff not receiving training and support to be able to deliver effective care for people who could display behaviours that may challenge. There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we looked to see if the provider had made necessary improvements and if this breach of regulations had been met and found that it had not.

● The provider had begun a process of training all permanent staff in Positive Behaviour Support (PBS) approaches when supporting people who may display or be at risk of displaying challenging behaviour. PBS is a holistic, person-centred approach to supporting people with a learning disability and/or autism. PBS promotes preventative and positive interventions from staff to help avoid the need for using reactive and restrictive practices. This enables people to enhance their quality of life and learn new skills to replace the challenging behaviour.

●PBS training had been delivered for half of the existing permanent staff team in April 2019, with more opportunities for the remainder of the staff team to receive training in May, June and July 2019. Despite some staff having received PBS training, staff were not putting this into practice, to ensure that people who required this support were being consistently supported in line with PBS principles.

●For example, behavioural monitoring records were in place for some people to help record information about when, where and what happened when they displayed behaviours that may challenge. For some people referrals to health and social care professionals about their support needs had led to specific recommendations about monitoring changes in specific behaviours. However, behavioural monitoring forms were not always completed as recommended when people displayed challenging behaviours.

●Where monitoring records had been completed they showed that people were not being supported in line with PBS principles. For example, for one person who displayed physical aggression towards staff and other people, staff had reacted immediately in a punitive manner towards the person. The person had then repeated the challenging behaviour shortly after and received the same reaction from staff. No review had taken place of these incidents when they had occurred. There had been no review of the monitoring records after the incident to analyse and identify what had occurred. Staff had not been supported to understand why the support had not been effective or the impact this could have on the person's well-being or other people's safety. This increased the risk this behaviour and ineffective support could reoccur.

●For people who could display behaviours that may challenge, functional assessments PBS plans and communication tools had yet to be completed. People's existing support guidance did not always identify or explain the functions behind individual's challenging behaviour or explain how staff should respond to behaviours based on the known reasons for their behaviours. Although recently reviewed, directions in some behavioural care plans about what staff should do if people did display challenging behaviour identified punitive, reactive and restrictive actions. This increased the risk that staff could continue not to know how to meet people's behavioural support needs in the best possible way.

●Agency staff were used to cover staff vacancies. The agency staff induction and supervision processes were not always effective in ensuring staff had the right knowledge to give effective care and support. Agency staff who regularly worked at the service had not always received training in subjects relevant to supporting people at Kingsmead Lodge, either from their respective agencies or via the provider. These issues and on-going use of agency staff had affected the ability of the service to deliver effective care. The manager said, "Use of agency is having a big impact. Most agency did not understand their responsibilities." One staff said, "It's much better with less agency staff. When working with permeant staff everyone knows what to do."

●Permanent staff were expected to receive regular supervisions of their practice during and after their initial probation period and complete training specific to people's needs. Although there had been an increase in staff completion of training since the last inspection, not all staff had received or completed training in subjects relevant to their roles. Due to changes in management, staff supervisions had not always been carried out regularly. Staff had not always had support to ensure their professional knowledge was up to date and they were delivering support to people in line with relevant best practice guidance.

● The failure to ensure staff had received appropriate support, training and personal development and evidence that the service had assured themselves of their competence to carry out the duties they are employed to perform is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We discussed this with the manager, who told us they were aware of the issues and had been working with the provider's internal training team to help prioritise and arrange for relevant training to be delivered as quickly as possible. The manager had met with some staff for supervision and had scheduled these in advance for the year ahead, to help ensure these would take place. The manager was working to address issues regarding agency staff competence and understanding. This included providing agency staff with more active supervision and support while on shift, from both staff and management.

●The provider's agency and permanent staff induction and probation processes were currently being revised to ensure they were more comprehensive. This included the expectation that all permanent new staff received relevant training and supervision that met Care Certificate Standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve. The provider was re-training staff in e-learning modules that corresponded with the care certificate learning if their previous induction and training did not include these equivalents.

Supporting people to eat and drink enough to maintain a balanced diet

● People had risk assessments and care plans that identified their eating and drinking support needs. Where relevant, additional support from specialist community speech and language therapist (SaLT) and dieticians had been sought, to help assess and provide guidance about how to provide effective eating and drinking support. This included information about how to manage complex needs, including risks such as malnutrition, PEG management, choking, aspiration and dehydration.

●People did not raise any concerns about the quality of the food or having enough to eat or drink. One person said the food was "Really tasty". Meals were appropriately spaced throughout the day and mealtimes could be flexible to meet people's needs. People could eat in a choice of dining areas or in their rooms. Meals were used as a social occasion and most people would all chose to eat in the same dining area for at least one of their main meals a day. Mealtimes took place in a calm environment with minimal distractions.

●There were monthly meetings between people and the chef where they could say what they would like to eat, including cultural or religious preferences. The chef used this information to plan menus in advance. Menus included these choices and were changed regularly. If people did not want what was on the menu on any day, they were offered alternative meal choices. Staff helped promote a balanced diet that met people's nutritional needs. For example, by explaining about the health properties and benefits of different foods when discussing people's menu choices with them.

Supporting people to live healthier lives, access healthcare services and support

●There were systems and processes in place to help ensure people's healthcare needs were met. People had support plans and about how best to meet their healthcare needs for staff to reference. 'Hospital Passports' were in use. These contained information about people's health and communication needs, to help share information about people's healthcare needs and treatment options if people needed to go to hospital or use other medical services. People had regular support to see the GP and HCAs and RGNS monitored people's well-being daily through talking with people and observing their presentation. People with specific healthcare conditions had received support to access relevant specialist services and make referrals for on-going advice and treatment.

Ensuring consent to care and treatment in line with law and guidance

● 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 Act 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

●At the last inspection, the provider had not ensured people's consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. There was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we checked to see if improvements had been made and this breach of regulations had been met. We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that improvements had been made and the breach of regulations had been met.

● All Staff had received MCA training to help them understand and put into practice the principles of this legislation when supporting people. In people's care files that we sampled, where people might lack mental capacity to be able to make decisions about different activities, this had been assessed. Where they were not able to make certain decisions, the person with authority to act in their best interests had been identified and involved in making any decisions about their care.

● Everybody living at Kingsmead Lodge had an active DoLS in place. An appropriate assessment process had been carried out for each person. The manager kept an overview of DoLS application status for each person, including when it was applied for, granted and expired. Where renewals of DoLS authorisations were needed, these had been applied for in a timely manner. Where relevant DoLS conditions had been authorised, these were clearly identified and were being met.

Adapting service, design, decoration to meet people's needs

●People had their own bathrooms with en-suite facilities. People's bedrooms had been personalised with their own pictures, decorations and furnishings. One person said, "I like my bedroom." There was a large central communal space and smaller communal areas in different areas of the service, including a conservatory and two smaller lounges. These spaces were used by people to take part in activities and spend time with each other or with visitors. Communal areas were decorated with pictures and photographs of things people liked.

●There was a separate sensory room containing specialist equipment designed to help create a motivating environment and encourage people's emotional self-awareness. We observed people enjoying spending time there regularly over the two days of the inspection. The conservatory area was decorated to create a different sensory environment based on certain themes. Themes were changed on a rotating basis every few months. For example, there was currently a jungle theme that included sensory objects and decorations based on a jungle environment.

●The service had a separate self-contained paved outside area that people could use to spend time in the garden. The area contained flower and vegetable beds which were currently being developed to create a sensory environment and provide an opportunity for people to do some gardening if they wanted to.

● The premises had been designed to accommodate people with physical disability support needs. There were wide doorways and corridors to allow for wheelchair access throughout all areas of the service. Equipment such as ceiling track hoists had been installed in individual bathrooms and bedrooms to support people with transferring from one place to another. There was appropriate signage on doors to toilets and other communal rooms and facilities, to help people find their way around the building.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence, ensuring people are well treated and supported; respecting equality and diversity, supporting people to express their views and be involved in making decisions about their care

●At the last inspection, we identified the service required improvement to give caring support to people. We identified specific concerns that people's independence was not always being promoted or their privacy and dignity respected. At this inspection we looked to see if the provider had made necessary improvements and found they had not.

● Following an assessment of a person's needs by health and social care professionals, eating and drinking guidelines stated their preference and ability to feed themselves. The guidelines directed staff to always encourage the person to feed themselves when supporting them to eat. We observed staff feeding the person directly, making no attempt to encourage or allow them to do this independently. Staff told us, "We always feed them because they make a mess. Their (relative) prefers us to feed them".

● We observed and reported on the exact same practice involving the same person at the last inspection. The person's preferences for how they wanted to be supported, including ensuring they could be as independent as they wanted to be, had not been respected or promoted by staff.

●At the last inspection, we raised concerns that people's care plans contained disrespectful and inappropriate language when providing instructions to staff on how to support them. This included descriptions of people's emotional and behavioural support needs being described as 'misbehaving'.

●We found that, despite being reviewed, the same care plan remained in use, describing people's behavioural and emotional support needs as 'misbehaving'. There was also similar disrespectful and inappropriate language used in behavioural care plans. For example, advising staff people's behaviours that may challenge should be considered 'untoward'.

●The failure to ensure that people are treated with dignity and respect and their independence is supported is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people we spoke with were unable to provide us specific feedback about how well staff took their preferences and needs into account but raised no concerns. Staff looked for accessible ways to help people

communicate in their day to day interactions with them. For example, we saw staff using people's individually preferred phrases or gestures and using objects of reference and pictorial aids to help engage and have conversations with people in ways they understood.

●We saw some staff use Makaton to talk to and listen to people who preferred to use this. Makaton is a language programme using signs and symbols to help people to communicate. Further Makaton training sessions were being arranged for all staff, along with more general communication training, to help support people's communication needs.

●Staff told us they understood the importance of respecting people's privacy. We saw examples of how staff did this when supporting people throughout the inspection. For example, where people chose to spend time alone or receive certain aspects of their support in their bedrooms, staff made sure they respected their wishes in a discreet manner. People were provided with support from people of their preferred gender when receiving intimate personal care. There were data protection and record keeping polices in place to make sure that people's personal information was correctly stored, used and shared.

●Staff had recently received equality and diversity training to help them to better understand why it was important to understand and respect people's needs and choices, including those related to their protected and other characteristics under the Equality Act 2010.

● One person told us "I am happy". Another person said, "I like it here". Staff were kind and compassionate. Staff said they had time to spend with people and talk with them during their shifts and when providing support with specific tasks. We observed some positive examples of staff taking time to listen to people and involve them in decisions about their care when providing them with support. For example, explaining and answering questions about people's support and asking permission when offering to provide it.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control, end of life care and support

●At the last inspection, people were not always being provided with personalised care that was responsive to their needs. We found there were specific issues regarding; information about people's care was not always available in the most accessible way; people's care plans did not fully reflect their needs and changing needs; activity support was not personalised or meaningful, and people did not have support to access the community or opportunities to participate in social groups. There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we looked to see if the provider had made necessary improvements and if this breach of regulations had been met and found that it had not.

●Following an initial assessment process that was focused on people's health and clinical needs, there was limited information captured regarding people's personal history, individual likes and dislikes, interests, and how these informed their support needs and choices. People's care plans therefore did not fully reflect their social and emotional needs, preferences and aspirations.

●People were not always supported to be involved in planning and reviewing their care. Regular reviews of care plans and delivery of peoples' care took place. For some people, changes to their needs had not been identified and their care plans had not been amended to reflect these. Staff told us they relied on informal verbal communication to ensure that everyone knew about any necessary changes. However, this presented a risk that staff may not have access to up to date information about people's support needs.

●Reviews of people's care were not scheduled in advance and people's involvement in these reviews was limited When people had been involved their input into plans and reviews was not documented. Language and directions for supporting people in some care plans was not respectful or dignified. People had not been supported to identify and review on-going individual aspirations and life goals.

●Since the last inspection, the provider had assessed people's communication needs. However, following these assessments, reasonable adjustments had not always been made to ensure these needs were met when recording or sharing information with people. For example, individual care plans and daily notes, information about menu and activity choices, support schedules and service policies continued to be available in written format which was not accessible for everyone. Some people used assistive technology to help them communicate but this was not always considered or used to help share information and gain

their views about their care. People's control was therefore limited by the lack of communication support

●The service was responsible for supporting all people living at Kingsmead Lodge to follow their interests and take part in socially and culturally relevant activities, including within the wider community. Since the last inspection, the service had recently appointed a new activities co-ordinator who told us they had met with people and their families to help understand their likes and dislikes, so they could develop individually meaningful activity support schedules.

●This was still underway, and many people's activity plans remained generic and focused on group activities. Staff did not always record or confirm what support people had received with activities, including during their allocated individually funded one to one hours. There was no formal regular review of people's activity support. There was limited informal communication between staff and people regarding the activity schedules in place and the support people were receiving, including when people's needs' and preferences changed. People's individual support needs and developmental life goals were not always reflected or responded to in the activity support currently being delivered.

●The failure to do all that is reasonably practicable to make sure people receive person-centred care that is appropriate, meets their needs and reflects their personal preferences is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●We discussed this continued breach with the manager who said that work was on-going to improve accessibility of information, review and re-write people's care plans and improve activities. There were plans to make changes to staffing structures, rota arrangements and implement a 'key-working' system.

●Where activity logs had been completed these showed there had been an increase in people accessing the community and taking part in more varied activities since the last inspection. There were examples of people taking part in culturally relevant activities, such as going to a local church to practice their religious faith every week. Some people continued to receive support to access social and educational learning opportunities at a local day centre. We observed people participating in and enjoying group and individual activities during one of the days of the inspection.

● Staff told us about how they provided appropriate emotional support and reassurance for people coming to the end of their life. People had been supported to identify what their spiritual and cultural needs and wishes were, to help ensure they were treated with dignity as appropriate to their personal beliefs.

●There was information about the approach to supporting people with their end of life care regarding emergency resuscitation in the event of a medical emergency. There was an expected pathway for arranging any necessary medical equipment and resources needed to support people approaching their end of life. This helped to ensure that people could be as comfortable and pain free as possible.

●It was not always clearly recorded when some people's preferences and choices regarding their social and communication support needs had changed while the service was providing their end of life care. It was not always documented that staff were aware of changes and were delivering support in line with the person's requests. This increased the risk that the person could not receive personalised and dignified support in their final days.

Improving care quality in response to complaints or concerns

● There was a complaints policy that outlined the service's commitment to ensuring complaints were dealt with without discrimination or disadvantage. Information about raising concerns formally was available for people and staff were expected to support people to raise a complaint if this was communicated informally to them. There had been no formally recorded complaints since the last inspection. The manager told us that any complaints received would be reviewed to help learning and encourage developing any areas of practice that might require improvement.

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

There were widespread and significant shortfalls in service leadership.

Leaders and the culture they created did not assure the delivery of high-quality care.

Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, continuous learning and improving care, working in partnership with others

●Since the last comprehensive inspection in January 2019, there had been improvements in some areas of practice including ensuring that people's consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. One identified breach of regulations had been met.

●However, areas of practice relating to risk management, people's healthcare, personalised support, staffing and quality assurance had not improved. Four breaches of Health and Social Care Act 2008 (Regulated Activities) 2014 had continued not to be met, including regulations 9, 12, 17 and 18. There was one newly identified breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Some of the specific issues we found at this inspection were the same as had been reported after our last inspection. This had left people exposed to potentially high risks of harm and poor-quality support and evidences a lack of continual improving care.

●Concerns about risk management, health monitoring, epilepsy, choking, managing behaviours that challenge, medicines, providing respectful and dignified care and poor leadership and governance have been highlighted to the provider in reports of inspections at many of their other services. This had not led to shared learning so that care at Kingsmead Lodge was developed and improved.

●At the last inspection, we identified that the service was not well-led. There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we looked to see if the provider had made necessary improvements and if this breach of regulations had been met and found that it had not.

●There were quality assurance and governance systems in use. These included different audit and quality review processes, undertaken by the manager and internal and external quality support staff. There was centrally accessible service development plan which had been designed to record identified actions from various audits, how these had been prioritised and when they would be completed by.

●However, these systems were not currently operating effectively. Audits did not always identify the actions

required to address any quality issues, how these should be prioritised and when they should be completed by. When this had been done, actions from individual audits were not always recorded, including on central development plans, to allow for effective managerial oversight. The provider had not always been aware of or been able to ensure that quality and safety issues had been addressed effectively, within expected timeframes or at all. Actions to address breaches of regulations identified at the last inspection had not been completed effectively or at all. People had continued to receive poor quality support and were placed at risk of receiving potentially unsafe care although this had, in some cases, been previously identified as requiring attention.

●For example, actions on the service development plan regarding improving accessible information about people's care had been identified and set a date to be completed by February 2019 but this had not been achieved. Actions relating to improving medicine audits, including ensuring audits were completed regularly and identifying and acting on issues had been signed off as completed in January 2019. However, there were several on-going issues with monitoring and management of medicines. There was confusion amongst staff about who should be carrying out medicine audits, when they should do this, what action to take regarding any issues and who should take responsibility for overseeing completion of any required actions. Immediate actions had been identified on the service development plan to improve people's PEG care in February 2019 and signed off as completed. However, we found that people's PEG care plans and risks assessments required improvement and records relating to people's PEG support needs did not show that people had been consistently receiving their PEG feed in a safe way.

●Specific issues relating to staff delivering undignified eating and drinking support to people at the last inspection were observed to be continuing. Safety incidents relating to possible neglect had not always been reported internally or externally. For example, where safety incidents relating to medicines errors and unexplained bruising had been reported they had not always been reported internally or externally reviewed, investigated and acted on to prevent a recurrence.

●People's care records were not always regularly reviewed or accurate. For example, people's care plans, risk assessments, medicine protocols relating to their epilepsy, skin integrity, behaviours that may challenge and activity support continued to contain minimal, incorrect or contradictory and conflicting information. People's healthcare monitoring records relating to their PEG care, behaviours that may challenge, NEWS and activity support had not been completed accurately or consistently.

●Recommendations and actions identified by partnership agencies regarding people's support needs had not always been implemented or consistently followed. For example, there had been actions identified for all parties involved following a joint review of a person's care by NHS community learning disability nurses and physiotherapists and the person's GP. The actions had been agreed to have been completed and a feedback review to take place by the end of January 2019. Some of the actions agreed for both staff at the service and the partnership agencies had significantly overrun the timeframe without being completed. No feedback review had been arranged to look at the progress of the actions and address any barriers to ensure the outstanding actions would be completed without any further delay.

●The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved and the service worked in partnership effectively with other agencies is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●At the last inspection there was no registered manager in post and this was a continued breach of section 33 of the Health and Social Care Act 2008. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

●The service had not had a manager registered with the CQC since February 2018. In the period between February 2018 and the current inspection, the provider had recruited several managers to the registered manager post at the service. Applications to the CQC to formally register had been submitted by successive managers who had been recruited over a period between March and April 2018.

●However, as these managers had left after only a short time in post, their registrations were not completed. Following this, later managers responsible for overseeing the service had not submitted applications to register with the CQC until the provider recruited a manager to the registered manager's post who started in April 2019. At the time of the inspection, the manager was in the process of formally registering with the Care Quality Commission (CQC).

●Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility, engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The manager acknowledged that a vision of high-quality person-centred support had not always been planned or promoted at local or senior level. They were committed to changing the existing culture within the service and were supporting staff to be able to understand and achieve the delivery of personalised support, including considering how better to involve people. They told us that, "I want to change the institutional culture. We are here to support people do what they choose with respect and dignity, not do things for them in a task-orientated manner."

●The manager told us it was important they were approachable, visible and had first-hand knowledge and experience of day to day issues and practice. This included ensuring that supervisions and team meetings now occurred regularly, and they spent time working with and observing staff on a day to day basis.

●Staff told us that the promotion of an open culture and the manager's visible approach was helping them understand their responsibilities and was motivating them to want to achieve good outcomes for people. One staff said, "People deserve the best of the best. We've had an unsettled time here with change in managers. However, with new management, morale is lifting. The new manager is very supportive, and their management style is very good."

● People and relatives were sent questionnaires to ask for their views on what was and was not working at the service and what staff could do to make their support better. The provider had recently changed their recruitment policy to make sure that all staff's involvement and engagement at all levels and the wider organisation would be encouraged and valued equally, regardless of any protected characteristics under the Equality Act 2010.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to ensure care and treatment is designed to meet people's needs. Failure to do all that is reasonably practicable to make sure people receive person-centred care that is appropriate, meets their needs and reflects their personal preferences.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Failure to ensure that people are treated with dignity and respect and their independence is supported.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, deploy suitably experienced and knowledgeable staff, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved and the service worked in partnership effectively with other agencies

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure staff had received appropriate support, training and personal development and evidence that the service had assured themselves of their competence to carry out the duties they are employed to perform

The enforcement action we took:

We imposed conditions on the provider's registration.