SHC Clemsfold Group Limited

Kingsmead Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 4 January 2017 and was unannounced. Kingsmead Lodge is a nursing home for up to 20 younger people with complex physical and learning disabilities. On the day of the inspection there were 16 people living at the home.

The home had a registered manager who had been in post since October 2015. A registered manager is a person who has registered with the Care Quality Commission 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.

People were not consistently supported to access the community when they wanted to. One person said, "I would like to be able to go out more." A relative told us, "There are not enough staff for people to be able to access the community." People did not always have enough to do. Organised activities were planned and people told us they enjoyed these. However staff were not always available to support them with meaningful activities and some people had little to interest or occupy them. We have identified this as an area of practice that needs to improve.

People had comprehensive and detailed care plans to guide staff in how best to meet their needs. Some people's care plans had not been updated when their needs had changed. This meant that there was a risk that some people might receive care that was not appropriate for their needs. We identified this as an area of practice that needs to improve.

The provider had robust recruitment procedures in place to ensure that staff were suitable to work with people. Staff had a good understanding of how to keep people safe. They knew what to do if they suspected abuse and understood their responsibilities to report any concerns. Risk assessments were completed and reviewed regularly and care plans were developed to ensure that risks were managed effectively.

People received their medicines safely from staff who were trained. There were sufficient numbers of suitable staff to care for people safely. People were supported to have enough to eat and drink and people's nutritional needs were managed effectively. People had access to health care services and received ongoing support from a range of health care professionals. One relative told us, "My relative did have health issues last year and they dealt with it very quickly, they let us know what was happening. It was excellent how it was handled."

Staff had a clear understanding of their responsibilities to comply with the Mental Capacity Act 2005. People's care plans included clear, personalised guidance for staff in how to seek consent from people. Staff told us they had the training and support they needed to be effective in their roles. One staff member told us that the training they had received was good, they said, "I'd say it helps us care for people better." People and their relatives said that they had confidence in the staff. A relative said, "The staff are excellent."

Staff knew the people they were caring for very well. They were able to communicate effectively with people and involved them in making decisions about their care and support. A health care professional gave us their views on the staff saying, "I love the way they are with the residents. They know them really well and are very knowledgeable and respectful". Staff respected people's privacy and maintained their confidentiality. A relative said, "They let people do as much as they can themselves and treat them like adults."

The registered manager was described as approachable and caring by people, their relatives and the staff. People and relatives knew how to complain and said they would feel comfortable to do so. They told us that staff asked them for their views on the care provided and responses from a quality assurance survey were positive. There were robust systems and processes in place to monitor the quality of care and the registered manager had a clear oversight of the quality of the service. Auditing processes were in place and were used to help drive improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were knowledgeable about identifying signs of abuse and knew how to keep people safe from avoidable harm.

Risks to people were identified, assessed and managed.

Safe recruitment practices were in place and there were enough staff to care for people safely.

Is the service effective?

Good

The service was effective.

Staff had received the training and support they needed to carry out their roles effectively.

People were supported to have enough to eat and drink. They had access to health care services and received on-going health care support.

Staff understood their responsibilities with regard to the Mental Capacity Act 2005.

Is the service caring?

Good

The staff were caring.

Staff knew people well and understood how to communicate with them effectively.

People were involved in decisions about their care and were supported to express their views.

Staff respected people's privacy and supported people to maintain their dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to access the community and did not receive consistent support to be engaged, stimulated and occupied.

Peoples care plans were not consistently updated when their needs changed.

Care provided was personalised and people's preferences and wishes were recognised and included in their care plans.

Is the service well-led?

Good

The service was well –led.

There were robust systems in place to monitor the quality of the service and to drive improvement.

The registered manager demonstrated clear leadership and staff knew what was expected of them.

The values of the service were embedded within staff practice.

Kingsmead Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 January 2017 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses, this type of service.

Before the inspection we reviewed information we held about the service including previous inspection reports, any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. This enabled us to ensure we were addressing relevant areas at the inspection.

We spoke to four people who use the service and three relatives. We interviewed five members of staff and spoke with the registered manager. We looked at a range of documents including policies and procedures, care records for five people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes, staffing rotas and information systems.

This was the first inspection of this service since the provider registered with the CQC in November 2014.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at Kingsmead Lodge. One person said, "I feel much safer here than at any other place." One relative told us, "Safety and security are not a problem," another said, "They are safe here," and a third said, "Security is spot on and I have no concerns."

Staff had received training in how to keep people safe from avoidable harm and they demonstrated a clear understanding of their responsibilities. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would let my manager know if I thought someone was not being treated well". Another staff member said, "If I saw a staff member doing something they shouldn't with a resident, I would remove them and tell the manager. If they didn't act, I would let you (the Care Quality Commission) know."

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). References and professional registration documents had been checked before staff started work. This meant the provider had undertaken appropriate checks to ensure staff were of suitable character to work with people.

People told us that there were enough staff on duty. One person said, "Yes, and staff respond quickly if you ring the bell." We noted that call bells were rarely pressed during the inspection, but when they did ring staff answered them quickly. A relative told us, "Staffing levels are OK, if you press the buzzer they come quickly. " Another relative said, "Yes, there are enough staff and they are the right staff." Staff rotas showed that the provider used bank and agency staff to cover vacant hours. The registered manager said that where ever possible they used regular staff who were familiar with the home to ensure continuity.

Staff told us that they did not feel the staffing levels were always adequate. One staff member said, "There used to be plenty of staff but not now." Another staff member told us, "I used to love working here and I still do I suppose, but it's hard." A third staff member said, "We are managing because we are a great team but things are getting worse". We asked the registered manager how they could be assured that there were enough staff to care for people safely. They explained that they used a dependency tool to calculate appropriate staffing levels. We noted current staffing levels were in line with those suggested by the dependency tool. The registered manager said there had been a recent reduction in staffing levels as a result of having some vacant rooms at the home and we saw that this was reflected in the staff rota. However the registered manager said that as new people were coming to live at Kingsmead Lodge the staffing level would be increased again to ensure that people's needs continued to be met. Throughout the inspection we noted that staff were busy, but they were able to respond to people's needs in a timely way. This indicated that there were enough staff on duty to care for people safely.

Risks to people were identified, assessed and managed. People living at Kingsmead Lodge had a range of complex needs and their care records included comprehensive risk assessments and care plans. Care records had tools to support with assessing risks for people. Care plans were highly detailed and

personalised and guided staff in how care should be provided to reduce risks. For example, one person had been assessed as being at high risk of developing pressure sores because they had limited mobility and were unable to reposition themselves. A validated tool had been used to assess the risk of pressure sores developing and their care plan covered all aspects of prevention to ensure the risks were minimised. This included ensuring that the person was supported to have good posture when in bed. Photographs were used to guide staff in positioning pillows correctly to provide the support recommended by the physiotherapist.

Another person needed support to transfer from their wheelchair to bed. Their care record included a risk assessment and detailed care plan to guide staff in how to achieve this safely. This included details about the type of hoist that should be used, the size of the sling and how it should be positioned. There were photographs to guide staff in how to do this safely for this person. A third person was living with epilepsy and had a history of seizures. Their care plan gave clear guidance in how staff should support the person during a seizure and what actions should be taken if the duration of the seizure was longer than expected.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. This included water temperature checks and water sampling for the spa pool that was used by people living at the home. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and each person had an individual personal emergency evacuation plan (PEEP) in place and fire drills were documented.

People received their medicines safely. One person needed to have their medicine administered at specific times and we noted that this was prioritised. Medication Administration Record (MAR) charts were in place and showed that records of medicines prescribed and administered to each person were completed accurately. There were safe systems in place to ensure that medicines were ordered, stored and disposed of effectively. We observed medicines being administered and noted that the nurse explained their actions, and involved the person in the process. For example, one person preferred to take their medicines in their food. The medicine was added to their food in front of them and they were assisted to have their medicines in the way they preferred. People were offered a drink with their medicines and were provided with support and encouragement when taking their medicines. People told us that they received their medicines when they needed them. One person said, "I am on a lot of tablets. The nurse tells me about any changes."

Some people were prescribed PRN or 'As Required' medicines. We noted that the nurse asked someone if they were in pain and when they indicated that they were they were offered their PRN medicine. People's care records contained clear guidelines for the administration of PRN medicines. One example included guidance on when to give PRN medicine if the person presented certain types of behaviour that may challenge others. This included guidance for staff in strategies to try that might reduce the behaviour before offering the PRN medicine. This ensured that the medicine was only administered when the person really needed it. Another example included details of how staff would recognise if the person was in pain as they were not able to communicate verbally. This included signs to look for such as certain facial expressions as well as vocalising and some physical symptoms. During the inspection a staff member noticed that this person was showing signs that indicated they were in pain and immediately asked if they needed their PRN medicine. This was brought to them in a timely way by the nurse on duty.

Good

Is the service effective?

Our findings

The service was effective and people and their relatives told us they had confidence in the staff. One person said, "The staff are all good." A relative said, "The staff are excellent." Another relative said, "I've no complaints, they seem to be updated with training. Do go the extra mile and work hard. "

Staff were supported to have the skills and knowledge to care for people effectively. Staff were supported through the provider's training academy to develop the knowledge and skills they needed. Staff were able to access training in subjects relevant to the care needs of the people they were supporting. For example, some staff had completed courses in Profound and Multiple Learning Disabilities, Diabetes Awareness and Reduction of Risk, Restraint and Restriction. We asked staff about the training they received. One staff member said, "It's good I would say. I'd say it helps us care for people better". Another staff member told us, "There's always training around. It's always been good here for that." Records showed that staff received regular supervision and appraisals. Supervision can be a formal meeting where training needs, objectives and progress for the year are discussed. These meetings provide staff with the opportunity to raise any concerns or discuss practice issues. One staff member said, "I do get supervision. It's fine". Another staff member told us, "Yes, it's very open and honest. I can say what's on my mind."

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met.

We asked staff about issues of consent and about their understanding of the MCA. All staff members had received training in this area and could tell us the implications of DoLS for the people they were supporting. One staff member told us, "People here tend to have profound disabilities, but that doesn't mean there are no choices open to them. We know how to communicate with them and find out what they want". Another staff member said, "It's about making sure we act in the resident's best interests". Our observations throughout the inspection confirmed that staff had a clear understanding of the importance of seeking consent from people before providing care and treatment. For example, staff members were heard asking people, "Can I help you with that?", "Are you ready to have your tablets now?" and "Would you like me to reposition you?" Staff were seen to wait for a response from the people they were helping and where they received a negative response we noted that they respected the person's rights. For example, one person was asked if they would like some support with eating their meal. When the person refused the staff member accepted this and moved away. They were seen to try again later when the person accepted their help and the meal was reheated for them.

People's care plans included clear guidance for staff in how to obtain consent from people who had difficulty with communicating. For example, one person's guide to obtaining consent stated 'Please explain everything to me before doing it. Use clear simple words. Give me time to respond. If I nod my head that means yes, if I say "no" or "It's horrible" you should move away and give me space." Another example stated "I understand familiar items and vocabulary. I can make a choice from up to four items of an A4 sheet." This guidance enabled staff to seek consent from people effectively and we saw staff using these techniques.

Where people were thought to lack capacity to make specific decisions about their care we saw that mental capacity assessments had been completed. For example, one person with complex physical disabilities had been assessed as needing bed rails to maintain their safety. A mental capacity assessment had been completed to confirm that they were able to consent to having the bed rails in place.

People were not always able to make their own choices and decisions about their care. A person with profound learning disabilities also required bed rails and a mental capacity assessment had concluded that they lacked the capacity to consent to this and other restrictive measures such as a lap belt on their wheel chair and the keypad on the front door. A decision had therefore been made by relevant people that these restrictive measures were in the person's best interests and this was documented as part of an authorised DoLS application. We noted that the registered manager had made appropriate DoLS applications and had notified CQC when these had been authorised. Staff were aware of the requirements of the MCA and understood the importance of complying with the legislation. One staff member said, "It's about protecting people's rights."

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People were supported to have enough to eat and drink. People we spoke with said they enjoyed the food and drink at Kingsmead. One person said, "It's good, they do what I want." Another person said, "I do get enough to drink, I never need to ask." The menu was a four weekly rotating menu and the chef told us that the menu changed with the seasons. We observed the lunchtime meal being served. Some people had been assessed as being at high risk of choking and needed to have their food pureed. We saw that the food was well presented. The registered manager told us that the home had introduced protected meal times to ensure that people were not interrupted when they were eating. Staff explained that this was important for some people who could become easily distracted during meal time as this could be dangerous if they were at risk of choking. Staff members sat alongside people who needed assistance with eating and drinking. We noted that staff checked that people were in the best position to receive their meal before starting to assist them. Staff chatted quietly to the person they were supporting, checking when they were ready for their food. One staff member was heard explaining what the different foods were on the plate and asked which food they would like to start with. Some people were able to eat their meals independently and staff were seen to be checking if they had everything they needed and offering gentle encouragement to eat their food. Staff were patient in their approach and the meal time experience was calm, pleasant and unrushed.

People's nutritional and hydration needs had been assessed. Some people had specific needs that required a special diet. The chef was aware of people's specific needs, likes and dislikes. They told us that communication with the care workers was good and that he was kept informed of any changes to people's diets or their needs. Some people received their food and fluids through a feeding tube. This allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth. Care records included clear and detailed guidance for staff in how to manage this process. One person had been assessed by a Speech and Language Therapist (SALT) as being able to have small amounts of food and drink orally. This enabled them to continue to experience the pleasure of tasting foods that they enjoyed although their main meals were administered via a tube. A staff member described melting small pieces of chocolate because this enabled the person to continue to taste their favourite food.

People's care records included an eating and drinking care plan. These were detailed and clear and included preferences, food allergies and dislikes. There were photographs to illustrate any specific equipment and how it should be used or positioned. For example, one person was able to eat and drink independently, but required a specific spoon and shaped beaker to be able to manage. Guidance for staff was seen in the care plan and included clear information regarding the correct consistency of the food, along with photographs to show the implements to use and how to position them in front of the person. We noted that staff had provided this at meal time and the person was able to manage their meal without support. Where there were concerns that people were losing weight risk assessments had been completed and people's food and fluid intake was monitored. Records showed that people's weight was regularly checked and any concerns were discussed with the GP and the SALT.

People were supported to have access to a range of healthcare services when they needed them. One person said, "The doctor comes every Tuesday." A relative told us, "My relative did have health issues last year and they dealt with it very quickly, they let us know what was happening. It was excellent how it was handled." Another relative said, "I mentioned that there may be a possible thyroid issue and it was acted upon very promptly. Very good." Records showed that people had regular contact with a range of health care professionals including dentists, dieticians and physiotherapists. Some people had regular appointments with specialists at the hospital. One person had developed a pressure sore and their records showed that the Tissue Viability Nurse (TVN) had been contacted for advice on a wound care plan. Staff had followed the care plan until the wound had healed. People's care records included a health care assessment as well as a hospital passport. This meant that if they had to be admitted to hospital the hospital staff would be informed about important information about the person and their needs.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Staff had developed good relationships with people and knew them well. One person said, "I get along with all the staff." A relative told us, "All the staff are caring, they respond to people very well." Another relative said, "The staff are excellent, our relative is happy, it's like a home from home."

Our observations throughout the inspection were that staff were very caring in their approach. People's reactions and body language indicated that they were happy to see staff members and they clearly enjoyed the interactions. We saw people smiling and reaching out to staff members who responded positively with gentle touch, kneeling down and gaining eye contact with people. There was often laughter, and some people were able to vocalise or make sounds to indicate their engagement. Staff had a good understanding of how to communicate with the people they were caring for and were able to interpret subtle indicators. For example, one person who was not able to communicate verbally used their eyes and raised their arm to indicate a positive response to a question. Staff were adept at communicating in this way and we saw them checking with the person to ensure that they had interpreted their wishes correctly.

We observed instances of genuine warmth between staff and people. We spoke with two visiting health care professionals about staff attitudes. One told us, "This is one of the best homes I visit. The staff are very caring and always available. There's a very homely atmosphere. People are safe here". The other professional said, "The staff are lovely and will always help me if they can. They seem really on the ball. I love the way they are with the residents. They know them really well and are very knowledgeable and respectful".

People and their relatives told us that staff supported them to be involved with decisions about their care. One person said, "I am able to make my own choices, for example I asked them if staff could check me every two hours at night and staff are doing that now." A relative said, "Where possible people can make their own choices, especially with meals, they have what and when they want." Another relative said, "Staff are always asking people to get their views." We saw that some people's care plans included symbols to enable people to understand the information. Review notes indicated that staff had sought the views of people. One stated 'Reviewed with (person's name), they indicated they are happy with the care plan by nodding their head.'

People's personal information was kept securely and staff told us that they understood the importance of maintaining confidentiality. People and relatives told us that staff tried to promote people's independence and preserve their dignity. One person said, "Staff always wait outside when I am using the toilet and only come in when I call them." A relative said, "They let people do as much as they can themselves and treat them like adults." When asked about dignity another relative said, "I have no concerns they look after people well." We noted a number of occasions when staff offered support to people in a sensitive way. For example, one staff member noticed that a person had food around their mouth. They quietly checked if it was alright to help them before discreetly wiping their mouth. A relative told us, "The staff make sure people look smart, and clean, they maintain people's dignity. We are asked for our views too, for example, whether out relative needs their beard trimmed, or when they need some new clothes."

Requires Improvement

Is the service responsive?

Our findings

The service was not consistently responsive to people's individual needs. One person said, "I would like to be able to go out more." A relative told us, "I think people would benefit from having more stimulating things to do, but staff are busy." Another relative said, "I know there is a new activities person and they are OK but there are not enough staff for people to be able to access the community. They should be going into town for a coffee or bowling, or going to a day centre, but there's not enough staff."

Staff told us that they were too busy to take people out. One staff member said, "We used to have more staff and that was without the one-to-one care we have to provide for some people now." Another staff member told us, "We don't have enough time to spend with people, we are just too busy." Staff told us that they had raised their concerns about staffing levels with the registered manager and the provider.

We noted that the provider had received a complaint regarding the lack of opportunity for people to go out from one person's relative. We also saw that a DoLS request had been authorised with a condition attached that the provider must ensure that the person who was subject to DoLS should have access to the community at every opportunity, to participate in or watch sports and other activities. However records showed that there were few recorded examples of this happening. Staff told us there was not always enough staff or available transport to comply with this condition.

The registered manager and provider told us that there were plans to increase staffing levels and that the level of activities available in the home had increased since the activities programme had been updated in September. The registered manager and the provider acknowledged that it was not always possible to take people out into the community on an individual basis, as staff were not always available.

During the inspection we saw that a member of staff did go out with one person to support them to attend a new day service. Another member of staff was heard making plans with someone to visit the January sales. People had individual activity plans in their bedrooms. For example, one person's included aromatherapy and we saw them receiving an aromatherapy session during the day. Some people were sitting in the lounge area and one person asked for some music, staff immediately put on the song they had requested. Five other people joined in and were clearly enjoying the music, laughing and tapping their legs and clapping to the music. One relative that we spoke with spoke highly of the organised activities saying, "There's plenty of entertainment, our relative likes to join in." A member of staff told us that there was an activities programme, but that this didn't include weekends. Our observations were that whilst some organised activities were taking place, people did not always have enough to do to give them stimulation and occupy them. Staff were not always available to support people to follow their interests or engage them in a meaningful activity. This is an area of practice that needs to improve.

People's needs had been assessed before coming to live at Kingsmead Lodge. Staff had completed detailed risk assessments and care plans to guide staff in how to support people. Although care plans were regularly reviewed they were not always updated when people's needs changed. For example, one care plan stated that a person used communication aids however we could not see these aids being used. Staff told us that

they were no longer used as they were able to communicate effectively using verbal communication and pointing to objects of reference. We saw that this was happening and noted staff were able to interpret the person's needs effectively in this way. However the care plan had not been updated to reflect this practice.

Another person had a diabetic care plan. This included details of the types of food that staff should offer. However a staff member told us that this was no longer accurate because the person's needs had changed. They were currently only to be offered liquid food supplements until the results of some recent tests were known. Although staff on duty and the chef were aware of this change, this was not reflected in the diabetic care plan, nor in the person's eating and drinking care plan. This meant that there was a risk that care could be inconsistent because records were not an accurate reflection of the care needs for this person. Maintaining accurate records when people's needs change is an area of practice that needs to improve.

We asked staff what they understood by the term 'person centred care'. One staff member told us, "It's care for people that's just for them". Another staff member said, "I think it's about treating people as individuals. We're lucky here as people spend years here, like the staff. We get to know them really well and find out what they are like as people". We saw numerous examples of care being provided in a person centred way during the inspection.

Care records were comprehensive, detailed and person-centred. People's care plans focussed on the things that people could do and what they wanted to achieve rather than on their disabilities. Care plans were often provided in picture format or symbols were used to enable people to understand the information. People and their relatives told us that they were involved in developing and reviewing their care plans and we noted that language used reflected the wishes of the person. For example, one person with a learning disability could sometimes display behaviour that could be challenging for staff. The care plan stated, "If you give me my money from my blue tin it will help me to co-operate, I like to put the coins in my purse." We noted that staff were using this technique when supporting this person.

Another person had a care plan to support them with expressing their sexuality. This included guidance for staff about providing opportunities to socialise and talk about sexuality in a way that the person found fun and humorous. There were also clear instructions about the type of face creams that they liked to use, including the specific brand and the order in which these should be applied. Staff were aware of this and spoke to us about how important it was to this person that they looked nice and maintained their personal appearance. A member of staff was heard discussing clothes with them during the lunchtime meal. We saw someone commenting to the person on their appearance and they were clearly pleased with the compliment.

People's care plans included details of their likes and dislikes as well as details of things that were important to the person. For example, one section of a care record described the person's gifts and qualities. It stated, 'I am fun, friendly and I have a good sense of humour and I love to gossip.' As well as being an accurate description this helped to give a sense of the person. People's rooms were well personalised, one person told us, "My room was painted the colour I'd asked for before I moved in."

People and their relatives told us that they knew how to complain and would feel comfortable to do so. The provider had a complaints policy and we noted that the registered manager had a sign on their door in symbols that invited people to come and discuss any issues that they had. One relative told us, "Any concerns I have are always promptly dealt with."

Good

Is the service well-led?

Our findings

People and their relatives spoke highly of the management of the home and said that they felt the service was well-led. One person said, "The home is well managed, communication is good and I can't think of anything that could be improved." One relative said, "Overall Kingsmead is well run," another commented, "It's all fine, we have no complaints."

People and their relatives told us that they knew who the registered manager was and said that they were caring and approachable. Staff also spoke well of the registered manager and described them as being easy to talk to and understanding. One staff member told us, "The manager is wonderful. They're very caring and I feel I can approach them anytime". Another staff member said, "The manager is doing a great job I think. I know where I stand."

The registered manager met regularly with staff as a team and individually and they were aware of the day to day culture within the home. They told us that they were aware of, and understood, staff concerns about current staffing levels. The registered manager said that they were actively recruiting to cover vacant posts and that staffing levels were constantly under review.

Staff understood their roles and knew what was expected of them. Staff members spoke positively about the care provided at Kingsmead Lodge and described a service that was focussed on the needs of the people living there. Their commitment to the service users was obvious and clearly demonstrated that the values described within the provider's statement of purpose were embedded within their practice.

The registered manager maintained oversight of the quality of the service. Systems were in place to monitor quality including a number of audits. Some audits were undertaken externally including an audit of medicines by a pharmacist. Each audit had an action plan which showed how the registered manager had taken action to address any issues identified. For example, a health and safety audit had identified that a floor carpet needed to be replaced and the action plan showed when this had been achieved.

Incidents and accidents were recorded and actions were taken to reduce the risk of reoccurrence. The registered manager maintained an oversight of all incidents, accidents and wound plans to ensure that any patterns were identified and that appropriate actions had been taken. For example, one incident involved a feeding tube that had split resulting in the person having to go to hospital. Following investigation of the incident the care plan was amended to avoid any re-occurrence.

The provider undertook quality assurance questionnaires with people living at the home using symbols so people could understand the questions. Positive responses had been received from all the people who had completed them. People and their relatives told us that the registered manager asked for their views on the care provided at the home. One relative said, "There is a suggestion box and I would just speak to the manager." A staff member told us about residents meetings, saying, "The registered manager asks service users for their ideas and checks that they are happy with things."