SHC Clemsfold Group Limited

Kingsmead Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
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 eight 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. The investigation is on-going, and no conclusions have yet been reached.

Kingsmead Lodge had been built and registered before the Care Quality Commission (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.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; People did not always receive personalised care. Staff did not always plan, review or develop people's individual support needs and wishes with them. People did not always have support with meaningful activities or be supported to access the wider community.

People's experience of using this service and what we found:
Risks to people were not always adequately assessed, monitored and managed, causing or exposing people to the risk of harm. Ongoing risks relating to epilepsy management, choking, behaviours which challenge and NEWS scores (National Early Warning Score charts) were not always managed safely. Best practice guidance was not always considered when assessing people's needs, or what people wanted from their support. Ongoing work was required to make the care planning process holistic and further involve people within the design and formation of their care plan.

Further work was required to ensure all agency nursing staff were competent to provide effective care. Clinical supervisions for agency nursing staff were not routinely carried out and the high usage of agency nursing staff meant staff were not always accountable for their actions. Systems and processes to assess, monitor and improve the quality and safety of the service were not consistently operated effectively. Staff's competence and knowledge on how to respond to emergency situations varied.

Ongoing work was required to ensure the provision of activities were meaningful and that people were regularly accessing the wider community on a regular basis. Safeguarding systems were in place, however, where people required support to manage their finances, financial care plans were not always in place. We have made a recommendation for improvement.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Medicines were being managed safely. There were safe recruitment practices. The premises had been designed to accommodate people's needs and was decorated in a personalised manner. Relatives told us that a number of recent improvements had been made at the service and spoke highly of the management team. People responded to staff with smiles and staff understood the importance of promoting people's dignity and independence. People's cultural and religious needs were being met.

People and staff were involved in the running of the service and staff felt able to raise new ideas and discuss any concerns with the management team. Relatives spoke highly of the kind and caring interactions between staff and their loved ones.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
We last inspected this service in May 2019. The service was rated Inadequate (Published 19 August 2019). There were multiple breaches of regulations and the service remained placed in special measures. The provider was found to be in breach of Regulation 12 – Safe Care and Treatment, Regulation 10 – Dignity and Respect, Regulation 9 – Person Centred Care, Regulation 18 – Staffing and Regulation 17 – Good Governance. At this inspection, some improvements had been made but the provider remained in breach of four regulations, Regulations 9, 12, 18 and 17.

This service has been in 'special measures' since September 2018.

There had been no registered manager at Kingsmead Lodge since February 2018. The provider had failed comply with Section 33 of the Health and Social Care Act which stipulates that it is a condition of their registration to have a registered manager at the location.

Why we inspected:
This was a planned inspection based on the previous rating.

Enforcement:
At this inspection, we have identified four continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulations 9 (Person Centred Care), 12 (Safe Care and Treatment), Regulation 18 (Staffing) and 17 (Good Governance).

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider.

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.

On 23 March 2020, we imposed further conditions on the provider's registration telling them that they could not admit any service users into Kingsmead Lodge 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 Kingsmead Lodge, 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.

Follow up:
The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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?

Good

The service was 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team:
This inspection took place over two days on 14 and 15 January 2020. The inspection team consisted of two inspectors and a registered nurse specialist advisor.

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 had a manager in post but did not have a manager registered with the Care Quality Commission. At the time of the inspection, the manager was on extended leave and the deputy manager was overseeing the service. This means the provider held sole legal responsibility for how the service is run and for the quality and safety of the care provided

Notice of inspection:
This inspection was unannounced.

What we did before the inspection:
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 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.

The provider was not asked to complete a provider information return (PIR) prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection:
During the inspection we spoke with four care staff, one registered agency nurse, the deputy manager and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the provider's chief executive officer.

We 'pathway tracked' five 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 one person using the service and observed people's support across all areas of the service. We spoke with one relative who was visiting 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.

After the inspection:
We continued to seek clarification from the provider to validate evidence found. Further information was emailed to the inspection team following the inspection. We also sought feedback from five relatives via telephone after the inspection and two healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. This was because medicines were not managed safely, safety incidents had not always been reported internally and risks associated with people's care were not managed safely. At this inspection this key question has improved to Requires Improvement. However, ongoing work was required to safely manage risks associated with people's care. This meant some aspects of the service were not always safe and there was limited assurance about peoples' safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management:

- At the last inspection in May 2019, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because risks associated with epilepsy, choking and behaviours which challenge were not managed safely. At this inspection, not enough improvement had been made and the provider remained in breach of Regulation 12.
- Risks to people with epilepsy were not always being monitored, assessed or managed safely, exposing them to risk of harm. The management of epilepsy at night also required further work. Risk assessments were not consistently in place on how staff supported people to manage their risk of epilepsy at night. One person's care plan identified the need for 15-minute visual observations at night. However, the risk of the person having a seizure in-between those 15-minute checks at night had not been assessed and no plan of care or risk assessment was in place to mitigate this risk. Documentation was not in place to evidence that these visual observations were taking place.
- A number of other people were living with epilepsy and were not monitored at night and no other method was in place to mitigate the risks. Risk assessments were not in place to demonstrate that the risk of seizure activity was minimal and that night time observations were not required. Epilepsy monitoring forms demonstrated that these individuals had not experienced recent seizures at night. However, failure to assess and monitor the risk meant the provider was unable to demonstrate how they were safely managing the risk of epilepsy at night. We discussed these concerns with the deputy manager and subsequent to the inspection, the deputy manager advised that a sensor mat had been ordered to help manage the risk of epilepsy at night (and during the day) for this individual.
- Care and support was provided to one person with audio equipment to help alert staff in the event of a seizure. However, guidance was not available on what staff should listen out for or how to recognise the sound of a seizure. One staff member told us that the person would often make noises during a seizure. This information was not documented in their epilepsy/seizure management care plan. For new staff members or agency staff, this information was not readily available.
- One person's epilepsy care plan identified that they had experienced a recent change in seizure activity. Previously the person was presenting as vocal during seizure activity but recently had been experiencing silent seizures. Documentation reflected that this change in seizure activity occurred in August 2019 and a meeting was held in November 2019 where a decision was made to source a video monitor to help manage the risk of seizure activity at night. However, on the day of the inspection, this video monitor was not in place and a risk assessment had not been completed on how to safely manage the person's risk of seizures at

night in the meantime. Staff were completing 15-minute observations, yet the risk of a seizure occurring in-between those 15 minutes had not been mitigated.

● We discussed these concerns with the deputy manager and on the day of the inspection, a video monitor was obtained. The deputy manager advised that input from a neurologist would also be sourced.

● At the last inspection in May 2019, NEWS (National Early Warning Score 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. At this inspection, some improvements had been made, but ongoing work was required.

● NEWS scores were still not always being taken as and when required. One person's care plan identified the need to calculate the person's NEWs score following seizure activity. Between May 2019 and January 2020 documentation noted that the person had experienced eight seizures. NEWS scores had not been documented following each seizure as per the person's care plan.

● Since the last inspection, a NEWS audit tool had been implemented. This audit tool was not consistently robust in driving improvement. NEWS charts were still not always being completed as and when required. There were still 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. For example, on the 2 January 2020, a person's NEWs score was assessed as 'four' and nursing notes reflected that the person also experienced an episode of vomiting after their seizure. A score of 'four' requires 999 to be called. Observations were not repeated, and documentation failed to evidence that the NEWs score was escalated or that 999 was contacted.

● We discussed the ongoing concerns regarding NEWS with the deputy manager. After the inspection, the deputy manager provided assurance that appropriate action had been taken. The deputy manager advised that nursing staff would receive competency assessments. A safeguarding concern was raised, and the deputy manager advised that the incident would be used as a lesson learnt to share with staff.

● Risks relating to people's physical and non-physical challenging behaviours were not always assessed, monitored or managed safely, increasing the risk of harm to people. One person's activity logs noted two incidences in October 2019 whereby the person was observed screaming and throwing an object. Corresponding ABC charts had not been completed (ABC charts are a tool to record what happens before, during and after an episode of behaviours that may challenge), which meant information was not captured on how the person was presenting before the incident or what may have caused the behaviour of concern.

● Feedback from this person's relatives demonstrated that the person was known to display behaviours of concern including screaming. A positive behaviour support care plan was not in place to direct staff on what these behaviours might mean, the trigger and de-escalation techniques. Staff told us that when the person presented with these behaviours they responded well to a cuddle. The lack of detailed information meant there was an increased risk staff were not responding appropriately or consistently. The service was using agency nursing staff and the lack of detailed guidance increased the risk of agency nursing staff not knowing how to respond in a consistent manner.

● Following the inspection, the deputy manager advised that the individual's mental health and wellbeing care plan had been reviewed and updated to reflect these behaviours of concern. Whilst the care plan referenced the need for staff to complete ABC charts, guidance was not available on how to support the person with their behaviour.

● The management team had sought support from the provider's positive behaviour support lead and one person had a positive behaviour support plan in place. However, recommendations from the support plan were not consistently being followed. The support plan referred to developing a weekly planner and teaching the person about emotions. These recommendations had not been carried out. Recommendations had also been made to staff to complete ABC charts. Staff told us that they no longer completed ABC charts and referenced any behaviours of concern within the person's daily notes.

● We discussed the above concerns with the deputy manager who confirmed that staff should be

completing ABC charts. Incident and accident documentation demonstrated only one recent incident whereby the person displayed behaviours which challenged. However, the failure to complete ABC charts and follow recommendations meant the person was at risk of receiving inconsistent care. During the inspection, the deputy manager said they would seek additional support from the provider's positive behaviour support lead.

The failure to safely manage risks associated with epilepsy and behaviours which challenge was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Other risks were managed well. At the last inspection in May 2019, risks associated with PEG care (percutaneous endoscopic gastrostomy (PEG) tube) were not managed safely. At this inspection improvements had been made.
● PEG care plans were in place and included clear guidance on positioning and when the feed should be paused. Care staff and nursing staff were knowledgeable about people's PEG care routine and documentation was now in place to demonstrate that people were positioned at the correct angle.
● At the last inspection in May 2019 concerns were identified that agency nursing staff did not have access to information on how to safely support people before leading a shift as a comprehensive handover did not take place. At this inspection, improvements had been made. Agency nursing staff and care staff spoke highly of the new handover that had been introduced. One care worker told us, "The new handover and shift allocation sheet has greatly helped. Our days are more structured, and we know who is leading on what. The handovers are also more detailed and give us an overview of any concerns that we need to be aware of."
● The management of constipation was safe. Daily bowel charts were completed, and guidance was in place to direct staff on the actions to take if a person did not experience regular bowel movements.
● Relatives spoke highly of the care provided to their loved ones. One relative commented, "We think risks to our loved one are managed very well by staff and they have quite a good awareness of risks themselves."

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong:
● At the last inspection in May 2019, not all staff understood their responsibilities to report incidents or make sure that if an incident occurred this was reported as soon as possible. Improvements have been made in relation to learning lessons from incidents. However, further work was required to embed and sustain the improvements.
● Staff had received safeguarding training. At the time of the inspection, the management team had been working with West Sussex County Council to drive improvement around safeguarding. A representative from the council visited the service in early January 2020 to review actions and recommendations from safeguarding concerns that had been raised. The visit identified that all safeguarding concerns were now closed, and recommendations made had been acted upon to further drive improvement.
● People appeared relaxed in each other's company and with the staff. There were good humoured exchanges between people and staff. Relatives told us that they felt confident leaving their loved ones in the care of staff. One relative told us, "I feel confident that my loved one is safe from abuse." Another relative commented, "I feel that they are safe at Kingsmead Lodge. Staff are communicating with people more now and the atmosphere is much more positive."
● Systems were now in place to review incidents and accidents internally. When required, incidents were now being reported externally, such as to local Safeguarding teams.
● The management team monitored incidents, accidents, safeguarding's and complaints and learned from them to reduce the risk of occurrence. The deputy manager told us, "One person was being found with a number of bruises. Following an audit completed by external consultants, they recommended completing a risk assessment as the person was living with DVT (Deep vein thrombosis) which heightened their risk of bruising. Following their recommendation, we implemented a risk assessment and I'm also trying to source

some in-house training for staff on DVT."
● One person required support to manage their finances and the Local Authority had deputyship for their finances. Guidance was not in place on how staff and the provider ensured the person had access to their finances and that safe financial arrangements were in place. Staff were unable to advise how they supported the person to gain access to their finances.

We recommend that the provider seeks guidance from a reputable source on managing people's finances.

Using medicines safely:
● At the last inspection in May 2019, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.This was because medicine management was not safe. At this inspection improvements had been made.
● People received their medicines on time and in a dignified manner. Nursing staff were aware of good practice guidelines and this was observed in practice. When administering medicines, nursing staff demonstrated patience and kindness. They explained to the person what their medicine was for, ensured they had a drink to hand and stayed with the person whilst they took their medicine.
● Protocols were now in place for the use of 'as required' medicines and Medicines Administration Records (MAR) charts were completed accurately and included the reason for administration on the back of the MAR chart.
● Staff completed Medicines Administration Records (MAR) which were up to date and accurate. The numbers of medicines on the MARs when reviewed matched with the numbers of medicines in stock.
● Medicine audits were completed on a weekly and monthly basis and helped to drive improvement with safe medicine management.

Staffing and recruitment:
● There were safe systems and processes for the recruitment of staff to ensure they were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Barring Service (DBS) and obtaining suitable references. Nurses deployed were checked by the registered manager and provider that they were registered with the Nursing and Midwifery Council (NMC) and were fit to practice.
● Staffing levels were based on people's individual needs alongside the skill mix of staff. The deputy manager completed a shift planner for each shift which considered the deployment of staff and that staff with the right skills and training were on each shift. Staff and relatives felt staffing levels were sufficient. One relative told us, "I have no concerns around staffing levels." Observations of care demonstrated that staff responded promptly to people's needs and staffing levels allowed for people to access the community during the inspection.
● The service had two full time permanent nursing staff who worked night shifts. Therefore, the provider was dependent upon agency nursing staff during the day. When agency nursing staff were required to ensure safe staffing levels, a comprehensive agency staff induction process was in place. Before agency staff completed their first shift at the service, the provider obtained a copy of their profile to ensure they had required skills and training to provide safe care. The profiles of agency nursing staff demonstrated that they received training on epilepsy awareness, PEG care and learning disability training. The deputy manager confirmed that the same agency staff were booked for continuity purposes.

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.
● Nursing and care staff used personal protective equipment such as gloves and aprons to reduce the risk of cross contamination. Laundry bags were appropriately labelled to distinguish soiled laundry. Hand

sanitisers were available throughout the service for people, staff and visitors to use.

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.

At the last inspection this key question was rated as Requires Improvement. This is because the assessment process focused heavily on people's clinical needs and information was not routinely gathered on their emotional or social needs. Staff did not always receive the appropriate training and support to ensure that they could effectively meet people's needs. At this inspection this key question has remained the same. Some improvements had been made but ongoing work was required to ensure people received effective care. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- At the last inspection in May 2019, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the assessment process focused heavily on people's clinical health needs and diagnosis and did not always consider their social needs. At this inspection, steps had been taken to drive improvement, however, ongoing work was required to ensure all assessments were holistic and based on best practice guidance.
- Care plans were in the process of being reviewed and updated. The deputy manager told us, "We are in the process of reviewing care plans and involving people and relatives in the care planning process."
- Further work was required to ensure the care planning process was holistic and considered people's overall mental, social, psychological and physical care needs. One person's care plan referenced that they had been receiving support from a psychiatrist. However, the care planning process failed to consider their mental health needs and how that might impact on their social and emotional needs. The deputy manager acknowledged that ongoing work was required to the care planning process. Subsequent to the inspection, the deputy manager advised of the steps being taken to ensure care plans were holistic of people's needs.
- Where care plans had been updated, the care planning process was now referring to best practice guidelines such as NICE (National Institute for Health and Care Excellence). For example, one person's care plan referred to NICE guidelines around social isolation and wellbeing.
- Ongoing work was still required to ensure all care plans were reflective of best practice guidelines. For example, one person's sexuality care plan stated, 'to express my sexuality in any way I choose, I may need support to develop an understanding about my own sexuality, I may need support to develop age appropriate relationships.'
- Guidance produced by Skills for Care explains that everyone has to the right to explore their sexuality and develop meaningful relationships. The care planning process failed to demonstrate how the person was involved and what steps were being taken to support them with developing meaningful relationships. This is an area of practice that requires ongoing improvement.

Staff support: induction, training, skills and experience:

- At the last inspection in May 2019, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as staff did not always receive the appropriate training or receive

regular supervision. At this inspection, steps were being taken to drive improvement however the provider remained in breach of the regulation.

● Care and support was provided to a number of people at risk of aspiration and choking (breathing in liquids, food or saliva). Choking risk assessments were in place which outlined the procedure to follow in the event of a choking incident. This included the use of back slaps, abdominal thrusts and then utilising a de-choker as the last resort (de-choker is device used to manage choking incidents). However, staff's competence and knowledge around the management of choking incidents varied. Staff provided varying accounts of whether they would administer abdominal thrusts. One staff member told us, "It is not possible to carry out abdominal thrusts, I would not know how to do it and it looks like it would be complicated."

● Training records demonstrated that permanent care staff had received first aid training and training on the use of the de-choker (which covered the administration of abdominal thrusts) and had their competency assessed. Despite the provision of training, staff's competency and knowledge around the management of emergency situations varied.

● Permanent staff were now receiving regular supervision and a new handover process had been introduced alongside a shift planner. Staff spoke highly of this new initiative and felt it provided more structure to the day. One staff member told us, "I feel more much supported now. I know when I come in what has been allocated to me and who's leading the shift."

● Whilst permanent staff were receiving regular supervision and having their competency assessed, agency nursing staff were not. The service relied on agency nursing staff to cover day shifts. To aid continuity the same agency staff were being booked, however, their competency to effectively lead the shift, manage emergency situations, assess NEWS scores (National Early Warning Score charts) or use the provider's de-choker device had not been assessed. For example, one agency nurse worked at the service two days a week and had been doing so for a year. Their competency had not been assessed and they had not received clinical supervision.

● Guidance produced by Social Care Institute for Excellence advises that 'good supervision should result in positive outcomes for people who use services as well as similar outcomes for the worker, the supervisor and the organisation.' Whilst a programme of supervision was in place to care workers employed by the provider, agency nursing staff working regular shifts at the service were not receiving supervision. Agency nursing staff told us that they felt supported and were able to approach management, the absence of clinical supervision meant agency nursing staff were not provided with a forum to reflect on their practice, discuss clinical concerns or discuss ongoing training needs.

● Our inspection findings included specific examples of where agency nursing staff had not meet people's needs in relation to epilepsy NEWS (National Early Warning Score charts) and choking in the 'Safe' sections of this report. We discussed the absence of clinical supervisions and competency assessments of agency nursing staff with the deputy manager who advised that the provider's internal quality team would be visiting the service to undertake clinical supervisions and to assess the competency of agency nursing staff. Whilst steps were due to be taken to address the above concerns, these actions were not yet embedded into practice.

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

● Staff told us that they felt supported and valued. One staff member told us, "The new management have been great. I get regular supervision and I can talk to them at any time."

● An ongoing training programme was available to staff and staff new to the care sector were also required to complete the Care Certificate, covering 15 standards of health and social care topics as part of their

induction into working in health and social care. Staff spoke highly of the training provided. One staff member told us, "We have access to a range of training and they really focus on staff development."
● Training was provided internally, and the management team also accessed training provided externally. The deputy manager told us, "We've been accessing a lot of training provided by the Integrated Response Team. They've provided us with training on nutrition and PEG care, it's been really helpful."

Supporting people to eat and drink enough to maintain a balanced diet:
● Staff had sought advice from SaLT (Speech and Language Therapists) to help advise them about the people's specific dietary needs and develop eating and drinking guidelines. People were involved in developing menus, which changed regularly. People were offered different meal choices daily.
● We observed staff providing support to people who needed help to eat and drink and encouraging them to finish their meal. With permission, we joined people for their lunchtime meal. Tables were neatly decorated, and the atmosphere was calm and relaxed. Staff engaged with people using humour and laughter and encouraged people to eat independently and at their own pace.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:
● Staff monitored people's day to day health and well-being. Staff and management also sought support from external healthcare professionals, however, referrals were not always made in a timely manner.
● One person was reviewed by the dietician in 2017. The review identified that if the person reached a certain weight to contact them again to seek additional support. In March 2019, this person reached that weight, however, a referral to the dietician was not done until September 2019, six months later. This increased the person's risk of harm as support from a healthcare professional was not sought in a timely manner. The person was reviewed by a dietician in January 2020 and recommendations made were promptly shared with staff and the kitchen team.
● People had individual health action plans in place. A health action plan is a guide to a person's health. It is made by the person with a learning disability and the people who know them best. It tells doctors and hospitals about the person's health and the best ways to support them to get the right treatment and health care. These considered people's overall health needs including sexual health. However, information was not readily available on when people last had smear tests, breast screening or bowel screening. After the inspection the deputy manager confirmed arrangements had been made to address these concerns
● People received ongoing support from their GP, dentists and opticians. Relatives spoke highly of the service and staff and felt that staff were confident in managing their loved one's health needs. One relative told us, "Healthcare needs are monitored well. Staff noticed that our loved one was going to the toilet a lot more than usual and got their GP involved to check that they didn't have a urinary tract infection." Another relative told us, "They have been very good. Recently our loved one needed dental work, they organised it straight away."
● Healthcare professionals' gave feedback that any recommendations made were followed by the management and staff team. One healthcare professional told us, "They had followed the recommendations that had been provided following the previous visit and were able to feedback on the success of these. Management were open and receptive to new ideas." Another healthcare professional commented, "It is promising to see that the deputy manager is not afraid to ask for outside help and we are now seeing more referrals to outside professionals, such as OT's (occupational therapists) being made."

Adapting service, design, decoration to meet people's needs:
● The premises had been designed to accommodate people with physical disability support needs. There were wide doorways and corridors to allow for wheelchair access. 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. Communal areas were decorated with pictures created by and photographs of people. People had personalised their bedrooms with their own furniture and decorations.
●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.

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff understood the importance of gaining consent from people and this was observed in practice. Staff were observed empowering people to make day to day decisions, such as to what to eat and drink and what they wanted to do. Daily notes also reflected that staff were regularly gaining consent from people.
● Everybody living at Kingsmead Lodge either had an active DoLS in place or was awaiting authorisation. 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 people had an authorised DoLS in place, we checked whether any attached conditions were being met. One person had a condition in place which stated the provider should ensure that community trips are not all-day centre related. We have commented further in the 'Responsive' domain on the provider's failure to meet this DoLS condition. Other DoLS conditions were being 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.

Good

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.

At the last inspection this key question was rated as Requires Improvement. This was because one 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. People's care plans also contained disrespectful and inappropriate language when providing instructions to staff on how to support them. At this inspection this key question has improved to Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:

- The provider and deputy manager were taking steps to drive improvement within the service and ensure a culture of care which promoted people's wellbeing and achieved positive outcomes. We have further reported on concerns around the provision of care and management of risk in other domains of the report. Despite these concerns, staff demonstrated a positive attitude towards people and were passionate about delivering care that was kind, compassionate and caring.
- Relatives spoke positively about staff approaches to people and described staff as kind and caring. One relative told us, "I cannot fault the staff. Staff have a good understanding of learning disabilities, will talk to the people here in the right way."
- Some people we spoke with were unable to provide us specific feedback about how well staff took their preferences and needs into account. Observations of care demonstrated that people responded well to staff and appeared relaxed in their company. 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 to help engage and have conversations with people in ways they understood.
- Staff were able to tell us about people's personalities, likes and dislikes, and demonstrated their knowledge about what was important to people. Staff told us how it was important to one person to have their book and teddy-bear to hand. This was observed throughout the inspection.
- People's diverse needs were respected and upheld. One person was supported to attend church every Sunday. Staff had 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.
- Staff recognised the importance of human touch and gently supported people, to provide comfort. For example, staff were observed holding a person's hand during an activity session to provide comfort and reassurance.

Supporting people to express their views and be involved in making decisions about their care:

- Staff recognised the importance of supporting people to be involved in decisions about their day to day care. Staff told us how they communicated effectively with people to empower them to make day today decisions. One staff member told us, "You have to learn about people and know what certain gestures mean or facial expressions."

● Staff understood the variety of people's needs and adapted their support based on people's needs. Information on people's communication needs were documented in people's care plans. Observations of care demonstrated that staff engaged in a caring and compassionate manner with people who were unable to verbally communicate.

Respecting and promoting people's privacy, dignity and independence:
● Staff were knowledgeable about the care practice they delivered. We observed caring interactions where people's privacy and dignity were respected. One healthcare professional told us, "The staff are very kind, and I can see where they have gone above and beyond for people."
● There was some work being done to increase people's independence. The deputy manager told us, "We've been working hard to change staff's opinion on what being independent means and ensuring that people live fulfilling and meaningful lives. Through working with staff and people we are slowly adopting a culture whereby people's independence is promoted."
● Staff told us how they were now supporting people to regain independence and become more involved with the running of the service. For example, people were observed setting the tables at mealtimes. With pride, one person came to tell the inspection team that they had set the table ready for dinner. Staff were also supporting people with daily tasks such as preparing supper. Staff were also working in partnership with one person who gaining more independence with their laundry and folding their clothes.
● Staff supported people to dress in accordance with their lifestyle and maintain their sense of appearance. With pride one person was showing the inspection team their jewellery and lights on their walking aid.
● People were encouraged to stay in contact with their relatives and friends. Visitors were made to feel welcome and there were no restrictions on the times they could visit.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. This was because people were not always supported to be involved in planning and reviewing their care. There was also 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. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences:

- At the last inspection in May 2019, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provision of care was not always person-centred, and the care planning process did not consistently involve the person and/or their relatives. Not enough improvement had been made at this inspection and the provider remained in breach of Regulation 9.
- The management team were in the process of updating and reviewing all care plans. However, care plans were still written exclusively by management and some of the agency nurses. People's involvement in the design and formation of their care plan was not clear. The deputy manager told us, "We are working towards a model whereby care staff and people are actively involved in writing and reviewing care plans."
- Care plans were reviewed monthly and the care planning process included a section titled 'service user comments.' People's or their relative's feedback or comments regarding the care plan review were not routinely captured. The deputy manager told us that steps were being introduced for relatives to be involved in care plan reviews and told us of a recent example whereby a person's relative reviewed their care plan and added comments. However, this practice was at an early stage and not yet embedded

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them:

- At the last inspection in May 2019, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people' activity plans were 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 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. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9.
- The service had been without a dedicated activity coordinator since December 2019. The deputy manager had taken over the responsibility of activity management and activities were now delivered by care staff daily.

● Relatives and staff spoke highly of the activities provided. One staff member told us, "People are doing so much more now." One relative told us, "Our loved one has a good social life." Another relative told us, "Historically activities have been poor, but things are now improving." Whilst feedback was positive, people were still not supported to set and achieve their goals or aspirations. The provision of activities remained group focused, and formal reviews of people's social activities were still not taking place.

● People had weekly activity schedules in place. Yet these were not always personalised according to their likes and dislikes. One person's weekly activity schedule referred to 'pampering' sessions. However, this was not listed as one of their likes within their care plan.

● One person's care plan referenced that they enjoyed shopping. We reviewed their activity logs and daily notes dating back to 1 November 2019. These reflected that during this three-month period they had accessed the wider community on four occasions and last went shopping in November 2019. Monthly care plan reviews failed to assess and consider whether the provision of community trips was sufficient in meeting the person's needs.

● Guidance produced by Social Care institute for Excellence advises that people living with a learning disability should be empowered to live ordinary lives and community inclusion should be promoted. The service had access to a mini-bus and was in walking distance to the local town. Documentation reflected that one person was regularly accessing the community. However, this was not consistent for all people living at Kingsmead Lodge. The daily notes and activity logs for one person reflected that they had not accessed the wider community in three months.

● Care documentation for one person identified that they had a DoLS condition in place which referenced that the provider needed to arrange and evidence community visits that were not day centre related. We reviewed the person's activity logs and daily notes dating back to November 2019. These reflected that the person had accessed the wider community on five different occasions. The care planning process failed to assess and consider if two trips a month were sufficient in meeting the person's social and psychological needs.

● Activity logs and daily notes reflected that people were not routinely accessing events or trips out in the evening. Care and support was provided to a number of people within their 30s and 40s. The provider was unable to demonstrate how the provision and delivery of activities was empowering people to live lives like ordinary citizens. We discussed these concerns with the deputy manager and operations director who told us that they were seeking opportunities for people to access events in the evening and had recently been looking at cinema's available for people to access. After the inspection, we were informed that four people had been supported to attend local theatre shows.

● Healthcare professionals' feedback was that ongoing work was still required to the provision of activities. One healthcare professional told us, "There are potentially missed opportunities to try new things as staff often stick to tried and tested activities rather think creatively."

● Guidance produced by NHS England and the Department of Health and Social Care 'Valuing People a New Strategy for Learning Disabilities for the 21st Century' advises that care and support should be personalised, enabling the person to achieve their hopes, goals and aspirations. The principles of registering the right support also focused on supporting people to set goals and achieve their potential. However, people living at Kingsmead Lodge were not routinely supported to set goals or aspirations for the future. Subsequent to the inspection, the deputy manager advised that staff had spoken with people to explore their goals and aspirations. They commented that these goals were now recorded, and staff would be supporting people to achieve these. Whilst steps had been taken to support people to discuss their goals, we were unable to assess the impact of this on people as the service needed time to embed and sustain this way of working.

● Similar concerns had already been highlighted to the provider about the evaluation of activities setting goals and aspirations and community-based activities. Learning from these findings had not been appropriately used to improve the provision of activities at Kingsmead Lodge.

The failure to provide centred care in relation to meaningful activities was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Other areas of care were responsive, and person centred. Since the last inspection in May 2019, the management team had introduced one-page profiles for people. These included information on what made the person happy, their likes and how to support them. These were also laminated in colours which were personal to the individual. For example, one person enjoyed princesses and the colour pink. Their profile was laminated in pink and included pictures of Disney princesses.
● After the inspection, the deputy manager and operations director advised that steps had been taken to create a visual activity board which was accessible to people living in a wheelchair. The operation director explained that the board was called 'my day, my choice.' They added that this board now enabled people to choose what they wanted to do that day and people could physically amend the board if they wanted to do something else.
● Following the CQC inspection, the deputy manager and operations director advised that an activity audit would be implemented to help review the provision of activities, independence and inclusion for people living at the service.
● Staff had set up with people a dedicated 'pampering' room where people could go and get their nails painted or have a massage. During the inspection, one person was observed with staff getting their nails painted.
● During the Christmas period, people helped decorate the service's conservatory to create a winter wonderland. Christmas parties were held in the wonderland and the service invited staff and people residing in other care homes operated by the provider to a Christmas party at the service.
● Some relatives told us they had been involved in planning and reviewing their family members care. Relatives told us staff were approaching them for their input more often than in the past. The nominated individual and deputy manager told us there were plans for a newly introduced keyworker role to take the lead from the nurses and management team in assessing, planning and reviewing people's care. They hoped this would help ensure these processes would be more personalised.
● 'Resident meetings' were held on a regular basis where people were provided with the opportunity to discuss activities. Meetings on these meetings were displayed in the communal lounge in easy read format. Minutes from the January 2020 meeting reflected that people had suggested trips out to the seaside and one person was keen to go horse-riding again.
● The deputy manager expressed dedication and passion in ensuring that people received person-centred activities. They told us, "I'm keen to ensure that people are going out in the evenings and living fulfilled and meaningful lives."

Meeting people's communication needs:
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● At the last inspection in May 2019, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people's communication needs were not always been met and information was not always available in an accessible format. At this inspection, we found that improvements had been made to information being accessible to people.
● The management team had taken steps to provide information in an accessible format for people. For example, menus were now displayed in easy read format. The activity programme was also displayed at wheelchair height in pictorial format. The provider's safeguarding policy was also displayed at wheelchair

height in easy read format.
● Steps were being taken to ensure communication care plans were also made available in easy read or pictorial format. Some people now had communication care plans available in pictorial format which included clear guidance on their communication needs. The deputy manager acknowledged that further work was required to ensure all care plans were available in a format accessible for the person. However, steps were being taken to comply with the Accessible Information Standard.

Improving care quality in response to complaints or concerns:
● A complaints policy was available, and a copy was also available in a format which was accessible for people. There was a log of all complaints and the actions taken by the management team. Complaints received had been reviewed, investigated and feedback provided within a dedicated time-period. The provider had not received any complaints since the last inspection in May 2019.
● Relatives told us that they would not hesitate in raising any concerns and felt confident that any concerns raised would be acted upon.

End of life care and support:
● No one was receiving end of life care at the service at the time of the inspection. End of life care plans were not consistently in place. The deputy manager was aware of this and there were planned arrangements to re-assess and comprehensively plan all people's end of life care needs. The review was identifying people's end of life care wishes, spiritual and cultural and emotional support needs.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Inadequate. This was because effective governance systems were not in place and people continued to receive poor quality support. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Continuous learning and improving care:

- At the last inspection in May 2019, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because there was a failure to ensure quality assurance and governance systems were effective. Risks to people's safety was not managed effectively and there was a failure to maintain accurate records. At this inspection, not enough improvement had been made and the provider was still in breach of Regulation 17. Steps were being taken to drive improvement, however these steps were at an early stage and not yet fully implemented to improve outcomes for people.
- Since the last inspection in May 2019, the management team had introduced monthly audits which considered NEWS (National Early Warning Score charts), fluid charts and bowel management. These audits were not always consistent in driving improvement.
- One person was living with epilepsy and their nutrition care plan dated May 2019 identified that if they did not meet their recommended daily fluid intake for two consecutive days, that the GP should be contacted, and fluids should be encouraged/pushed every hour. Daily fluid charts between July to December 2019 reflected numerous occasions whereby this individual failed to achieve their recommended daily fluid intake. Yet the actions advised in their care plan had not been followed. Staff had not contacted the GP and fluids had not been pushed every hour. The deputy manager confirmed that there had been a failure to follow the care plan. They commented, "Staff haven't been following guidance but since the introduction of the shift planner and nutrition training we have started to see an improvement in documentation. Their fluid intake in January 2020 has been low so the GP has been contacted and a blood test has been undertaken"
- In November 2019, the management team completed an audit of this individual's fluid intake charts and noted no concerns. Yet documentation from July, August, October and December 2019 reflected ongoing concerns around the person not meeting their recommended daily intake and follow up actions were not recorded or evidence. Whilst audits were completed, these had not picked up that the person was not getting the support they needed.
- Systems and processes to improve the quality of care were not always effective. The management team were completing NEWS audits. These audits considered if the NEWS score was calculated correctly and if appropriate escalation was made. Whilst these audits were completed monthly, they were not effective in driving improvement. For example, on 2 January 2020 a person was assessed as having a NEWS score of 'two'. A score of 'two' required repeat observations. These were not completed. We discussed this with the deputy manager who confirmed that they would expect nursing staff to record their rationale as to why

repeat observations were not undertaken. Nursing staff were not consistently completed tasks that were expected of them.

● The provider's governance framework was not consistently robust in identifying and addressing shortfalls. At the last inspection in May 2019, we identified concerns that epilepsy care plans lacked detail on how people's epilepsy presented and the steps to take to manage the person's epilepsy. For example, one person's epilepsy treatment plan referred to emergency medicine being required if the person experienced recurring seizures in a three-hour period. Guidance was not available on how seizures constituted recurring, the length of the seizure and type of seizure before being required to administer the emergency medicine. Documentation reflected on 14 December 2019 that this person experienced two seizures within a three-hour period, however, no emergency medicine was administered. We discussed these concerns with the deputy manager who advised us after the inspection that the GP was reviewing the person's epilepsy protocol and sent us an amended copy of the person's epilepsy care plan. Whilst action was taken during the inspection process, internal audits failed to proactively identify this shortfall.

● Care and support was provided to one person who required suctioning (tube used to remove secretions from the mouth). We enquired with care staff when they had received suctioning training. Care staff were unable to recall when they last received training and the management team were also unable to demonstrate when staff last received training and had their competency assessed. As the provider was unable to demonstrate that care staff had up to date training, staff were booked onto a training course in February 2020. Whilst steps were taken to address this shortfall, internal audits and checks failed to address and identify this shortfall.

● A centralised service improvement plan was in place and the provider had recently introduced weekly management calls to monitor the progress of actions within the service improvement plan. Whilst the provider was taking steps to monitor the progress of actions that were ongoing, a number of actions cited on the improvement plan had been ongoing since January 2019 and remained an ongoing concern. For example, an action around documentation was added to the service improvement plan in January 2019 when concerns were raised that there was a failure to maintain accurate records, including care charts and NEWS charts. At this inspection, we found ongoing concerns regarding the completion and documentation around NEWS charts.

● The imposition of provider level condition had not been effective in driving improvement or preventing repeat themes of concern re-occurring in relation to people's safety and the quality of care at Kingsmead Lodge. Every month the provider was required to submit to the Care Quality Commission a monthly report which included an analysis of all incidents and accidents, unplanned hospital admissions, and the steps taken to assess the skills and competency of staff (including agency nursing staff). At this inspection, we found that agency nursing staff had not consistently received competency assessments and were not receiving regular clinical supervision. This provider level condition was imposed in January 2019. The provider had failed to utilise the requirements of this condition to proactively and accurately monitor and improve services at Kingsmead Lodge

● Staff did not always understand their responsibilities and the provider failed to manage staff's accountability effectively. The service only had two permanent nursing staff employed who both worked nights. A clinical lead was not in post at the service and day shifts were solely run by agency nursing staff. Clinical oversight was often missing, and agency nursing staff lacked accountability for their actions. This was demonstrated through the failure to manage NEWS score effectively.

● People remained at risk of receiving poor care. Kingsmead Lodge has been in repeated breach of regulations since August 2017 and has been rated Inadequate on four consecutive inspections since September 2018. The concerns found at this inspection have been highlighted in inspection reports about many of the provider's other services. Concerns around epilepsy, NEWS care, provision of community-based activities and fluid intake remain ongoing risks identified at many of the provider's other services. This information had not led to similar risks to people at Kingsmead Lodge being reduced.

● On the day of the inspection, the acting manager was on extended leave and the deputy manager was overseeing the running of the service. During the inspection process we were informed that the acting manager would not be returning from extended leave and the deputy manager would continue overseeing the service. Subsequent to the inspection, we were informed that the acting manager would be submitting an application to become the registered manager.
● The service has been without a registered manager since February 2018. This means the provider had failed to comply with a condition of their registration which requires a manager to be registered with CQC to manage the regulated activities provided at the service. This is a breach of Section 33 of the Health and Social Care Act 2008.
● Subsequent to the inspection, the deputy manager and operations operator provided CQC with an action plan based on the feedback from the inspection. This action plan identified that an epilepsy audit tool would be implemented alongside a behaviour management audit tool. The action plan also identified for risk assessments to be implemented for people living with epilepsy. The action plan explained that these risk assessments should consider bathing and shower risks. Whilst the action plan identified the need for risk assessments to be implemented, it failed to consider risks around people having seizures in-between 15 minute checks at night. We have further reported on these concerns in the 'Safe' domain of the report.

The failure to ensure quality assurance and governance systems were effective was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Other areas of leadership and culture showed improvements. Staff spoke highly of the improvements made since the last inspection in May 2019. One staff member told us, "It's a completely different place now. Management are available, and morale has improved. We've come a long and we are slowly getting there."
● Relatives spoke highly of management and the impact they were having on their loved one's care. One relative commented, "New management has been great. Kingsmead Lodge is a second home to us." Another relative commented, "I'm happy with how things are progressing at the service. The deputy manager is approachable and overall we are seeing positive improvements."
● Healthcare professionals also spoke highly of the ongoing improvements being made. One healthcare professional commented, "The management team have overseen improvements within the service. Since management started there has been an increase in training, supervision and greater detailed handovers, the atmosphere of the home is more relaxed, staff and customers seem to be working together well within a more equal and respectful relationship. The home is now more proactive in seeking advice and has developed positive working relationships with both external agencies and family members."
● The management team were committed to improving and developing the service. They were open and honest about the work still required but expressed dedication in improving the overall quality of care provided.
● Staff spoke highly of the deputy manager and felt that they led by example. Throughout the inspection, the deputy manager empowered people to be part of the inspection and it was clear that the deputy manager understood the importance of person-centred care and promotion of independence. For example, the deputy manager was observed engaging with one person who wanted to watch television. They encouraged the person to use their television remote independently and asked the person to show them which button to press.
● Relatives and staff spoke positively about the recent changes in the culture at the service. One staff member commented that morale had improved and that there was a greater focus on involving care staff with paperwork and becoming key workers. The deputy manager recognised the importance of empowering staff and was taking steps to get staff more involved with care plan development and care plan reviews.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong:
● The management team understood their responsibilities under the duty of candour and had kept relatives informed when something had gone wrong.
● The CQC's rating of the home, awarded at the last inspection, was on display at the home and on the provider's website. The deputy manager had also displayed the CQC report in easy read format in the service for people to access.
● The provider had a mission statement and set of values in place which governed the day to day running of the service. The operations director told us that the provider was re-looking at the governing values and that steps were being taken to enable people to devise their own values which underpin the day to day running of Sussex Health Care.
● The operations director was working in partnership with the provider's quality team and deputy manager to drive improvement. The operations director told us about a number of new initiatives they were in the process of rolling out. These include weekly meetings with the deputy manager to discuss their service improvement plan. HR (human resource) clinics to be held at the service monthly to help aid staff retention. Weekly community meetings with people living at Kingsmead Lodge and risk and learning meetings were to be held.
● The provider was in the process of reviewing their organisational objectives and were considering their objectives moving forward. This included the development of a clinical excellence strategy and clinical audit framework.
● The deputy manager was committed to developing a culture of transparency and honesty within the service. Healthcare professionals' feedback that they found the deputy manager open and honest.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others:
● Forums were in place to involve people in the running of the service. 'Resident' meetings were held on a regular basis and the operation director was in the process of organising regular relative meetings. Staff meetings were also held on a regular basis and provided staff with the forum to raise concerns or discuss new ideas. Daily handovers and the shift planner were utilised for staff to receive key information.
● Staff's dedication and hard work was recognised, and the provider awarded individual staff members or specific teams within the service with a 'star award' (award to recognise hard work). The kitchen team at Kingsmead Lodge were recently awarded a star award for achieving a level five food hygiene rating (excellent rating).
● People, relatives and staff spoke highly about the management of the service. Satisfaction surveys were sent out to relatives to gain their feedback. Recent feedback from relatives demonstrated that they were happy with the care provided. Comments included, 'These last few months have showed a marked improvement all round. Atmosphere much better, staff more willing to help and far more activities going on. Food is excellent, and cleanliness is really good. I am very pleased with Kingsmead Lodge at present. Please keep it up.'
● The management team provided regular newsletters to relatives providing updates on recent activities and outings. The 'December' newsletter provided key information on activities that took place at Christmas.
● Newsletters were also provided to the staff team providing key information on organisational updates.
● Links with the local community were in the process of being established. Some people were beginning to access a local hairdresser and trips out to Brighton were being organised. However, ongoing work was required to further strengthen community links.

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
Treatment of disease, disorder or injury	The care and treatment of service users did not meet their preferences, was not appropriate and did not reflect their preferences. Regulation 9.

The enforcement action we took:

We imposed a condition 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
Treatment of disease, disorder or injury	Care and treatment was not provided in a safe way for service users. Regulation 12.

The enforcement action we took:

We imposed a condition 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
Treatment of disease, disorder or injury	Systems or processes were not established or operated effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Persons employed by the service provider did not receive appropriate training, support and supervision. Regulation 18.

The enforcement action we took:

We imposed a condition on the provider's registration