SHC Clemsfold Group Limited

Kingsmead Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 18 September 2018 and was unannounced.

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

Kingsmead Care Centre provides accommodation and nursing care to people with a range of needs in two units, both of which are located in one building. Haven provides nursing care and accommodation for people with a learning disability, physical disability and/or acquired brain injury and other complex needs. The nursing home provides nursing care and accommodation for older people with a variety of healthcare needs and physical frailties including some people living with dementia. Kingsmead Care Centre is registered to provide nursing care and accommodation for up to nine people in Haven and up to 25 people in the nursing home. There were nine people living in Haven and ten people living in the nursing home.

There was a well-established registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Kingsmead Care Centre has not been operated and developed in line with all the values that underpin the Registering the Right Support and other best practice guidance. Kingsmead Care Centre was designed, built and registered before this guidance was published. However, the provider has not developed or adapted Kingsmead Care Centre in response to changes in best practice guidance. Had the provider applied to register Kingsmead Care Centre today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a
learning disability and/or Autism should be operated to meet their needs. People with learning disabilities using the service should be able to live as ordinary a life as any citizen.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have been made. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and July 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

At our last inspection in June 2017 we rated the service Requires Improvement overall and the service was found to be in breach of legal requirements. At that inspection we found systems to assess and monitor the

service were in place but these had not been sufficiently robust as they had not identified a lack of consistency and gaps within agency nurse training on specific subjects such as PEG management and learning disability training. Whilst people's risks had been assessed, identified and mostly managed appropriately, there had been a lack of guidance available for staff regarding people's specific health needs such as asthma. We had also found that there was a lack of personalised activities provided.

This inspection found that improvements had been made and the breaches of Regulation 18 and 17 met, but there were still improvements to be made to fully meet Regulation 9. The overall rating has remained as Requires Improvement.

We found the activities and stimulation opportunities provided to people were still inconsistent across the home. People had activity plans in place however we found that not all people had received their specific activities as stated in their care plans. The provision of activities did not consistently meet people's needs and reflect their preferences. This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Whilst the provider had progressed quality assurance systems to review the support and care provided, there was a need to further embed and develop some areas of practice that the existing quality assurance systems had missed. This included updating care plans when an identified need or directive of care changed.

A number of audits had been developed, including those for accidents and incidents, care plans, medicines and health and safety. Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Staff said they were encouraged to suggest improvements to the service. Relatives told us they could visit at any time and, they were always made to feel welcome and involved in the care provided.

People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at reflected the positive comments people made. Care plans reflected people's assessed level of care needs and care delivery was person specific, holistic and based on people's preferences. Risk assessments included falls, skin damage, behaviours that distress, nutritional risks including swallowing problems and risk of choking, and moving and handling. For example, pressure relieving mattresses and cushions were in place for those who were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes and epilepsy. There were systems for the management of medicines and people received their medicines in a safe way. Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. The provider was actively seeking new staff, nurses and care staff, to ensure there was a sufficient number with the right skills when people moved into the home.

All staff had attended safeguarding training. They demonstrated a clear understanding of abuse; they said they would talk to the management or external bodies immediately if they had any concerns. Staff had a clear understanding of making referrals to the local authority and CQC. Pre-employment checks for staff were completed, which meant only suitable staff were working in the home. People said they felt comfortable and at ease with staff and relatives felt people were safe.

Nurses and care staff were involved in developing the care plans and all staff were expected to record the care and support provided and any changes in people's needs. The registered manager said all staff were being supported to do this and additional training was given if identified as required. People were

supported to eat healthy and nutritious diets. Food and fluid charts were completed when risk of poor eating and drinking had been identified and showed people were supported to eat and drink.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service. This included the care of people with specific health needs such as swallowing difficulties (dysphagia), learning disabilities, acquired brain injury. Staff had formal personal development plans, including two monthly supervisions and annual appraisals. People were supported to make decisions in their best interests. The provider assessed people's capacity to make their own decisions if there was a reason to question their capacity. Staff and the registered manager had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought consent before delivering care and support. Where people's care plans contained restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. People we spoke with were very complimentary about the caring nature of staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapport with people and they responded to staff with smiles. People previously isolated in their rooms were seen in communal lounges for activities, meetings and meal times and enjoyed the atmosphere and stimulation.

Further ideas for the prevention of social isolation were being discussed by the management team, such as sensory table equipment that will promote engagement with individual people. Staff had received training in end of life care and were supported by the Local Hospice team. Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. The service worked well with allied health professionals.

Staff said the management team was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and they would be happy to talk to them if they had any concerns.

At this inspection we found a breach of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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

Kingsmead Care Centre has improved to Good.

Measures were put in place where possible to reduce or eliminate risks. Medicines were stored and administered safely.

Comprehensive staff recruitment procedures were followed. There were enough staff to meet people's individual needs.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it.

Visitors were confident that their loved ones were safe and supported by the staff.

Is the service effective?

Good

KIngsmead Care Centre has improved to Good.

People were supported to maintain good health and were supported to access health professionals.

Staff received regular training, supervisions and an annual appraisal.

People were supported to eat and drink to maintain their health and ell-being.

People's rights were protected by staff who had received training and had knowledge of the Mental Capacity Act 2005.

Is the service caring?

Good

Kingsmead remained Good.

People were supported by staff who were kind, caring and supported their independence.

People were involved in decisions about their care and the home.

People's privacy and dignity was respected and maintained.

Is the service responsive?

Requires Improvement

Kingsmead Care Centre remains Requires Improvement.

There was a lack of person specific activities provided on The Haven to ensure they were meaningful and beneficial to each person.

People's preferences and choices were respected and support was planned and delivered with these in mind.

A complaints procedure was in place. People and visitors knew how to raise a concern or make a complaint but also said they had no reason to.

Is the service well-led?

Requires Improvement

Kingsmead remains Requires Improvement.

Whilst quality assurance systems were in place, they needed to be further developed and embedded into everyday practice to ensure safe and consistent delivery of care.

The registered manager, staff and provider encouraged people, their relatives and friends to be involved in developing the service.

The registered manager promoted an open culture in the service. The provider's values were embedded in staff working practices.

The service worked in partnership with other relevant organisations.

Kingsmead Care Centre

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 18 September 2018 and was unannounced. The inspection team consisted of three inspectors' and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before our inspection we reviewed the information, we held about the service including previous inspection reports. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We used a range of different methods to help us understand people's experiences. Some people who lived at the home had limited verbal communication. Therefore, as well as speaking with twelve people, we also observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit.

We spoke with two registered nurses, eight members of staff, two activity coordinators, the maintenance coordinator, operations director, an administrator and a chef'. We also met with the Service Review and Transformation Lead who had been working independently with the provider since February 2018, providing professional support and guidance to initiate positive developmental changes.

During our visit we spoke to two visiting professionals who provided specialist support to people on a weekly basis who lived in the home.. We also contacted the dietician from West Sussex County Council's community team, for their feedback on the quality of care being delivered in regard to people's nutritional

and dietary needs.

To help us assess how people's care needs were being met, we reviewed seven people's care plan files and associated records. We also case tracked a further three people who received specialist diets and with other more complex needs, such as epilepsy and acquired brain injury. Case tracking involves talking to the person (if they are able), observation of their care, talking to staff directly supporting the person and examination of care records. We looked at other records, these included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures. We displayed posters in the communal area of the service inviting feedback from people and relatives.

During the inspection, we spoke with three relatives for their views about the safety and quality of the services provided for people. Following the inspection, we were contacted by a visitor who wished to share their views. We contacted three families whose family member lived in Haven to capture their views and thoughts. We also sought feedback from Health Watch and staff from the local authority on their experience of the service. Health Watch are an independent organisation who work to make local services better by listening to people's views and sharing them with people who can influence change. The feedback we received is included in this report.

Good

Is the service safe?

Our findings

At our inspection in September 2017 this key question was rated Requires Improvement because improvements were needed to ensure people's health needs were appropriately risk assessed and managed safely. This inspection found that steps had been taken by staff to ensure peoples' health needs were managed safely and the rating had improved to Good.

People told us they felt safe living in the home and we observed people were relaxed and comfortable. People told us, "I feel very safe, they are kind and attentive," and "I have never had to grumble about anything."

Risk assessments were in place that identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. Risk assessments for health-related needs were in place, such as skin integrity, asthma, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw detailed plans which told staff how to meet people's individual needs. For example, people with complex physical and mobility problems had had an assessment by the in-house physiotherapist who had created a plan that gave clear guidance with photographs of equipment and how staff should use it. This was supported by a nurse led care plan which included holistic guidance and details of specific equipment, such as type of hoist, type of sling and sling size. We saw that staff followed the guidance in place to deliver safe and consistent care.

Some people lived with complex health needs that required specific care to keep them safe, such as asthma, epilepsy, breathing difficulties associated with chronic chest conditions and receiving a percutaneous endoscopic gastrostomy regime (PEG). A PEG supplies nutrition and medicines via a tube straight into the stomach for people who can not eat or drink. Care plans contained clear directives for enteral feeding and detailed the amount of nutrition to be given with fluid requirements. This was backed up with fluid recording charts and a management plan for how to care for the peg, including rotation of tubing, balloon and water changes. The nurses were supported by visits from the Community Enteral Feeding nurses. Staff spoken with were knowledgeable of each person's specific risks and how to adjust care to meet individual needs.

Risk assessments identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. Risk assessments for health-related needs were in place, such as skin integrity, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was protected and promoted. We saw detailed plans which told staff how to meet people's individual needs. For example, people with mobility problems had an assessment that was used to give clear guidance for staff to follow. This included specific equipment to be used, such as hoist, type of sling and sling size.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a

business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal emergency evacuation plan (PEEP).

The home was clean, and there were regular audits to make sure cleanliness levels were maintained. People told us, "Always very clean, never any odours." Staff made sure infection prevention and control was considered when supporting people with their specific care needs, such as continence care, and used the relevant personal protective equipment (PPE) such as gloves or aprons when needed.

Accidents and incidents were documented and recorded. We saw that incidents were responded to by updating people's risk assessments and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to ensure people's safety and this was clearly recorded. We saw specific details and follow up actions by staff to prevent a re-occurrence was documented. Any subsequent action was shared with all staff and analysed by the management team to look for any trends or patterns. This demonstrated that learning from incidents and accidents took place.

The provider had ensured the proper and safe use of medicines within the service. Medicines were given by registered nurses (RN) who had received appropriate training and competencies. Medicine records showed that each person had an individualised medicine administration record sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts are a document to record when people received their medicines. MAR charts indicated that medicines were administered appropriately. Records confirmed medicines were received, disposed of, and administered correctly. There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. People who were prescribed PRN oxygen had clear guidance in their care plan and MAR for its safe use. Staff had received training in how to give oxygen therapy and how to monitor its effectiveness. We saw registered nurses gave medicines through PEGs following best practice guidance. All medicines were securely stored in a clinical room and there was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests.

Emergency equipment for health emergencies was available. This included suction machines. All had been serviced and were ready for use. On Haven unit some people had them in their room for immediate use should it be required. All staff had received emergency first aid training and basic life support and were confident in how to use the equipment safely. One staff member said, "I had training and found it really boosted my confidence."

Staff had received training in safeguarding adults and records confirmed this. Staff understood their roles and responsibilities in supporting people to keep safe from potential harm or abuse. Staff were knowledgeable about the different forms of abuse and how to recognise the signs of abuse taking place. Staff told us, they would not hesitate to report abuse to the registered manager and were confident they would take appropriate action. The registered manager understood their responsibilities in reporting any concerns about people's safety which included reporting incidents of potential harm or abuse. A staff member said, "There are various kinds of abuse; physical, financial, emotional, sexual. If I come on shift and I am alerted to something I'd check the person to make sure they're ok and then do an incident report and tell the manager." Procedures were in place for whistleblowing and safeguarding, as well as policies in relation to emergencies, fire safety, medicines, bullying and harassment. People were protected as far as possible from abuse.

Staff recruitment practices remained robust and thorough. Staff were only able to commence employment upon the provider obtaining suitable recruitment checks which included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Staff record checks showed validation PIN for all qualified nursing staff. The PIN is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). Recruitment checks helped to ensure that suitable staff were employed.

Sufficient numbers of skilled and experienced staff contributed to the safety of people who lived at the home. At the time of our inspection there were three care staff and one registered nurse supporting nine people in Kingsmead Haven and four care staff and one nurse supporting ten people in the nursing home. Sufficient staff were deployed during our inspection to ensure people's needs were being met in a timely manner. Not everyone could verbally tell us of their experiences, but those that could told us, "Always come when I ring, never left waiting," and "very good, they look after me very well." One person used Makaton signage to tell us everything was good and another person used eye blinks to our questions, which told us that they felt comfortable with the staff. When staff were on leave the registered manager told us that they used agency staff to ensure people's clinical needs were being met. They used regular agency staff that really knew the service and people well. The management team told us they were still actively recruiting nurses.

Good

Is the service effective?

Our findings

At our last inspection this key question was rated requires improvement and improvements were needed to meet the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staff had not always received appropriate support and training to enable them to carry out their duties they are employed to perform. This inspection found that the breach of Regulation 18 had been met. The rating for this question had improved to Good.

People and relatives had confidence in the skills and abilities of the staff employed at Kingsmead Care Centre. People told us, "You can't fault the staff. They're kind and know what they're doing. They have good instincts and know when I'm feeling unwell." "The staff are lovely and, yes, I think they are well trained. "Visitors said, "We visit regularly."

The provider had ensured that staff had the skills, knowledge and experience to deliver effective care and support. The organisation had their own training academy to support staff training. We viewed both the training programme and individual certificates that confirmed that staff received training and refresher training. Essential training included safeguarding, infection control, moving and handling, health and safety, infection control and fire safety. Specific training which reflected the complex needs of people who lived at Kingsmead Care Centre was also provided, such as learning disability and physical disabilities, dementia, acquired brain training, PEG care and end of life.

Staff told us that the training programme was good and that they also received support with training whilst working with people. One staff member said, "I was shown how to change a stoma bag and then I was observed doing it to ensure I was doing it properly." This enabled senior staff to monitor how effective the training programme was and had resulted in bespoke training. During the day we observed staff supporting people with moving and re-positioning. Staff followed good practice guidelines, ensuring that people who needed hoisting had their personal sling, explaining what was happening and offering reassurance throughout. These 'on the floor' sessions contributed towards staff supervisions by giving staff and the registered manager an opportunity to share and reflect on their practise. Staff told us they were supported through supervisions and the records in the service confirmed this. Records showed staff had received supervisions as well as appraisals. A member of staff said, "I feel supported and receive supervisions regularly."

People had access to care, support and treatment in a timely way with referrals made to appropriate social and health services when people's needs changed. We saw records of visits and letters from healthcare professionals in people's care files, such as speech and language therapists (SALT), diabetic team, chiropodists, opticians and dentists. We saw SALT had assessed people with swallowing problems and guidance was in place regarding food texture and thickening levels for fluids. Staff were knowledgeable about people's nutritional needs. All this information was on the person's care plans and in the kitchen. People had access to their GP if needed. One person told us, "They're really on the ball, I've seen the doctor when I've needed to and they look after my health really well." Another said, "I have appointments and staff come with me." Visiting healthcare professionals told us people were referred to them appropriately. One

health professional said, "They respond quickly when a health problem is noted and work well with us." Another health professional said, "They know their residents well."

People's needs were assessed before they came to the home. Information was sought from the discharging service, people's relatives and other professionals involved in their care. Care, treatment and support was delivered in line with legislation and evidence-based guidance. For example, staff had a copy of newly published guidance by the International Dysphagia Diet Standardisation Initiative (IDDSI) which described new definitions for texture modified foods and thickened liquids for people with dysphagia (difficulty swallowing).

Staff were working within the principles of the Mental Capacity Act 2005 (MCA). 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).

People that could, commented they felt able to make their own decisions and those decisions were respected by staff. People told us, "The carers first tell me what they want to do and ask if that's okay with me," and "Very respectful and polite, always tell me what's about to happen." On Haven we saw staff constantly talking, explaining to people and waiting for responses before assisting them or moving them in their wheelchairs.

Staff had received training and understood the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. There were also procedures to access professional assistance, should an assessment of capacity be required. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. For people who did not always have capacity, mental capacity assessments and best interest decisions had been completed for their care and treatment, for example for bed rails, medicines given via a PEG and life changing choices about medical treatment and intervention or where to live. Records of best interest decisions showed involvement from people's relatives, GPs and staff. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. The provider had up to date policies and procedures in relation to the MCA and staff were provided with information on how to apply the principles when providing care to people who lived at Kingsmead Care Centre. We were also made aware of people subject to DoLS authorisations.

A relative told us, "I am involved with all aspects of care and decisions. I feel my views and contributions are valued." Another relative told us, "They sit and talk to us both, really." Another relative told us, "We are always consulted on any decisions and attend most appointments."

Care records included people's Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) status. This meant that if a person's heart or breathing stops unexpectedly due to their medical condition, staff were aware that no attempt should be made to perform cardiopulmonary resuscitation (CPR). The DNACPR records were up to date, included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals who were involved in the decision.

People were supported to eat and drink enough. People said that they liked the food, they were given choices and food that they enjoyed eating which was cooked well. We saw that alternatives were available if

people wanted something different. Throughout the day we saw that people had access to drinks with staff offering hot and cold drinks. People had drinks in their rooms and communal areas were well supplied with drinks. Food and snacks were available throughout the night.

People's weight was regularly monitored and documented in their care plan. Senior staff told us, "The kitchen staff and staff talk daily about people's requirements, and there is regular liaison with Speech and Language Therapists (SALT) and GP." The staff we spoke with understood people's dietary requirements and how to support them to stay healthy. Staff kept the kitchen informed of any changes to peoples' dietary needs and who needed their food fortified. Guidance was readily available in people's care plans about any special dietary requirements such as a soft or pureed diet. One person's care plan had a report which identified they required a 'thick pureed dysphagia diet texture 3'. We saw that this was followed. Staff informed us that this person was eating very little and their food intake chart reflected this and contained information about how to increase calorie intake.

People's individual needs had been met by adaptations to the home and equipment was provided to ensure they were as independent as possible. The two units were totally separate and each had their own communal areas. Not all rooms had an ensuite facility however there were specialised baths and wet rooms for communal use. People were supported to move around the home and were assisted to remain mobile by staff. Communal areas and most corridors were suitable for people who used wheelchairs and self-propelling wheelchairs. Walking aids, such as walking frames were provided and staff assisted people who were unable to weight bear to transfer using either ceiling hoists or electrical hoists. The lift enabled people to access all parts of the home, however the second floor was currently closed. The garden areas were safe and accessible to people who lived at Kingsmead Care Centre. People had brought their own ornaments, pictures and furniture to the home if they chose to and rooms had been personalised with pieces of furniture and photos of relatives and pets.

Good

Is the service caring?

Our findings

At out last inspection this key question was rated Good and this inspection found it remained Good.

We observed and heard that people were treated in a kind and positive manner and there was a warm and friendly atmosphere throughout the home.

People told us they were happy living at Kingsmead Care Centre. Staff had developed good relationships with people and we saw warm interactions between staff and people. Staff spoke respectfully to people and knew the people they supported well. Staff recognised when people needed emotional support. We observed a person receive emotional support from a member of staff who recognised that they were becoming upset. The staff member sat with them, holding their hand and talking to them in a kind, reassuring way. The person's body language indicated that it had made a real difference to their wellbeing. Staff bent down to address people at their own eye level and maintained good eye contact. Staff spoke with people calmly and warmly and ensured they had everything they needed such as drinks and snacks in between meals. A staff member told us they explored with each person where they wanted to spend time. This meant the staff member considered what the person wanted to do and how they wanted to spend their day.

The staff team had the information they needed to provide individualised care and support because they had access to people's plans of care. These included details about people's past histories, their personal preferences and their likes and dislikes. A member of staff said, "We have an equality policy in place. Everyone is different and we treat people as we would like to be treated respecting our differences."

We saw that people's communication needs were recorded in their care plans providing information and guidance on how best to communicate with people who had limitations to their communication. For example, we saw staff communicating with a person who had difficulty expressing themselves verbally. Staff spoke to the person slowly, listened and observed for facial expressions. This meant peoples' opportunity to communicate effectively had been considered by the staff.

We could see people were happy and engaged, cared for by staff who understood how to communicate with them, knowing their gestures, when these were used instead of words. Communication needs were recorded in detail in people's care plans to guide staff on the best way to engage with people. Understanding peoples' specific ways of communicating also meant staff ensured people were able to consent to and be involved in decisions about their care. For example, if one person pretended to be asleep staff knew this meant the person did not want to engage at that moment and would leave them until they could try again.

People's human right to be treated with respect was clearly understood by staff, who protected their privacy and cared for them respectfully. Staff spoke about people in a caring and thoughtful manner way. Support records reflected how staff should support people in a dignified way and respect their privacy. Support plans were written in a respectful manner. Staff told us how they ensured people's privacy was protected by

ensuring they knocked on their bedroom doors, kept people covered during personal care, and whilst supporting to the communal bathroom. We saw and were told that peoples' privacy and dignity was respected. We saw staff knocking on people's doors before entering and closing them before delivering care. A member of staff said, "We always knock before we go in. We close curtains and doors during personal care." One person said, "They are very good about ensuring my dignity at all times." Staff told us, "People need a lot of support with their personal care and we keep in mind at all times that some things are very private." This showed staff understood the importance of privacy and dignity when providing support and care.

People and their families or representative were involved in developing their care plan as much as was possible. Records showed where appropriate, people, relatives and advocates signed documents in support plans to show they wished to be involved in the plan of care.

People's independence was promoted. Staff told us that people were encouraged to be as independent as possible. A member of staff said, "We promote independence as much as possible, we encourage people to do bits of personal care, and we have special cutlery to help them be independent in eating." We saw that those people who liked to move around independently were supported discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "Shall I accompany you to the dining room." They leant down to talk to the person face to face so they could see their expression, and waited until the person responded.

People were supported to make their own decisions. Staff told us, "We let people make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." People confirmed that staff involved them in making decisions on a daily basis. One person said, "I can choose to have breakfast in bed or in the dining area. Staff always ask me." Another person said, "I think they are just wonderful. Really caring."

People were supported to express their views and were involved in making decisions which were respected. During the day we saw that people were making a variety of choices. People chose what drinks they wanted, where they sat, where they wanted to go and what they wanted to do in the way of activities. For those who were unable to verbally make choices staff offered choices and waited for the person's reaction to ensure it was their choice.

People's rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones. Lounge areas were welcoming and we saw people enjoying spending time in this area with visitors during the days of our visits. There were items of interest from the provider, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. Information on the use of advocacy services was available and the registered manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People were able to express their views and were involved in making decisions about their care and support and the running of the home. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw that ideas and suggestions were taken forward and acted on. For example, menus, activities, trips out and laundry services.

Staff understood and respected confidentiality. A member of staff said, "We do not talk about residents to anyone even people we work with unless they need to know". We saw that records containing people's personal information were kept secure. Where information was stored on a computer, the service complied with the Data Protection Act. The registered manager and staff had an understanding of General Data Protection Regulation (GDPR) which came into effect in May 2018. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy. Staff confirmed that they had received training in GDPR.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection this key question was rated as Requires Improvement as there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people who lived in Kingsmead Haven had not consistently been provided with activities which were meaningful and reflected all people's needs and preferences. This inspection found that whilst improvements had been made there was still further work to be done to meet the breach of regulation.

The service employed specific staff to organise and facilitate activities and entertainment and they worked as part of the team. They knew people well and were attentive to people's individuality and differing needs and abilities. People in the nursing home told us, "There is always something going on and special events take place if we want to join in." Another person said, "I love living here, I can join activities or not as I wish." The activity co-ordinator told us that over time people had got frailer and preferred to spend their time in bed or in their room. They told us, "I visit each person everyday for one to one sessions and assist with breakfast and lunch."

Since the last inspection a new activity co-ordinator had started work on Kingsmead Haven who explained that there was a mixture of group activities and one to one sessions. We saw each person had their own activity schedule that had been drawn up in March 2018 by the activity co-ordinator. However, it was noted that activities for each person were uniformly similar with minor variations: for example, some people attended external day care centres on certain days while other people did not. People had different days on which they were scheduled to have support to go out for non-specified 'day trips', with some people scheduled to go out more frequently than others. Group activities were the same for all people and took place on set days each week, such as arts and crafts sessions, watching films, reflexology and aromatherapy. There was no evaluation of peoples' participation or enjoyment of activities that could assist staff in developing a more person-centred activity schedule.

Within the care plans there was a record of peoples likes and dislikes but it was not always evident that this had been considered when scheduling activities. One person had a love of cars and all staff knew this but there was no reflection in the person's activity schedule to support them to engage and follow this interest. There were several different forms being used that recorded activities people had been supported with, however samples of activity forms showed inconsistencies in whether planned and assessed activities had taken place as planned. For example, one person had been assessed as requiring support to attend twice weekly physiotherapy sessions and twice monthly hydrotherapy sessions but for the last three months records showed that they had not received this number of sessions. There was no record of why they had not occurred and no alternative offered. Another person was supposed to go out twice weekly in to the community but records showed that this had not always occurred. There was little recorded about whether these sessions benefitted people or whether an assessed goal had been achieved.

Our observations found that the communal dining room (lounge) did not allow much room for people with their custom-built wheelchairs and this had meant people were lined up in a row. At one point during the day people were arranged in two rows in front of the television. This had made it difficult for staff to interact

directly with people. On discussion with the management team, activities had been identified as needing further improvement. The service was recruiting further activity co-ordinators, training was booked for Makaton and further communication training. The activity provision at this time, whilst improved, still need to be developed to ensure everyone received meaningful and beneficial activities.

The above examples demonstrate that the provision of activities did not consistently meet people's needs and reflect their preferences. This is a continued breach of Regulation 9of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.

People were supported with their specific communication needs. Staff understood how to use pictures and objects of reference where appropriate on a one to one level. Some people also used Makaton to communicate. Makaton is a language programme which uses signs and symbols to help people to communicate. Each person had a communication care plan which detailed the difficulties people had and contained clear guidance for staff to follow on how to communicate effectively and be responsive to individual needs. However, there were many notices on the walls around the home regarding health and safety issues. They were on A4 sheets in small type. There was no indication that they were staff notices. There were also some 'easy read' notices on the walls but again on A4 and small type with cartoons. They were at eye level for an average adult standing but not at a level suitable for wheelchair users. The signage on shower rooms and the fire doors were also very small and at average adult standing eye height but again not suitable for wheelchair users. People's independent activity schedules on Haven were in a written format and there was a board displaying written activities for the week ahead in Haven's communal lounge. Neither of these formats were accessible for people and they relied on staff to verbally explain which activities were taking place on a day to day basis. This was an area that required improvement.

Since our last inspection, the provider had appointed a Service Review and Transformation Lead.' The Service Review and Transformation Lead had just started to review the activities within the home. This involved looking at what was already in place and seeing if they matched the needs of the people supported. We found the impact of this appointment had been very positive for people and their relatives in sister homes within the organisation. It is acknowledged that their first day was the day of the inspection process.

Staff knew people very well and we saw people enjoying one to one interaction with staff. Staff demonstrated an awareness of people's individual personalities and responded to specific facial expressions and body language. Signs of discomfort or agitation were picked up quickly by staff and responded to with patience and distraction techniques. Throughout Haven there were photographs on the walls showing groups activities that had taken place at the service throughout the year. For example, birthday celebrations, Halloween and other occasions such as parties and BBQs. There were also photographs of unscheduled group and individual outings to parks, pantomimes and garden centres.

We saw really positive interaction from staff as they supported people with daily activities throughout the home. Positive comments from people and visitors about activities and the one to one sessions being undertaken for people who preferred or needed to remain on bed rest or in their room. One person said, "They do their best, I have visits in my room and that's nice." We saw one staff member sitting with one person who had a visual impairment and they were doing a cross word together, and were told, "Normal

everyday things makes everything brighter for me." Staff told us of plans they had for developing activities within Kingsmead Care Centre. One staff member said, "We would like more room and sensory equipment and this is being discussed."

Regular staff and resident/family meetings were being held, times of meetings were displayed and details of suggestions and discussion points were recorded and actioned. For example, meal choices. The action plan included surveys and regular meetings with the chef. The minutes of meetings were shared with people and families and available in the home.

People's needs had been assessed before they moved into the home, to ensure they could provide the support and care needed to meet their needs. The information from the assessment was used as the basis of the care plans and there was evidence these had been written with the involvement of people, and their relatives, if appropriate. Records confirmed that people and their families or representative had agreed with the information recorded, as well as consent for photographs, sharing the information with external professionals and for reviews of their care plan.

Care plans had been reviewed regularly and updated when people's needs changed. Staff undertook care that was suited to people's individual needs and preferences. The care delivery was person specific and in line with people's preferences. For example, what they preferred to eat and drink, what time they got up and what time they returned to bed. For people unable to tell staff their preferences we saw that staff had spoken with families and friends."

Each care plan looked at the person's individual needs, the outcomes the support and care aimed to achieve and the action staff had taken to achieve this. For example, one person had recently developed swallowing problem known as dysphagia, there was a referral to the dietetic team about positioning of the person when eating, a care plan that clearly showed staff of the correct positioning along with details of required texture of food and thickener use for fluids. The care plan also detailed that staff assisting needed to be trained in safe meal time management. The care plan referred to potential of choke risk and the recent SALT assessment. The care plan had added guidance that said if the person was refusing to eat they could have readybrek up to three times a day, along with two thickened supplement drinks per day. Staff followed these care directives and this person was seen to be eating safely and enjoying their meal. Staff reviewed these strategies regularly to ensure they remained appropriate. Staff demonstrated a good understanding of this person's changing needs, both health and socially. One member of staff said, "If someone becomes confused or appears unwell we look for a cause, such as a urine infection and immediately encourage fluids and contact the doctor." Another staff member told us that they monitored people's weight and immediately sought advice if a person was losing weight. This meant that care delivery was responsive to people's individual needs.

Staff were kept up to date with changes in people's needs and the services provided through the handovers at the beginning of each shift. In addition, any significant information was recorded in a communication book that was passed on to the next staff team. Staff recorded the support offered in the daily records kept in people's room and these were checked daily by senior staff to ensure they reflected the support provided.

The provider had established an accessible effective system for identifying, receiving, recording, handling and responding to complaints. A complaints procedure was in place and displayed in the reception area of the home and in other communal areas. The complaint system was also available on the website for the service. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A

complaints log is kept and monitored by the registered manager. There was evidence that complaints were fully investigated, responded to, apologies given if there was a need to with actions they were going to take.

When compliments and thank you cards had been received these were shared with staff at meetings and displayed in the home which showed staff they were appreciated.

Satisfaction surveys had been sent out regularly in respect of getting feedback on the service. These were collated and the survey outcomes shared with people families and staff. The actions to be taken were also shared. One visitor said, "I have been asked to complete forms - I give feedback all the time."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection this key question was rated as Requires Improvement because there was a breach of regulation 17 as there was a failure to consistently assess, monitor and mitigate the risks relating to the health, safety and welfare of all service users. This inspection found improvements had been made and the breach of regulation met. However the quality assurance systems need to be further developed and embedded into everyday practice. This key question remains Requires Improvement.

Quality monitoring systems had been developed since the last inspection. There were a wide range of audits undertaken to monitor and develop the service and we looked at a selection of these. Audits were carried out in line with policies and procedures. Some areas of concern had been identified and changes made so quality of care was not compromised. We saw that learning objectives were taken forward by the management team. However, we did find some areas of care being delivered that was not accurately reflected in the care plan which the audits had not identified. For example, one care plan stated the person should be wearing hand splints when in their wheelchair. When we asked why the person wasn't wearing hand splints, we were told that this had been changed by the physiotherapist and there were new instructions. This was immediately updated within the care plan. Another inconsistency found was a care plan that stated a person required orthotic boots always when in their wheelchair for comfort and safety purposes. We saw that the person was not wearing their boots during the inspection, when queried with staff they said the person only wore the boots when going out. The care plan was immediately updated to reflect this with a rationale for that decision. Some health and safety checks such as legionella water testing had not been carried out since 2013. Other necessary checks for legionella such as water temperature checks, flushing of unused taps and showerhead cleaning had been consistently checked. We were told that this was an oversight and a test was due the week of inspection. These shortfalls identified that whilst the quality assurance systems had been improved there was a need to further improve and develop systems to ensure people received safe person-centred care at all times.

The registered manager told us that areas for improvement were on-going such as ensuring person centred activities were offered to people and care planning. Where recommendations to improve practice had been suggested, from people, staff and visitors, they had been actioned, such as laundry service, visual aids and menu choices.

Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. Call bell responses were monitored to ensure staffing levels were sufficient. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified.

Effective management and leadership was demonstrated in the home. The registered manager was knowledgeable, keen and passionate about the home and the people who lived there. The management team were open and transparent about the challenges they had faced, but were very proud of what the staff team had achieved in the past twelve months. They were committed to embrace the changes and continue to grow and develop the service.

The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The culture of the service was described as open, honest and friendly, by people and staff. The registered manager said their door was always open if staff, people and visitors wanted to have a chat with them. One member of staff said; "You're not going to get any better bosses," Staff were happy to challenge poor practice if they saw it and would contact the registered manager or other senior staff immediately if they had any concerns.

Staff told us that the philosophy and culture of the service was to make Kingsmead Care Centre a home. Staff of all denominations had contributed to developing values for the home. The values of the service included, 'Service users have the right to live as normal and fulfilling a life as possible and to have the respect of those who support them.' Staff spoke of the home's vision and values which governed the ethos of the home.' One staff member said, "Our residents are all special and very different personalities." The ethos of the home was embedded into how care was delivered and the commitment of staff to provide good quality care and person specific care. The registered manager and staff had a strong emphasis on recognising each person and their identity. Staff wanted to provide care that was individual to that person and it was clear staff recognised each person in their own entity. From observing staff interaction, it was apparent staff had spent considerable time with each person, gaining an understanding of their life history, likes and dislikes. Health care was specific to each person and staff clearly focused on the individual and their qualities.

Systems for communication for management purposes were established and included a daily meeting with the staff. These were used to update staff on all care issues and management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "The senior staff are open to suggestions, staff meetings give us the opportunity to raise issues and solve problems." Each shift change also had a handover meeting so staff changing shifts shared information on each person. A handover sheet given to staff facilitated this process with key aspects of care being recorded. Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are involved in developing the service here," "I think the management is really approachable" and, "We feel listened to."

The management team had been working consistently to develop the support and care provided at the home. The registered manager said, "We are continually looking at ways to improve people's lives." All the staff spoken with were enthusiastic about their role in the service. One staff member said, "It's a good place to work, supportive and approachable." Another staff member said, "We get lots of training and are encouraged to develop our skills."

The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "Really good communication and they are pro-active when something needs changing, they ask for advice and listen." We were also told, "Very good communication with us, the staff are dedicated sand committed."

Relatives felt they were able to talk to the registered manager and staff at any time and the relative's meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "I can talk to the staff and the manager is excellent, very kind, very knowledgeable, so I have always felt listened to."

The service had notified us of all significant events which had occurred in line with their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that all service users received consistent personalised care that meet their individual needs and preferences. Regulation 9 (1) (a) (b) (c) 3 (b)