SHC Clemsfold Group Limited

Kingsmead Care Centre

Inspection report

Crawley Road
Roffey
Horsham
West Sussex
RH12 4RX

Tel: 01403265335
Website: www.sussexhealthcare.co.uk

Date of inspection visit:
18 October 2016
19 October 2016

Date of publication:
29 November 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 18 and 19 October 2016 and was unannounced.

The last inspection took place in August 2015. As a result of this inspection, we found the provider in breach of a regulation relating to safe care and treatment and asked them to submit an action plan on how they would address this breach. An action plan was submitted by the provider which identified the steps that would be taken. At this inspection, we found that the provider and registered manager had taken appropriate action and the regulation had been met.

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; some people have associated dementia needs. Kingsmead Care Centre is a modern, purpose-built nursing home, situated in its own grounds, with gardens and dedicated parking. It is registered to provide nursing care and accommodation for up to nine people in Haven and up to 25 people in the nursing home. At the time of our inspection, nine people were living in Haven and 23 in the nursing home. Two of the beds in the nursing home are reserved for people who require short breaks or care and support that enables them to move back to their own home or into other care settings. All rooms are of single occupancy, including two double rooms in the nursing home. In Haven, there is a large community room which is utilised for activities and as a sitting and dining area. In the nursing home, there is a large sitting room with activities area and a separate dining room.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's risks were assessed, identified and managed appropriately. A range of risk assessments were contained within people's care plans and were reviewed monthly or, as needed, following an incident or accident. Staff had been trained to recognise the signs of potential abuse and people told us they felt safe living at the home. Staffing levels were assessed based on people's needs using a dependency tool. In the nursing home, some staff felt rushed in delivering personalised care to people and that some people might have to wait for staff to attend to them, especially at busy times of the day. New staff were recruited following appropriate checks on their suitability. Medicines were managed safely.

Staff completed training in a range of areas and new staff followed the Care Certificate, a universally recognised qualification. Staff were required to attend supervision meetings three times a year and to have an annual appraisal. However, not all staff had received supervisions with this regularity and the provider had identified this as an area for improvement. Team meetings were organised. Staff understood how to

gain people's consent to their care and treatment, but some staff did not have a thorough understanding of the Mental Capacity Act 2005. People felt there was a good choice of food on offer and they were involved in menu planning at residents' meetings. People were supported to maintain good health and had access to a range of healthcare professionals and services. Individual rooms were personalised in line with people's tastes and preferences.

People were looked after by kind and caring staff who knew them well and how to meet their needs. People's personal histories, preferences, likes and dislikes were identified and included in their care plans. Relatives and friends could visit people freely and people were encouraged to maintain contact with them. People were supported to express their views and to be involved in making decisions about their care. They were treated with dignity and respect. At the end of their lives, people's wishes were taken account of and they were supported by trained staff to have a comfortable, dignified and pain-free death.

Care plans provided advice and guidance to staff on people's care needs and the support they required. People were involved in reviewing their care plans. Activities were planned in Haven and in the nursing home. People in Haven often went out during the day and participated in a range of interests. Complaints were managed in line with the provider's policy.

Residents' meetings were organised so people could share their views about the home and discuss issues, for example, in relation to activities and menu planning. Formal surveys were also sent out to gather the views of people, their relatives and staff. Staff were positive about working at Kingsmead Care Centre and relatives were complimentary about the quality of care on offer. People and staff felt the home was well managed and that any concerns they had would be listened to. A range of audits measured and monitored the quality of care delivered and any improvements identified were acted upon.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were safe, but staff felt they did not always have time to deliver personalised care to people.

People's risks were identified, assessed and managed appropriately.

Staff had been trained in safeguarding adults at risk and knew how to protect people from harm.

Medicines were managed safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff had completed training on mental capacity, but some staff had a limited understanding of the Mental Capacity Act 2005. However, consent to care and treatment was sought in line with legislation and guidance.

People were given a choice of what they wanted to eat at mealtimes and were supported by staff where needed. One person was not supported to have their thickened fluid in a sensitive manner.

Staff completed training in a range of areas, attended team meetings and received supervision. Some staff had not received regular supervisions during the year.

People had access to a range of healthcare professionals and services.

Is the service caring?

Good

The service was caring.

Staff knew people well and warm, friendly relationships had been developed.

People were involved in making decisions and choices about their care and support.

People were treated with dignity and respect and had the privacy they needed.

At the end of their lives, people were supported to have a pain-free, comfortable and dignified death.

Is the service responsive?

Good

The service was responsive.

Care plans contained comprehensive and detailed information about people's care and support needs and guidance for staff.

A range of activities was organised for people in both parts of the home.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

People were asked for their views at residents' meetings. People, their relatives and staff gave their feedback about the service through formal surveys.

Staff spoke positively about the management team and felt any issues or concerns they had would be listened to. People and their relatives were complimentary about the quality of care delivered.

An auditing system identified areas for improvement and actions were taken to address these.

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 was also planned to check whether improvements had been made since the August 2015 inspection where the service was rated 'requires improvement' overall.

The inspection took place on 18 and 19 October 2016 and was unannounced. Two inspectors undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including eight care records, six staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with five people living at the service and spoke with one relative. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the deputy manager, two members of the provider's senior management team, a team leader, chef manager and three care assistants. We also spoke with a physiotherapist who was employed by the provider and an aromatherapist who was visiting at the time of our inspection.

Good

Is the service safe?

Our findings

At the inspection in August 2015, we found the provider was in breach of a Regulation associated with safe care and treatment. We asked the provider to take action because of insufficient detail recorded in people's care records and lack of guidance for staff on how to minimise risks to people. When risk assessments were reviewed and updated, the information was not always used to update people's care plans. Information on how to mitigate risks was inconsistent and additional detail was not promptly added to people's care records. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

We looked at a selection of risk assessments for people living in Haven and for people living in the nursing home. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risk assessments were in place for activities of daily living, falls, moving and handling, sleeping, skin integrity, bowel management, urinary tract infection and wound management. Some people were living with low grade pressure ulcers and we discussed how these wounds were managed with the registered nurse. Wound management records showed how people's pressure ulcers were treated, the types of dressings used and the progression of treatment. Regular 'Wound Care Link Meetings' were held with registered nurses from some of the provider's other homes and there was liaison with a tissue viability nurse. People's risks of developing pressure areas were assessed using Waterlow, a tool specifically designed for this purpose.

We asked staff whether they had been trained in safe moving and handling techniques and the physiotherapist confirmed this adding, "We work very much as a team. Staff let me know any concerns and I will carry out assessments. We involve the senior physiotherapist and nurses and carers". They told us, "Everybody has their individual equipment, individual wheelchairs, slings and hoists. Care plans list what equipment service users have and how staff use it". A care assistant said, "We make sure before we hoist. We have to look for hazards. We look at the equipment and check before we use. We have to check the environment". Staff we spoke with had a good understanding of moving and handling and how to move people safely. Moving and handling training for staff was refreshed annually.

Risk assessments were reviewed monthly and were discussed with people as part of their care planning reviews. For example, one person was involved in giving their consent to have bed rails, to prevent them from falling out of bed. Other risk assessments in place for people included accessing the community, eating and drinking and management of epileptic seizures. Risk assessments provided clear information about people's risks and how staff should manage and mitigate risks. We also looked at how accidents and incidents were managed. Records showed these were documented and reported to the registered nurse on duty. Any actions taken by staff were also recorded and risk assessments reviewed and updated as needed. In addition to risk assessments relating to people, general risk assessments had been completed for the environment; these included the laundry room, management of substances that might be hazardous to health (CoSHH), health and safety checks, electricity and gas maintenance and fire safety. All assessments

were current and fit for purpose.

People were protected from possible abuse and harm because staff had been trained to recognise the signs of potential abuse and knew what action to take. A recent safeguarding issue had been managed effectively and we discussed the outcome of this with the registered manager. Staff understood their responsibilities in keeping people safe. A registered nurse told us, "You have to safeguard and protect people from harm and abuse". A member of care staff said, "We're here to protect the people we look after because they're vulnerable. There's a whistleblowing policy. We discuss different categories of abuse". Another member of care staff, who had recently completed their safeguarding training, commented, "I will go to my manager with any concerns. [Named manager] is always responsive". Records confirmed that staff had completed safeguarding training and a noticeboard in Haven provided advice and information to staff on safeguarding procedures.

Staffing levels were assessed based on people's care and nursing needs and a dependency tool calculated how many staff were required. The dependency tool had assessed that a minimum of four care staff and a registered nurse were needed to care for 23 people in the nursing home. We asked people whether they felt there were sufficient numbers of staff on duty. One person said, "No, the staff don't have time to chat with me and the days can be long". However, another person said that when they rang their call bell, "Staff come very quickly. It depends where they are in the corridor. I don't have to wait for long". We observed one person was calling for staff from their bedroom, saying, "Help me please" and that their calling became louder as time elapsed. Ten minutes later, a member of staff was passing their room, heard them calling and attended to their needs. People who were unable to use their call bells were reliant on staff being within ear shot or on staff checking on people to see if they needed anything. If staff were busy elsewhere, then people could have to wait to be attended to. Call bell monitoring records had not been completed since July 2016.

We checked staffing rotas over a four week period and these confirmed there were four care staff and a registered nurse on duty during the day in the nursing home and three care staff and a registered nurse in Haven. On the day of our inspection, there was one agency nurse and three care staff in Haven and we observed that people's needs were addressed promptly. A student nurse was also on duty in the nursing home. A member of care staff told us, "[Named registered manager] tries to sort out issues with staffing levels, she does try. If we're short staffed, we have agency". They added, "It's a bit rushed, especially in the morning when we're delivering personal care. People may have to wait, especially if they need a bath or shower. The nurse would help more if people are unwell". The activities co-ordinator in the nursing home also helped out where they could, for example, with serving meals and ensuring people had drinks to hand at mealtimes. The majority of staff we spoke with felt that person-centred care was frequently compromised and that care delivered to people was often 'task led'. One member of staff referred to staffing levels and said, "It's been a challenge for a while". Another member of staff identified staffing levels as an area for improvement and said, "I would honestly say that we need an extra member of staff". They explained to us that with two people lived at the home on a temporary basis and the support they needed to improve their independence, coupled with assisting with physio exercises and people's moving and handling needs, left little time to deliver personalised care. They explained, "We have people with interim needs now, we haven't always had that. At the moment we could do with one more care staff". They then described it as a 'queuing process' sometimes to meet people's needs. Some staff were beginning to feel the stress of working 12 hour shifts over several consecutive days. However, a member of the nursing staff said, "Even though we're short of staff, we have a good team here". In contrast, staffing levels at Haven were such that staff had time to spend with people and to care for them in a personalised way. We discussed staffing levels with the area manager and with the registered manager. They told us that safe staffing levels in the nursing home were a priority and this issue would be investigated further.

New staff were recruited safely and we checked staff files. These showed that new staff had completed application forms, a record was made of the interview, two references obtained and all necessary checks undertaken, for example, with the Disclosure and Barring Service (DBS). DBS checks helps employers make safer recruitment decisions and help prevent unsuitable staff from working with people.

Medicines were managed so people received them safely and registered nurses administered medicines. We observed a registered nurse administering medicines to people in the nursing home at lunchtime. Medicines were dispensed from a medicines trolley. We observed that people had time to take their medicines in an unhurried way and the registered nurse waited with people while they took their medicines. We observed that people were given a drink to help them swallow their medicines and that the registered nurse washed their hands after handling medicines, for example, when administering one person's eye drops. When the trolley was unattended, it was kept locked and stored in the medicines room. Medicines that were required to be refrigerated were stored in a dedicated fridge and daily temperature recordings were taken. We saw that people's prescribed topical creams were stored in a box in the bath of one of the downstairs bathrooms. This meant that anyone could have taken or used the creams inappropriately. We discussed this with the area manager at the end of our inspection and they agreed that the box should be removed and people's topical creams would be stored securely and safely. Medicines audits were completed relating to stocks of medicines, temperatures of the refrigerator and medicines room and ensured that Medication Administration Records (MAR) had been completed appropriately by staff to confirm people had taken their medicines as needed.

Requires Improvement

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. A team leader told us that they mentored new staff and had achieved a qualification in mentoring. New staff completed an induction programme which included a tour of the building. They shadowed experienced staff for at least three shifts and were paired with a senior member of staff until they were assessed as capable of working more independently.

Staff completed a range of training which was arranged by the provider's training academy. Training included fire safety, moving and handling, infection control, first aid, mental capacity and epilepsy. Staff were also encouraged to study for additional qualifications, such as National Vocational Qualifications (NVQ) in health and social care. Nursing staff completed training specifically to understand people's health conditions and in providing palliative care. A registered nurse told us they had updated their training on Multiple Sclerosis and said, "We have the training for particular healthcare needs. If I'm not sure, I will discuss with the academy". A member of staff said, "I can say the training is very good and they offer more training from head office. You can do nursing training if you want". After looking at the staff training matrix, it appeared that specific training was not delivered to care staff relating to dementia, learning disability or acquired brain injury and we discussed this with the area manager. They told us that these topics would be covered by new staff as part of the Care Certificate, however, it was not clear whether existing staff had received specific training on these areas. Two staff told us that they had not completed training related to dementia. The physiotherapist told us, "The carers are with people most of the time, so they know them. I think we do a great job working as a team".

Staff had some supervision meetings with their line managers. We were told that staff received three supervisions per year and an annual appraisal. However, staff did not always receive supervision meetings this regularly. For example, one staff file showed the member of staff had received their last supervision on the first day of our inspection. However, no other supervision meetings or records of these meetings had been completed for 2016, although the file showed that this person had a performance appraisal in June 2016. The area manager had identified this as an area for improvement in their audit and stated that, 'Most staff had the required amount of supervision meetings, but some still needed to be done in order to achieve the annual amount'. Further, 'These needed to be carried out and up to date by the end of September for everyone', but this action had not been completed at the time of our inspection. One member of staff said they had supervision every three months with the deputy manager and that they found this, "Very helpful. We talk about tidiness of the home, all our residents, about my training". Another member of staff said, "[Named deputy manager] gives supervision every six weeks" and added they felt they had enough training. They told us, "This year, I've done moving and handling, fire training, infection control, first aid, mental capacity and epilepsy".

Staff meetings were held during the year and we looked at minutes of meetings relating to April, July, August

and October 2016. The last meeting in October showed items under discussion were the CQC inspection, accidents and incidents, a forthcoming audit, name badges and a reminder to staff to write clearly in care plans.

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. Staff told us they had completed training on the MCA and demonstrated their understanding of their responsibilities under this legislation. One staff member told us, "Everyone is deemed to have capacity unless assessed as otherwise". Another member of staff said, "It's a law designed for people who don't have capacity to decide for themselves" and then went on to talk in detail about the five key components within the MCA, the least restrictive options and best interest meetings. However, two staff in Haven seemed less sure. One said, "If people can't make decisions, we would go to their next of kin". Another staff member told us, "Some residents don't have the capacity to decide, so next of kin decide". This may be an area for improvement for the provider to ensure all staff are clear about the principles of the MCA. Capacity assessments, where needed, had been completed appropriately for people.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were deemed to have capacity, records showed they had been involved in giving their consent, for example, in relation to the use of bed rails. DoLS applications had been completed for everyone accommodated in Haven and for a large number of people living in the nursing home. At the time of our inspection, very few authorisations had been completed by the local authority and the majority of applications were still awaiting a decision by the local authority.

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. We asked people what they thought about the food on offer. One person said, "Food's very good. I like roast pork and chicken. I like puddings like fruit and custard, ice-cream or yogurt". Another person said, "You always get a choice. If you don't want something, you can opt for something else". They also told us that, despite being unable to see, they were still able to eat independently and said, "They put a contraption on my plate which stops me from flinging the food around!". We later saw this person having their lunch, that they were able to eat independently and that they were told where their drink was on the table, for easy access and to prevent them from knocking the drink over accidentally. A third person said, "Food is a bit plain. I like curries and spicy food, but I can always have an alternative". They added that they chose what they wanted to eat the day before saying, "They bring the menu round and ask me what I want from it". Menu choices were written up on a menu board on display in the dining room in the nursing home. However, the writing was small and difficult to read. In addition, on the first day of our inspection, the date was written up as the 16th, when in fact it was the 18th. This could have been confusing for people.

We observed people having their lunchtime meal in Haven and in the nursing home. The meal on offer on the first day of our inspection was spaghetti Bolognese followed by semolina and jam or ice-cream. Other menu choices were available. In Haven, one person decided they would like egg and chips and they were encouraged to pick up the phone and talk to the chef to place their order. A little later, their chosen lunch was brought to them and they appeared to enjoy the meal. People were asked where they would like to eat their lunch and they were reminded what food they were eating. Staff sat next to people at their eye level and chatted to people. We saw one person received nourishment through a percutaneous endoscopic

gastrostomy (PEG). PEG is a procedure in which a flexible feeding tube is placed through the person's abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus.

However, we observed an occasion when a staff member was giving one person a thickened drink. The staff member put a quantity of the drink onto a dessert spoon and offered it to the person to drink. The person was shrieking and kept turning their head away, with the result that about half of the thickened drink was spilt down their chin or onto their clothes protector. The staff member continued to spoon-feed the person, even though they appeared to be distressed and unhappy. In the end, the staff member gave up and about one-third of the thickened drink was left. We looked at the person's care plan which stated, '[Named person] may not want to be fed by someone she does not know and may turn her head away from them'. The staff member did not support the person in a sensitive way, nor did they speak reassuringly to them. They had not supported them to ensure they had sufficient fluids to drink. We drew this to the attention of the area manager at the end of our inspection and they stated they would follow this up.

In the nursing home, people were sat in the dining room and there was a relaxed, informal atmosphere during the meal. Where needed, staff provided 1:1 support and helped people with their food. People were asked whether they wanted to wear protectors to keep their clothes clean and free from food spillages. People were offered a choice of hot or cold drinks and staff engaged people in conversation.

We spoke with the chef manager about menu planning and he told us that menus were organised over a five weekly cycle and changed during the summer and winter months. The chef manager was knowledgeable about people's specialist diets, their likes and dislikes and any food allergies. The chef manager told us that menu planning was also discussed at residents' meetings. Meals were cooked using fresh ingredients and the main meal was served at lunchtime.

People were supported to maintain good health and had access to healthcare professionals and services. Each person had a named nurse who addressed their clinical needs and people were also allocated a keyworker who co-ordinated other aspects of their care. A physiotherapist was employed by the provider and attended Kingsmead Care Centre on Tuesdays and Thursdays. People were provided with 1:1 support and the physiotherapist supported people with exercises and other forms of therapy to treat their illness or disability. One person told us that the GP visited regularly and said, "Well she normally pops her head around, but I only see her if I need to". The physiotherapist told us they would be involved in contacting a GP if needed and said, "We have a good relationship with the GPs. I will phone them if I need more information. We refer when people need assessing". Care records showed the involvement of healthcare professionals such as GPs, dentists, opticians, dieticians and psychiatrists. Hospital passports had been completed for people. A hospital passport provides important information to hospital staff about people's health when they are admitted to hospital. A relative told us that they were always contacted if their family member became unwell.

People's rooms were personalised and furnished with items of special importance to them. In Haven, rooms had been decorated in different colours according to people's preferences.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We were told that one person was currently in hospital and that care staff would visit them whilst they were in hospital. We observed that staff were warm and friendly with people and knew people well. One person said, "Some staff do chat to me, but I'm not a chatting sort of person", adding that they preferred their own company. A relative talked about the staff and said, "Everybody seems really friendly. They've always got things on here". Care plans showed that people could choose whether they wanted to be cared for by male or female staff. A staff member, when asked what they felt was 'Good' about working at Kingsmead Care Centre, said, "Getting on with people. I love working here". People's preferences and personal histories were recorded in their care plans. In Haven, relationship circles had been completed for people and copies were placed in their care plans. A relationships circle identifies people who are or have been in a person's life. It can help a person to maintain relationships with people who are important to them. It can also help to establish characteristics of people who the person would like to receive support from. For example, in one care plan, the relationship circle named the person's aunt, their advocate, cousin and social worker as being important to them.

As much as they were able, people were supported to express their views and to be actively involved in making decisions about their care treatment and support. People were encouraged to make day-to-day decisions and choices about their care and support and they were supported to be as independent as possible. The physiotherapist explained, "You always encourage them to do a bit more every day". They talked about hydrotherapy and said, "We encourage people to use this. When we are in the water, we are the same level with service users. You give them a bit more independence as then they can float independently". Another member of staff told us, "We have to ask the service users, for example, if they want a wash; then they will have a wash". They added, "We ask what people can do. 'Can you put your head up when we help with a wash?' And they choose what they wear. We ask them all the time what they want". Another member of staff confirmed this saying, "We give people a choice in everything, about food, how they want personal care. We ask them if they want to go out, shopping, church, etc".

Generally people were treated with dignity and respect. One person, who was unable to see, told us that some staff did not always introduce themselves when entering their room, so they did not always know which member of staff was attending to them. Another person was positive about the way they were treated by staff and said, "Oh yes, they're very good like that. They have to wash me and they look after me very well". We asked staff how they treated people with dignity and respect and whether people had the privacy they needed. One staff member said, "We provide them with private space. We close the curtains and the door. First of all, you inform the service user and ask for their consent. You keep them clean and safe and ensure all their needs are fulfilled". Another staff member said, "We ask first for consent from the service user. We close curtains and we check the environment. We make sure bed rails are up at night". A third staff member told us, "We make sure we knock on the door before we enter the room. We ask them if they want a wash or shower. We use the shower curtain and cover them with a towel or blanket".

At the end of their lives, people were supported to have a private, comfortable, dignified and pain-free death. Nursing staff had completed training in palliative care and in end of life care. Some people had

recorded how they wanted to be cared for at the end of their lives, so staff would be able to provide them with care in line with their wishes and preferences. 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms had been completed appropriately for some people at Kingsmead Care Centre, where it was identified by healthcare professionals that resuscitation would be either futile or unsuccessful, due to their underlying health condition. Cardiopulmonary resuscitation is an emergency treatment used to restart a person's heart and breathing if they stop.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans were clearly written and provided comprehensive, detailed information about people, their care needs and how staff should support them. Care plans were reviewed monthly. A care plan for one person living in Haven provided information about their potentially challenging behaviour. The plan stated that the person could harm themselves, biting their arms and hands and slapping their face. Guidance to staff was, 'If she displays challenging behaviour, allow her time to calm and settle down. Care staff to document any episode of challenging behaviour on the specific form'. An associated risk assessment for this person had also been drawn up and was reviewed monthly. Other areas included in people's care plans were: continence and elimination, expressing sexuality, likes and dislikes, medication, mental health and wellbeing, safe environment and mobility. Physical ability assessments had been completed by the physiotherapist for people living in Haven. Daily records were completed by staff and we saw records relating to people's weights, medicines given, the person's emotional and physical wellbeing and that food and fluid charts had been completed to monitor people's nutritional intake.

A member of staff felt that care plans were personalised and individual to the person and told us, "Care plans are put together by the manager, staff, nurse, family and GP". At the front of each care plan, staff had signed a form to show they had read and understood people's documented care and support needs. A member of staff told us, "We discuss care plans with residents and make sure people are happy with their care plans". Referring to people living in Haven, a staff member said, "We talk to service users. They do let you know by body language what they want, even if they are not verbal". We were told that one person used Makaton, an accessible way of communicating through pictures and symbols. Some people had assessments in place that identified whether they were feeling distressed and helped to identify the signs or cues that might signify whether someone was content or in distress. People were encouraged to stay in touch with their families or other people that were important to them. One staff member said, "Families are able to visit. [Named person] uses an iPad to speak with his sister and mum. Families come for birthdays and we ask people if they are happy".

A programme of activities was on offer to people living in the nursing home and an activities co-ordinator supported and encouraged people to be involved in various activities during our inspection. We asked people whether they had enough to do and how they spent their days. One person felt there was enough to keep them occupied and said, "No I'm not bored. I listen to the television". On the first day of our inspection, this person was offered a foot massage by the activities co-ordinator which they appeared to enjoy. Another person told us they tended to stay in their room and said, "I don't move around a lot as I get disorientated, so I stay put 95 per cent of the time. It can get a bit monotonous, I'm plonked here. I just listen to the radio. Sometimes they have Bingo and other things going on, a sing-song and stuff". This person preferred to have individualised support, so the activities co-ordinator met with them on a 1:1 basis. This person also told us that they enjoyed going out into the garden. Another person preferred to stay in his room and told us that his wife visited regularly and he liked watching television. He added, "I don't read much now, but I'm quite content with life. I wish I hadn't had a stroke, but that's life". A third person said, "Sometimes I get fed up", but told us they enjoyed going to the sitting room and looking at newspapers.

A member of staff talked about the activities on offer and said, "[Named activities co-ordinator] has an activities programme and people can choose to participate or not". On the second day of our inspection, some people had their hair done by the hairdresser, others had 1:1 support with activities in their rooms and in the afternoon, we sat with people while they made Hallowe'en masks and witches hats. People were enjoying this activity and were supported by staff to make a mask or hat. Staff asked people whether they used to do anything particular on Hallowe'en when they were young which engaged people in lively conversation. The activities co-ordinator said, "We always ask what people want to do. We've had one hour of arts and crafts and one hour of games today". They said that one person had enjoyed having a massage and that other activities during the week included quizzes, Bingo and other games. The activities co-ordinator added, "But if people want to do something else they can", for example, baking cakes.

The activities co-ordinator in Haven had recently left and so staff were largely responsible for organising activities for people. One member of staff told us, "We have an activities diary. We help people with what they want to do". A notice in the communal sitting/dining room in Haven showed a programme of 'Tentative Weekly Activities'. These included, arts and crafts, shopping trips, exercises, reflexology, music therapy, and bowling. On the second day of our inspection, an external entertainer was engaging people with music and they were encouraged to play percussion instruments. We observed one person playing a xylophone and then a cymbal. People were given a choice of music and one person chose the Hokey Cokey, which involved them being pushed around by staff in time to the music, which they clearly enjoyed. Another person, who may have been listening to the music, was also occupied in matching shapes in a puzzle. On the first day of our inspection, we observed people in Haven playing a guessing game, a group activity. The game involved one person wearing a band on their head with a card placed in it and the object of the game was for people to guess what the card might indicate. The person who was wearing the band kept trying to remove it from their head and it was difficult to assess whether people really understood the game and whether it was a meaningful activity. We discussed this with the area manager who agreed to look into this further. We saw that people had individual activity planners which showed the activities they had participated in and any trips out into the community. Unless people went out, then aside from resting or receiving personal care in their bedrooms, they spent the majority of their time in one communal area, engaging in activities or eating round the table.

We asked people whether they knew how to make a complaint and who they would speak to if they had any concerns. One person said, "It's very nice here. There's not a lot you can complain about really. They treat you very well". Another person told us that if they had a complaint they would see either the registered manager or the deputy manager. They added, "Or one of the nurses, but basically I'm a very happy bunny here". A relative told us, "I usually go to whoever's on the desk to be honest". We looked at the record of complaints and three complaints were recorded in 2016. The date of the complaint, the issue, action taken and whether it was resolved satisfactorily were all recorded and managed appropriately in line with the provider's complaints policy.

Good

Is the service well-led?

Our findings

At the inspection in August 2015, we identified areas for improvement relating to pressure mattresses and bed rail assessments; these issues were rectified immediately following our visit. Improvements had also been made with regard to ensuring that any actions required following the internal quality audit were recorded and completed appropriately.

People were actively involved in developing the service. The majority of people were aware that residents' meetings took place and one person told us, "They talk about all sorts of things". Another person said, "I don't go, I stay in. I prefer my own company". A third person said they did not know that residents' meetings took place. We looked at minutes of residents' meetings that had taken place at Haven and in the nursing home. Meetings in Haven had taken place in October 2015, June 2016 and September 2016. At the September meeting, eight people had attended and items under discussion included recent activities, trips out to Littlehampton, Worthing, a farm and Horsham shopping centre, in house activities and a BBQ held in June. In July, a Hawaiian themed BBQ had taken place and families were invited. Whilst records documented the items considered at residents' meetings, we discussed, with management, the possibility of using a more accessible format, for example, pictures or symbols, to aid people's understanding of meetings. We saw minutes of a residents' meeting that had taken place in the nursing home in September 2016. People had discussed activities and events and people's birthdays. A request was made for some new general knowledge quiz books and these were subsequently purchased. A staff member confirmed that meetings were held and that, "All people were involved. They discuss activities, food, what they really want and any complaints".

People and their relatives were also asked for their views about Kingsmead Care Centre through formal surveys. People stated that they liked living at the home and felt well cared for. A relative of a person living at Haven stated that more space would be advantageous as people spent mealtimes and activity time in the same room. One relative of a person in the nursing home had written, 'Care and help by staff first class. Very kind to my dear [named person]. Can't thank them enough'.

Staff were positive about working at Kingsmead Care Centre and we asked some staff members about the culture of the home. One staff member said, "We have to make sure people are safe from harm and abuse. They are offered choice", adding there was an open culture. Another member of staff said, "They value people" and described the culture as, "Welcoming. You feel like you are part of a big family. It's a nice environment to work".

We asked staff about the management of the home and whether they felt any issues they wanted to raise would be listened to. One staff member said, "We're really open here and discuss things at supervision". Another member of staff said, "We have regular contact with [named area manager] and she knows the staff. I feel confident to go to her and I will be listened to". A third staff member told us, "It is well led. We are being listened to and we exchange opinions. The manager informs us of new procedures. She keeps up to date with changes and regulations". A fourth staff member said, "I think it's well led. If I have any problems, I would talk to my nurse or the manager". A visiting aromatherapist told us, "I think [named registered

manager] is a very good manager. She is liked by staff and she is very professional. I wouldn't have worked here for this length of time otherwise; they all chip in".

We asked people about the quality of care they received. One person said, "I like it here and I don't want to move". Another person told us, "It's quite pleasant and the food's good". A third person said, "I'm very happy with them. I'm looked after well. It's a very good home from home. It's very tranquil here and I can look out [of the window]". A relative had written in a card, 'We would like to thank you all very much for all the kindness and excellent care you gave to [named family member]. We couldn't have wished for more'. A staff member felt that team morale was good and added, "We have regular agency and bank staff. They always say what a nice place it is to work. We are like a family as well. We don't tolerate poor care". Another member of staff said, "We have issues with staffing levels, but we do try and give the best care. I think the staffing levels is an area for improvement. It's different every day. We can have emergencies, so how can we always deliver the care they need?"

The provider had notified the Commission of incidents or events that they were required to complete in line with the registration requirements, for example, notifications of serious injury, death and Deprivation of Liberty Safeguards authorisations. Weekly health and safety audits were completed by maintenance staff which checked on lighting, storage, cleanliness, fire safety, Legionella, boiler and gas safety. Where areas for improvement were identified, appropriate action was taken. After the inspection, the area manager sent us audits they had completed for August and September 2016. The area manager had sampled a range of documents and looked for evidence that supported compliance under 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well Led'. Whilst areas for improvement had been identified and actions recorded to address these, some issues were still outstanding, for example, in relation to staff supervisions (see 'Effective' section of this report). Random checks were undertaken in relation to completion of care plans, risk assessments, health and safety checks, complaints and a range of other areas. The registered manager also completed monthly reports which described the action they had taken to address any areas for improvement identified in the area manager's audit.