Innowood Limited

Kingswood House Nursing Home

Inspection report

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East Sussex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 and 22 August 2017. The first day was unannounced. Kingswood House is registered to provide nursing, care and accommodation to 22 people. There were 19 people living in the home when we visited. People living there were all adults who were living with past or present mental health nursing and care needs. Some people had additional needs in relation to substance dependency. Some people had needs relating to medical conditions such as living with diabetes, stroke or epilepsy. For some people Kingswood House was their permanent home, for others they were living at Kingswood House for a period of time before they moved on to other accommodation, or back to their own homes.

Kingwood House provides accommodation over three floors. There were communal sitting rooms and a dining room on the ground floor, and a patio and garden to the rear. The house was situated close to the middle of St Leonards.

There was a registered manager 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. The provider is Inwood Limited. Kingswood House is the only home Inwood Limited is registered for.

The home has been inspected twice since 2015. At the inspection of 24 and 25 August 2015, the home was rated as inadequate and six breaches in the HSCA 2014 regulations were identified. The home inspected again on 21 and 26 April 2016. At that inspection improvements were identified and it was rated as requires improvement, however a continued breach in Regulation 12 of the HSCA Regulations 2014 in relation to safe care and treatment continued to be identified.

At this inspection, we found the provider and registered manager had not been successful in making all relevant improvements and several areas identified at the inspection of 24 and 25 August 2015 were again identified.

As at the last and previous inspections issues relating to safe care and treatment were identified. This was particularly in relation to the high risk to fire safety. Areas relating to the mitigating of risk to people and cleanliness were also identified, as they had been at the inspection of 24 and 25 August 2015.

At the last inspection improvements were required to ensure the service was well-led. This related particularly to the provider's systems of quality assurance which had not been effective in identifying matters and ensuring appropriate action was taken. As at the last and previous inspections, the provider continued not to identify all relevant actions, some matters were not documented and some areas did not have action plans to outline how they were to be addressed. This related to a range of areas, including audits of care planning and maintenance of the home environment, as well as safety.

People were not supported by person-centred care plans relating to their daily lives to ensure their individual needs for activity and engagement were assessed, planned with them, and reviewed. This had also been identified at the inspection of 24 and 25 August 2015.

The home environment needed attention to a wide range of areas to ensure it provided a clean, therapeutic and homely place for people to live. This had also been identified at the inspection of 24 and 25 August 2015.

The provider was not ensuring it complied with all relevant areas in accordance with the Mental Capacity Act (2005), to ensure people were supported appropriately in consenting to care and treatment, or if they were not able to do so, such care and treatment was provided in their best interests.

Staff were trained and supported in their roles, however we recommend that the service follow current guidelines in relation to the induction of new staff. Safe staffing levels were maintained and staff were recruited in a safe way.

Some people were not supported in being able to make choices about certain relevant aspects of their care. This was not the case in all areas and in other parts of their care choice was fully supported.

People were safeguarded from risk of abuse by staff who understood their responsibilities. Staff took action to reduce people's risk in certain areas, such as supporting people in moving safely.

People were supported in taking their medicines in a safe way. Medicines were securely stored and medicines records were maintained.

People had clear care plans about their mental health and medical care needs. Relevant external professionals were contacted where people had additional nursing and care needs. Directives from external professionals were followed.

People spoke favourably about the meals. Where people needed additional support and treatment in relation to eating and drinking, care plans were followed.

People said they liked the staff and were treated with respect by staff who were kindly towards them. They said they could raise issues of concern to themselves and felt they would be listened to. Staff told us the management style of the home was supportive and they could bring forward issues which they felt needed to be addressed.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspection is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

People's safety was not consistently ensured across a range of areas. This included areas relating to fire safety for people and others.

Appropriate staffing levels were maintained.

People were supported in taking their medicines in a safe way.

People who could be at risk of abuse were protected by staff who were aware of their responsibilities.

There were safe systems for recruitment of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the MCA and Deprivation of Liberties Safeguards (DoLS) were not always being followed.

The home environment did not provide a clean, therapeutic, homely premises in a range of areas.

Staff were trained and supported in their roles, however we recommend current guidelines on the induction of new staff be followed.

People spoke favourably about the meals. Where people needed additional support to eat and drink, this was provided.

People were referred to relevant external healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not involved in making decisions about all aspects of their care.

Staff supported people's privacy and showed them respect.

Staff showed a kindly, friendly approach to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have person-centred plans developed for how they wanted to spend and develop their own lives.

People had clear care plans about their medical and mental health needs. These were followed by staff.

People said they could raise issues and they were responded to appropriately if they did this.

Is the service well-led?

Inadequate

The service was not well-led.

The provider and registered manager had not identified they had reverted back to being in breach of a wide range of areas.

Relevant matters were not always documented in audits. Audits did not always identify areas for action. Some relevant action plans had not been developed.

People said managers were approachable.

Staff said they could raise issues with managers and if they did this, they would be listened to.

Kingswood House Nursing Home

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.

The inspection took place on 21 and 22 August 2017. The first day of the inspection was unannounced. The inspection was undertaken by two inspectors.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. The provider had sent us an information return (PIR) in which they outlined how they ensured they were meeting people's needs and their plans for the next 12 months. As part of the inspection, we reviewed the PIR. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. After the inspection, the registered manager sent us further information and we considered this as part of the inspection.

We met with nine people who lived at the home and observed their care and treatment, including lunchtime and support with medicines. We spoke with three visiting external professionals. As some people did not feel like talking to us or had difficulties with communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people. We inspected the home, including the laundry, bathrooms and some people's bedrooms, with their permission. We spoke with four of the care workers, the activities worker, two registered nurses, the deputy manager and the registered manager.

We 'pathway tracked' six of the people living at the home. This is when we looked at people's care

documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included three staff recruitment, training and supervision records, medicines records, risk assessments, accident and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found the home was not providing safe care and treatment. The provider was not meeting the requirements of Regulation 12 of the Health and Social Care Act (HSCA) (Regulated Activities) Regulations 2014 in relation to fire safety. At the previous inspection in August 2015, we had also identified the provider was not meeting this Regulation.

The fire safety measures continued to not be sufficiently robust to ensure people's safety. The home's fire risk assessment identified the use of smoking materials as a fire safety risk. Several of the people chose to smoke. Staff told us some people who chose to smoke also smoked in their rooms, which they were not meant to, rather than using the designated smoking area. We went into one of these people's rooms. They had a range of combustible items in their room, including dust and tissues under the radiator at the head of their bed. We asked staff what they did about the fire risk from this person. They said they spoke to the person when they found out they were smoking in their room and actively discouraged them from doing this. We looked at the person's records. Although it was documented in June 2017 that they were known to smoke in their room, they had no assessment about the risk to themselves or others about this and their care plan review of July 2017 about smoking in their own room was not being followed. The registered manager said an assessment about the risk would be drawn up, but this did not take place until we asked about the risk during the inspection, despite there being previous records of the person smoking in their room.

The home had a designated smoking area where people could smoke. However people were clearly smoking in other non-designated areas. The first and second floor fire exits showed a large number of cigarette ends on the floor and cigarette ends were also visible on the ground below the fire exits. There were no safe metal bins for smoking materials in either area. There was no plan to ensure people were discouraged from smoking in these places. The registered manager told us cigarette ends were regularly removed when needed but there was no cleaning or other plan to ensure cigarette ends were regularly cleared away to reduce fire risk from them.

The registered manager confirmed that if the fire alarm sounded all people were expected to leave the building. Some of the people were wheelchair users. We looked at one of these people's personal emergency evacuation plans (PEEPs). The person's PEEP was dated the month of the inspection. It was inaccurate in that it stated the person's room was on the ground floor, when at the time of the inspection they were living on the first floor. Their PEEP stated they would need two people to evacuate them from the building. There was no information in their PEEP about how two staff were to safely do this, including supporting them down the external fire escape. Fire safety documentation also did not include consideration about how people on upper floors could be safety supported to leave the building at night in the event of a fire, when there were only two staff on duty.

Due to our concerns about fire safety for people and others, we held a management review meeting after the inspection. The risk to people and others was assessed as being high, therefore at that time, this area was judged to be inadequate, because of the range of areas about fire safety identified at this inspection. We

also reported our concerns to the local Fire and Rescue Service. Following this meeting, we wrote to the provider to outline our serious concerns in relation to fire safety and to require they sent us an action plan to set out how they would make improvements to ensure people's safety. The provider sent us an action plan which set out how they had, and would, take prompt action to ensure the safety of people and others in relation to fire safety

The provider was not ensuring people's safety in other areas. The medicines and healthcare regulatory authority (MHRA) issued a safety alert in 2015 in relation to the use of safety belts (otherwise known as lap belts) on wheelchairs and other devices. The alert reported on serious injuries persons had sustained from slipping down and falling out of wheelchairs where lap-belts were incorrectly used, fitted or maintained and from lack of appropriate staff training in their use. The alert included the areas providers, including care homes with nursing, were to follow. We saw at least two of the wheelchair users had lap belts in use during the inspection. We spoke with staff about people's safety when using wheelchair lap belts but they did not know about the serious risks identified by the MHRA. When we asked staff about one of these people, they told us differing reasons about why and when the person needed to use their wheelchair belt. We looked at both people's records, no risk assessments or care plans had been completed to ensure people's safety when using their lap belt.

The National Institute for Health and Clinical Excellence (NICE) issued guidelines on actions to take to reduce risk of pressure damage to people, in 2014. The provider was not ensuring these guidelines were followed. The guidelines state because pressure wounds, once developed, take an extended period of time to heel, can be very painful and present a risk of infection, the emphasis must always be on their prevention before they occur. Two of the wheelchair users were assessed as being at high risk of pressure damage. One person had no care plan to direct staff on how their risk was to be reduced. Staff we spoke with did not report on planned strategies to reduce this person's risk. The other person was living with a condition which meant they had limited sensation to a part of their body which was at high risk of sustaining pressure damage. Their care plan did not include any information on how risk to this part of their body from pressure damage was to be reduced. When we asked two members of staff about the risk to this person from this area of their body, they did not know what actions they were to take to reduce the person's risk.

The provider was also not ensuring people's risk of infection was reduced. The light pull cords in all of the communal bathrooms and toilets were stained in the areas where people placed their hand to turn the light on or off. This could present a risk of cross infection to all users. There was an infection policy, it followed good practice by outlining among many other areas, the importance of effective hand drying, as well as hand washing. Different people used the toilet in the bathroom on the first floor. The room had a hand dryer in it to enable people to dry their hands. It was not working on either inspection day. There was no information on how long the dryer had not been working. We informed the Registered Manager about this during the first day of the inspection. By the end of the second day of the inspection, no action had been taken to ensure people could safely dry their hands until the hand dryer was mended and no record had been made about it in the maintenance book. On both days, mop buckets showed deposits on the insides. As they were not clean, there was a risk of contamination of mop heads when these buckets were used.

This is a continued breach of Regulation 12 of the Health and Social Care Act (HSCA) (Regulated Activities) Regulations 2014

People gave us mixed views about staffing levels. One person told us, "There's not enough staff" and another who told us they needed assistance to go out of the home said they could not always go out when they wanted because staff were not available to support them. This was not echoed by others. One member of staff told us, "There's enough staff here," another, "There's usually enough staff to take residents out

when they want" and another, "They're on top of the staffing here." We saw there were enough staff on duty to support people, including assisting people who needed support at mealtimes and assisting people in going out into the smoking area to the rear of the building. When an altercation occurred between two people in one of the sitting rooms, there were enough staff to support both the people and also other people in the room who might have been affected by the incident. We asked visiting external professionals about staffing. One of them told us, "I've never had any problem about staffing here." Another told us there were always enough staff to go through all of their client's information with them and staff did not rush them at such times.

There were safe systems to support people with taking their medicines. A visiting professional told us registered nurses had been supportive to a person in ensuring issues relating to their medicines had been sorted out when the person was admitted to the home. We observed a registered nurse giving people their medicines. They addressed people by their preferred name to gain their attention, before giving them their medicine. They discussed people's medicines with them when asked and asked them if they needed any of their 'as required' medicines, for example painkillers. They checked each person had taken all of their medicines before completing the medicines administration record (MAR). This included one person where the registered nurse monitored them from a distance because they did not like being closely observed.

Medicines were securely stored in a dedicated room. All medicines were tidily stored which supported audit and stock control. There was a computerised system for documenting medicines. This ensured a full audit of medicines taken into the home, given to people and disposed of from the home. The system reduced risk of medicines error, for example by creating an alert where a person had not taken their medicine and ensuring the reasons for this were recorded. Where guidelines stated certain medicines required the signatures of two registered nurses, the computerised system ensured this took place.

Staff ensured the safety of people in some areas. Where people needed to be supported to move, this was done in a safe way and staff followed current guidelines on supporting people to move. Staff noticed small but important details to ensure people's safety. For example, when they helped people who were wheelchair users to move from their wheelchair to an easy chair, they checked their feet were not put at risk of injury from wheelchair foot pedals. Where the domestic worker was mopping a floor, they always put up warning signs to advise people that the floor was wet. They also verbally reminded people of the risk, when they saw them walking on a wet floor.

People told us they felt safeguarded from risk of abuse. One person told us, "I feel safe and I get on with other residents," another person told us, "I feel safe here, and the door is always locked at night." On one of the days of inspection, a person started showing verbal aggression towards another. This was noted at once and appropriate action was taken by staff to ensure all people in the area were safeguarded. Staff had been trained in their responsibilities for safeguarding vulnerable people. They knew how to identify risk to people and what actions to take to protect people from risk of abuse. One member of staff told us they would "never leave anyone who was being verbally aggressive," this was because they needed to make sure everyone in the vicinity was protected. Another member of staff told us they were "confident," if they reported any concerns, the senior staff on duty would "take the right action." Another member of staff told us they always wrote any concerns down and if they felt appropriate action had not been taken "it's quite easy to report to social services – the number's in the office."

The home had established systems for the safe recruitment of staff. We looked at three files for recently recruited staff. These showed relevant checks on their suitability for employment had been carried out before they were employed. This included an employment history, proof of identity, at least two satisfactory references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a

criminal record or were barred from working with children or vulnerable adults. This helped the provider to ensure that only suitable people worked at the home.

Requires Improvement

Is the service effective?

Our findings

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 MCA recognises that people may have capacity in some areas but not other areas, so assessments need to be decision specific. Under the MCA, people can only be deprived of their liberty so that they can 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). Staff confirmed none of the people living at Kingswood House were subject to a DoLS. Two members of staff told us they were currently reviewing one of the people and were considering drawing up relevant documentation in relation to a DoLS application for them.

People were not consistently supported in consenting to all aspects of their care. One person was heard to repeatedly call out for a cigarette during the inspection. We asked staff about this, they told us the person did this often. The person's repeatedly calling out for cigarettes was documented in reviews of their smoking care plan. Their smoking care plan set out that staff retained control of the person's cigarettes. It detailed a timetable of when the person was to be given cigarettes. The person's care plan had been drawn up in 2015 and had not been signed by them. The person had a mental capacity assessment in relation to another aspect of their care, this indicated they did not have capacity to make decisions about that part of their care. There was no mental capacity assessment in relation to the person's smoking behaviours and no best interests decisions about this. The person was therefore being deprived of their liberties without their consent or appropriate authorisation to do so.

One of the people who used a wheelchair lap belt also spent some time in a recliner chair in the sitting room. As the use of a lap belt or a recliner chair restricts a person from being able to move themselves independently when they wish, both can be considered a form of restraint. The person did not have a mental capacity assessment nor a best interests decision for this area of care to indicate how these potential forms of restraint were in their best interests or if they had capacity to consent to their use.

This is a breach of Regulation 11 of the Health and Social Care Act (HSCA) (Regulated Activities) Regulations 2014.

Due to our concerns about supporting people in consenting to care, we held a management review meeting after the inspection. Following this meeting, we wrote to the provider to outline our serious concerns in relation supporting people in consenting to care and to require they sent us an action plan to set out how they would make improvements in this key area. The provider sent us an action plan which set out how they had and would take prompt action to ensure they followed the requirement of the MCA.

One person gave us negative comments about the quality of the home environment. We saw the premises needed attention in a wide range of areas. For example, many of the walls, skirting boards and room doors were stained and scratched. Plaster had deteriorated on corridor ceilings and upper walls in two areas on the first and second floors. An area of flooring was damaged on the second floor corridor, it had some signs

of hazard tape being put on it but much of it had been removed, probably by usual wear and tear. These areas, as well as being unsightly, could lead to risk of infection as they were not clean and were a tripping hazard in some areas. Most of the strip lights did not have covers or diffusers on them which as well as not providing a homely environment would affect the lighting to the rooms. A toilet in the first floor did not have a button on the flush and there was a chip out of the bath in the same room. As these surfaces were not intact, it would be difficult to ensure cleanliness of these items. Several of the plastic coverings on the dining chairs showed deterioration, including holes and tears. This meant they could not be effectively wiped down to prevent cross contamination. These matters were not documented in the maintenance book or plan. The drain in the shower room on the ground floor did not have a grating on it. This had been identified as needing urgent attention over a month before the inspection but no further action had taken place. In a wet area, this could create a major tripping hazard.

This is a breach of Regulation 15 of the Health and Social Care Act (HSCA) (Regulated Activities) Regulations 2014.

Kingswood Nursing Home provided care to some people who were subject to certain sections of the Mental Health Act and to people who were under a community treatment order (CTO).The MHA sets out when a person can be admitted, detained and treated in hospital or the community to ensure their mental health needs are met. A CTO is where a legal order is made by the Mental Health Review Tribunal or a magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community. We discussed some of these people with staff and reviewed their records. Staff had a clear understanding of MHA and CTOs. People's records were clear, outlining restrictions placed on them. There was evidence of review of these people's needs by relevant professionals.

Staff told us there were effective systems to train them in their roles. One newly employed member of staff told us their induction had included reviewing all of the people's care files so they were up to date. Another told us they were pleased they had been given training in supporting people who were living with epilepsy during their induction because some of the people lived with that condition. We looked at records of induction for new staff. These had been signed and dated, usually either on the same day or within a few days of the member of staff starting to work in the home. This and the standard induction form we were given during the inspection did not conform to recommendations from the Social Care Institute for Excellence (SCIE) guidelines for social care. These outline that induction for new staff should take place over a 12 week period and outline eight standards which should be included in the induction of new staff such as effective communication and person-centred support. SCIE guidelines were set up to enable social care workers to demonstrate how they provide high-quality care and support. They can also be used towards future social care qualifications. While their use is not mandatory, they support new staff in ensuring good outcomes for the people they care for.

We recommend that the induction for new staff be amended to conform to current guidelines, to ensure new staff are sufficiently supported in their roles to effectively meet people's needs.

Staff told us about their ongoing training. One member of staff told us they had found their training in moving and handling and infection control helped them in their role. Another member of staff told us they had been trained in supporting people who were living with behaviours which may challenge and ensuring their safety when supporting people who are experiencing such behaviours. They said they had found this training supported them when caring for the people in the home. Another member of staff told us that as well as formal training, they received "lots of training from registered nurses." They told us about they had been supported in developing their skills in distraction techniques when people showed signs of becoming

upset or angry. Staff told us they received regular supervision. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. One member of staff told us, "I've had more frequent supervision here than other places I've worked at," another member of staff told us, "I'm quite happy to bring anything up" during supervision.

The registered manager had a training and supervision plan. This enabled her to see who was due to attend which training. She told us her plan enabled her to identify staff who were reluctant to undergo training and meant she could ensure such staff were identified so she would take relevant action in accordance with the provider's policies and procedures. She told us as part of the training plan, she also planned to provide training to meet people's needs, for example she was currently arranging further training in management of epilepsy for staff. She said although supervision was carried out by her senior staff, she read records to ensure she could identify themes and trends. She also retained a file of any agency staff employed. This showed they received an appropriate induction when starting to work in the home.

People gave us favourable comments about the food. One person told us, "Food's much better than the last place I was in" and another, "The food is lovely. We get given a choice and you can ask for what you want." One person told us they were a vegetarian and that this was, "Not an issue here." We observed a lunchtime meal. People had a light lunch, they had their main meal in the evening. People had a choice of soup and different sandwiches. One person looked at their sandwich and asked for salad cream, the member of staff promptly went and got some for them. People were offered fresh fruit if they wanted. There was an area in one of the sitting rooms where people could help themselves to cold or warm drinks as they wanted to. We saw people doing this throughout the inspection.

One person had been assessed as having a swallowing difficulty shortly after their admission. A prompt referral had been made to the speech and language therapist (SALT). Another person had an on-going swallowing difficulty. They had been seen by the SALT. Staff told us about factors relating to their individual risk of choking, and how they prevented this. The person had a clear care plan about how they were to be supported to ensure they did not choke. Staff followed this care plan throughout the inspection to ensure the person's safety.

People said their healthcare needs were met. One person told us, "I need some more dentures and the staff are going to help me get some more." External professionals said staff liaised effectively with them about people's current and changing needs. One of them told us staff were "always accommodating" towards them. Another said they were "confident," staff followed their instructions. Another external professional said they had "No problems with placement with a client here." Some people were living with past or present substance abuse. One of the external professionals told us the staff supported people with alcohol withdrawal in an effective way. One person had a clear plan about their reduction in alcohol intake. They had signed this plan to show their agreement to it. Staff described how they were currently supporting the person with this plan, they showed an empathetic approach, understanding this was not always easy for the person. People had clear records to show they worked closely with the consultant psychiatrist, especially when a person's condition changed. One person's file showed staff were in regular contact with their consultant psychiatrist to monitor the effectiveness of a recent treatment change.

Requires Improvement

Is the service caring?

Our findings

Some people said they could not choose certain aspects of their care. This included several comments about not being able to choose when they could go out of the home. The front door to the house was locked, using a number-code system. People were not given access to this number. We asked staff how people got out of the home when they wanted to. They all said if someone asked to go out, they would check first with the registered nurses, before letting the person out. Registered nurses were available on every shift, however sometimes they were busy with their other duties, such as supporting people with their medicines or holding meetings with external professionals; at such times people had to wait. We asked why people were not just given the number, so they could independently make a decision about going out. We were told some people might be subject to a DoLS, staff needed to know who was in the building, and some people might forget the number or give it to third parties. No-one was subject to a DoLS at the time of the inspection. The service had not considered the wide range of ways, based on people's individual needs, of implementing a system to support them in exercising choice about when they went in and out of the home, based on their individual needs. This is an area which needs improvement to ensure people can exercise choice.

People could choose in a range of other areas. A member of staff brought a person who used a wheelchair into the sitting room. They asked them if they wanted to remain in their chair or move to an easy chair. They listened to what the person replied and did what the person said they wanted. At lunchtime, staff took time to listen to what people said about their preferred choice of snack and consistently gave people what they wanted, this included when they changed their decision about what they wanted. A person asked a member of staff for their soup in a cup, not a bowl. The member of staff smiled and promptly went to get them a cup. One person said they would like to have their lunch outside on the patio, staff supported the person so they were able to do as they wanted. People could spend their days where they wanted to, on the patio, dining room or either of the sitting rooms. One wheelchair user was free to spend much of the day wheeling themselves about the ground floor of the home because that was what they wanted to do. One person decided they did not want to get up until later morning, staff did not pressurise them to get up before they wanted to.

People gave us positive comments about their care. One person said warmly, "I like it here," another smiled and winked, saying, "It's all right here" and another, "This place really looks after you." One person told us about the staff, saying "I trust staff here, they help with any issue." An external professional commented on the caring nature of the home, telling us "It's calm and peaceful each time I come." Staff showed a caring, positive attitude about people. One member of staff said they liked working at the home because, "The people here are all different."

Staff treated people with politeness and respect. A member of staff supported a wheelchair user, they took time to explain how they were going to support them throughout the time they were with them. They were patient, kindly and respectful to the person. Staff were consistently polite to people. At lunchtime or on the patio, they always asked people if they could move their chairs, so they could get by. They always addressed people by their preferred name and said "Please." One member of staff slightly knocked into a person in the

dining room, stopped and politely said, "Sorry" to the person, even though the person may not have noticed what had happened. A person became agitated and showed signs of aggression. One member of staff sat down with them to try to find out what the person's concerns were, they listened to what they said in a kindly, patient way, then tried to divert them to discussing matters which did not upset them.

People's privacy was respected. One person told us this was one of the things they liked about the home, saying "Staff are helpful. It is private and confidential – staff don't talk about us." People had their own key to their room and several people locked their rooms when they were not in them. Where meetings were held with people by external professionals, they were supported in going either to their room or a quiet area so they could have privacy. Staff always shut the office door when they were discussing people's individual needs to ensure such conversations were confidential.

Requires Improvement

Is the service responsive?

Our findings

We asked people how they spent their days. One person told us they would like to go out more, another said that nothing much happened. While some of the people had involvement with family and friends, others did not and were reliant on staff to support them with engagement. The registered manager told us that currently no people were working or attending adult education or engaged with clubs or similar activities outside the home. The home employed an activities worker. They were not in the home on the first day of the inspection. On that day staff played some music for those people who sat in one of the sitting rooms and held brief conversations with people. Other people sat outside in the smoking area or in the other sitting room, they were not actively engaged with anything, apart from the people who smoked. On the second day, the activities worker was on duty and ran a group for some people. Other people sat in other rooms in the home or outside on the patio, not being actively engaged with anything.

Staff we spoke with did not outline how they supported people in a person-centred way. For example, we were told some people responded well to certain music when they showed agitation or distress associated with their mental health needs. There was no assessment of the benefits to such people of the music they preferred and no plan about how this might be used to support them when they showed symptoms. On the first day of the inspection, one person showed frequent episodes of agitation, some of which could be slightly aggressive. On the second day, when the activities worker was on duty, they did not show such behaviours and appeared to be engaged with what was happening. They had no care plan about how involvement in activities supported them with reducing their agitated behaviours and how this could be progressed when the activities coordinator was not on duty.

The activities worker described areas they had involved people with, this included arts and crafts and hand chair exercises. They said music was particularly popular with some of the people. They also said they took people out on shopping trips, and walks. In the evenings they had organised Chinese and Mexican meal nights. We asked about their training in their role. They said they had not received any formal training in their role but had learnt on the job. They said some people tended to become disengaged after attending one or two activities and it was difficult to motivate others.

The home's philosophy of care, which was given to each person stated 'At Kingswood House we will work with every service user to help and support them in working towards, and achieving their hopes and dreams.' This philosophy reflected the wide range of guidelines about the benefit of activities for people who are living with mental health needs. These outline that the focus should be on considering the person within their environment and the activities and occupations which are important to them. As well as supporting them in their lives, the emphasis of these guidelines is on working in a collaborative way with the person to develop a programme which suits their individual needs, hopes and aspirations. The provider was not following its philosophy or guidelines on supporting people who were living with mental health needs. We looked at records about activities, including information sent to us by the registered manager following the inspection. The information was not person-centred and did not show the home was following such guidelines. The information sent to us documented activities provided to people by the activities worker, the numbers of people attending and relevant risk assessments. None of the people had an individual care plan

about what they wanted to be involved with and how it could support their independent living skills, mental health needs and engagement with others. None of the people had a timetable of activities which they wanted to be involved with.

The lack of person-centred planning in relation to meeting people's individual needs and preferences is a breach of Regulation 9 of the Health and Social Care Act (HSCA) (Regulated Activities) Regulations 2014.

People's other needs were responded to. We met with a person who told us they had been recently admitted to the home. Their assessment for why they needed to come into the home reflected what they told us. Two external professionals told us people's conditions had improved since they had been admitted to the home. Two of the registered nurses were very knowledgeable about people's physical and mental health needs. Care workers were also aware of people's medical and mental health needs. Care workers told us they read people's care plans so they knew how to meet people's needs. One care worker told us if they had been away, for example on annual leave, they always looked through people's care plans to update them on what had been happening while they had been away.

People's care plans described their mental health needs and were regularly up-dated. For example one person's records showed they could experience hallucinations. It clearly documented how they showed they were experiencing such symptoms and what staff were to do to support them. Their records showed regular monitoring of their condition and relevant changes were referred back to external clinicians. When changes were made by external clinicians in their treatment regimes, records showed these were closely monitored to assess the benefits or otherwise for the person. Results were reported to the person's lead clinicians and adjustments made to care plans where necessary.

Some people had medical needs, for example people who were living with diabetes, including people who were insulin dependent. These people had clear care plans, which followed current good practice guidelines, on the management of diabetes. Records showed people's care plans were being followed. Both registered nurses and care workers knew how different people showed symptoms of low or high blood sugar levels and the actions they were to take, in accordance with the person's individual care plan, when this happened.

Registered nurses told us a new computerised care planning system was to be introduced shortly. Currently people's records were kept in the form of paper care plans, daily diaries and shift handover records. This meant that on occasion some matters were documented in handover records, not people's own diaries. For example, the shift handover record for one person showed they had an altercation with another person, which included shouting. This had been documented on the shift handover sheet but not their daily record, so over time such occurrences would not be easily accessible to assess the person' s progress within their treatment regime. The registered manager told us that once the new system was in place, all such information would be included in people's records and be fully available to support review.

We asked people about how they raised complaints or issues of concern. People said they felt they could raise matters if they needed to. One person told us, "If I had any worries, I could talk to any of the staff," another person told us they would speak to a relative who would take it forward for them. We looked at complaints records. Complaints were investigated and responded to in accordance with the provider's policy. Where actions needed to be taken following issues raised, they were identified. For example following one complaint, staff responsibilities for certain matters were reviewed and confirmed.

Inadequate

Is the service well-led?

Our findings

At the last inspection, this domain had been judged as requiring improvement. This was because the provider's quality assurance system did not identify service shortfalls in relation to fire safety. The provider was assessed as not meeting the requirements of Regulation 12 of the Health and Social Care Act (HSCA) (Regulated Activities) Regulations 2014. After the inspection, on 18 July 2017 the provider sent us an action plan in which they stated the 'requirements have been met and will continue to be met.' The service was not well-led because the provider's quality monitoring system had not identified that this was not the case. This could have put people at risk to their safety.

This home had also not met the HSCA Regulations 2014 in the past. At the inspection of 24 and 25 August 2015, the home was rated as inadequate and were identified as being in breach of six Regulations of the HSCA Regulations 2014. The service was not well-led because the provider had not identified that they had returned to not meeting the requirements of four of these Regulations. This was in relation to person-centred care, safe care and treatment, the home environment and good governance. This could also have put people at risk across a wide range of areas, as the provider had not acted to identify and address such matters.

The registered manager told us they felt they provided people with a safe, good environment to live in. However she and the provider had not identified a range of areas which needed to be addressed. The provider's quality assurance systems had not identified they were not ensuring safe care and treatment for people. Fire risk assessments and other information identified one person had a tendency to remove fire extinguishers from their placements and also use an extinguisher to prop open the fire door on an upper floor of the home. This had first been documented nine months before the inspection. The action in the fire risk assessment was that staff were to check regularly on this throughout the day and night. This had not been effective because we found the person continued to do this, including on both inspection days. The provider had not identified that the actions it outlined were not working in practice and had not taken action to ensure the safety of people and staff working in the home. The records of a recent fire evacuation drill showed three people had refused to be involved in the drill. There were no actions documented arising from this to ensure the safety of the people and of the staff who would need to go and find the people in the event of an emergency. Although the fire risk assessment identified smokers' materials as a fire risk, we were told some of the people continued to smoke in their rooms. The provider had not identified this as an ongoing risk in their risk assessment or identified actions in their fire risk assessment to reduce the risk. After the inspection we held a management review meeting about the service and sent the provider a letter outlining our concerns in relation to fire safety. The provider sent us an action plan following the inspection which set out how they would address fire safety. However as the provider had not identified risk in relation to such areas as part of their ongoing quality review processes or taken action to address them before they were identified by us, the risk is assessed as high.

The provider's systems had not identified that they had returned to not ensuring the safety of people in other areas. This included the safety of people such as people who used wheelchair lap belts and the risk of infection to people. The provider had also not identified that they had returned to not ensuring people had

person-centred plans about key areas of their daily lives and were also not ensuring a suitable home environment for people to live in. They had also not identified they were not working within the requirements of the MCA.

The provider completed a range of quality assurance reviews. These were not consistently accurate and actions were not always recorded. We looked at seven people's records about the application of prescribed skin creams. Two clearly showed when they were to be applied and to which part of the person's body, four documented when they were to be applied but not to which part of the person's body and one did not state how often the prescribed cream was to be applied. The monthly medicines audits were ticked as being met and had not identified these discrepancies. Audit documentation recorded that care plans were regularly reviewed, additionally there was also a system called 'resident of the day' when individual people's needs were reported to be reviewed in detail. These systems were not effective in identifying issues. One of the people had been resident of the day in July 2017, but it had not been identified that although they were assessed as being at high risk of pressure damage, they had no care plan about how the risk was to be reduced. It had also not identified that the person continued to repeatedly ask for cigarettes so had not agreed to restrictive practices in the storage and access to these that were outlined within their care plan. No consideration had been given to a review of their current care plan in light of this. Audits had not identified that some records were unclear and did not support a review of people's conditions. Some people had their food intake documented, records stated what the person had eaten, for example 'porridge' or 'sandwich,' but not the quantity they had eaten, so accurate assessments of their food intake could be made.

Other audits had not identified matters, or they had not been documented. There were also no action plans about how such matters were to be addressed. The building showed signs of wear and tear, this included among other areas, scrapes to the walls, stained and damaged doors, damage and bubbling to plaster-work in the corridors on the second and first floors and damage to the floor in one part of the sluice room. Several of the dining chairs showed tears and damage to their plastic coverings. These matters were not documented and there was no written action plan about improvements to such matters. There was damage to the flooring on the second floor. The registered manager told us this was known about and there was a plan for its improvement. This was not documented on the maintenance plan to provide a timescale for when it would be actioned.

Some areas of maintenance were not documented, or where they were, actions to address the matters were not included. A person had been admitted who was assessed as being at high nutritional risk. They had not been weighed, we were told this was because the home's scales were broken. We asked how long they had been broken for and were told between a month and a fortnight. There was no documentation about this and no action plan about when the situation would be rectified to ensure the person's assessment and care plan could be accurately reviewed. In the downstairs shower-room, there was no cover to the drain, this could present a tripping hazard, as well as being unsightly. This was documented in the maintenance book on 12 July 2017 and noted as being urgent. It had not been addressed by the time of the inspection. The matter had also not been included in the provider's weekly reports.

The registered manager had a system for reviewing accidents and incidents to people. These documented the dates accidents and incidents occurred and which people had been involved. The audit did not review times of day, to assess if they were more frequent at certain times of day. They also did not review where they occurred in the home so relevant areas of risk could be identified and reduced as much as possible.

This is a breach of Regulation 17 of the Health and Social Care Act (HSCA) (Regulated Activities) Regulations 2014

The provider had taken action in other areas. This included swapping round the dining room and a sitting room to make more space for people, putting in a breakfast bar to encourage people in serving their own breakfasts and widening certain door frames to support access for people who used specialist wheelchairs. One area of the home had been designated the therapy area and was wallpapered in a way to support people in developing their arts and creative skills. A sprinkler system was planned to be installed shortly to support fire safety. A computerised system for people's care plans and other documentation was to be put in to enhance care assessment, planning and review.

Questionnaires had been sent out to both people and staff. The majority of responses from both people and staff were positive. A few less favourable comments had been made. We asked the registered manager how they followed these up. They said very few such comments had been made so at present they were not followed up and would be reviewed in the future.

The registered manager was supported by a deputy manager who was a registered mental health nurse. Both registered mental health and general nurses were employed. Registered nurses were supported by care workers. The home also employed an activities worker, domestic workers and catering workers. All staff working in the home had job descriptions which outlined their roles and responsibilities. The registered manager reported they were visited regularly by a manager from the provider.

People made positive comments about the home. One person said comfortably, "I feel settled here," another said, "You can just talk - that's why I like this place." Staff were positive about working in the home. One member of staff said they liked working in the home because, "things get done." They said they could bring issues up at staff meetings. One member of staff said if they did this "something happens" and another that managers were "usually quite prompt" about responding to matters raised. We looked at minutes of staff meetings and saw people could raise issues. The most recent one had involved discussions about epilepsy training and records. Staff said the philosophy of the home related to meeting people's mental health needs, to ensure they were safe and able to live with their own range of needs, particularly where they experienced symptoms relating to their mental health.

External professionals gave us positive comments about joint working with the staff. The home had not had a recent review from the local authority quality management department. As no people attended adult learning activities, external clubs or were involved in work, links with such agencies were limited. The registered manager said they would ensure involvement with such external agencies should they become involved in the future.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider must ensure that people's care and treatment is provided with their consent. Where people are unable to give consent because they lack capacity to do so, the provider must act in accordance with the MCA 2005. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment All premises and equipment used by the service must be clean, suitable for their purpose and properly maintained. Regulation 15 (1)(a)(c)(d)(e)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider was not ensuring that people's care and treatment was appropriate, met all of their needs and reflected all of their preferences. They did not ensure all people had an assessment of all of their needs and their care and treatment was designed with a view to achieving their preferences and ensuring all their needs were met. Regulation 9(1)(a)(b)(c)(2)(3)(a)(b)

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider must ensure that safe care and treatment is provided to people. They must ensure risks to their health and safety are assessed and do all that is reasonably practicable to mitigate any such risks. They must also ensure risk of infection to people is reduced. Regulation 12 (1)(2)(a)(b)(h)

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider must establish systems or processes which operate effectively to ensure they assess, monitor and improve the quality and safety of the services provided, including mitigating the risks relating to the health, safety and welfare of service

users and others who may be at risk. They must also maintain records relating to the management of the service.
Regulation 17(1)(2)(a)(b)(c)(d)(i)

The enforcement action we took:

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