SHC Clemsfold Group Limited

Kingsmead Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 4 and 7 August 2017 and was unannounced.

The inspection was bought forward as we had been made aware that following the identification of risks relating to people's care, the service had been subject to a period of increased monitoring and support by commissioners. The service has been the subject of nine safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation. Our inspection did not examine specific safeguarding allegations which have formed part of these investigations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May and August 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

Kingsmead Lodge provides nursing and personal care for up to 20 people who may have learning disabilities, physical disabilities and sensory impairments. Most people had complex mobility and communication needs. At the time of our inspection there were 17 people living at Kingsmead Lodge.

People living at the service had their own bedroom and en-suite toilet. The service was split into two wings, 'West' wing and 'East' wing. In each wing was a communal lounge and dining area where people could socialise and eat their meals if they wish. Twenty-four hour nurse support was available and there was a large activity room, sensory garden and sensory room. The environment was spacious throughout and adapted to meet the needs of people who used wheelchairs. The service was decorated with pictures and photographs of people living at the service. Kingsmead Lodge also offers a spa and hydrotherapy facilities which were in use at the time of our inspection.

The service had a registered manager who had been in post since October 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in January 2017 the service was found to be complying with legal requirements and was given a rating of 'Good'. However, we asked the provider to make improvements to the provision of meaningful activities and access to the community for people. At this inspection, we found improvements had not been made and the quality of safety and care had deteriorated and we identified three breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were maintained with regular use of agency staff. However, staff confirmed this was having a negative effect on people's well-being and quality of life. Staff felt there was added pressure to their role to oversee agency staff and ensure procedures were being followed. Overall staff felt people's basic care needs

were being met but they were struggling to meet people's social, emotional and psychological needs.

Steps had been taken to ensure that activities were now available for people to access. An agency staff member was deployed each day to undertake group activities. However, for people who did not participate, the risk of social isolation had not been addressed or mitigated. People were not consistently receiving personalised care and those who were funded for one to one care were not receiving that care. Staff and relatives felt that the provision of meaningful activities for people had deteriorated.

Robust systems were not in place to ensure that agency staff had the necessary skills, training and competence to provide safe, effective and responsive care. Gaps in staff training also meant that not all staffed were competent and qualified to administer emergency medicines in the event of a person having a seizure. This impacted on the number of staff who were able to support people to access the community and go on trips away from the service.

The management of medicines was not safe as people did not always receive their medicines on time. Protocols involving the use of covert medicines had not routinely been reviewed to ensure the use of covert medicines was still required and the safest way to administer medicines.

Care plans and individual risk assessments were in place. However, documentation was not always fit for purpose or accurate. Discrepancies and gaps in recording had not consistently been identified by the provider as a shortfall and consequently the provider was unable to demonstrate if people received the care required or whether it was a failure to document the care provided.

Systems to assess and monitor the service were in place but these were not sufficiently robust as they had not ensured a delivery of consistent high care across the service or pro-actively identified all the issues we found during the inspection. Incident and accident documentation was in place and following advice from a recent monitoring visit from West Sussex County Council, the provider was reviewing all incidents and accidents to ascertain if any met the threshold for a safeguarding concern to be raised.

Mental capacity assessments were not consistently in place. The provider was in the process of reviewing all capacity assessments but in the interim, they were unable to demonstrate that the application of restrictive practice was in people's best interest and lawful. We have identified this as an area of practice that needs improvement.

Care plans provided an overview of people's life history, likes and dislikes. However, they were not consistently personalised and lacked reference to people's personal preference on when they wished to get up and go to bed. We have identified this as an area of practice that needs improvement.

Environmental risks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing. Staff employed by the home underwent a thorough safe recruitment process. People were supported at mealtimes to access food and drink of their choice.

Staff knew the people they were caring for very well. It was clear that permanent members of staff had built positive rapports with people. People's privacy and dignity was respected and staff communicated with people in a kind and caring manner. People, relatives and staff spoke highly of the registered manager, describing her as having a "heart of gold."

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response to these breaches of legal requirements and will publish our action

when this is complete.

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

Kingsmead Lodge was not consistently safe.

Medicines management was not always safe. Staffing levels were sustained with regular input from agency staff. However, high use of agency staff added pressure to permanent staff members.

Appropriate recruitment checks were undertaken before staff began work. Checks on the environment and equipment were completed to ensure it was safe.

Safeguarding procedures were in place.

Is the service effective?

Requires Improvement

Kingsmead Lodge was not consistently effective.

Mental capacity assessments were not consistently in place.

Staff did not always receive training in key subjects to enable them to carry out their role effectively.

People were supported to have sufficient to eat and drink and received 24 hour nursing care with access to external health professionals when needed.

Is the service caring?

Good

Kingsmead Lodge.

The home was relaxed and friendly with a homely feel to the environment.

Staff were kind and caring. They were aware of, and took into account, people's preferences and different needs.

Staff treated people with respect and they ensured that people's dignity was maintained at all times. Attention was given to ensuring that people's bedrooms as far as possible reflected their choices and tastes.

Is the service responsive?

Requires Improvement

Kingsmead Lodge was not consistently responsive.

The provision of meaningful activities required strengthening. The risk of social isolation required addressing and people were not consistently receiving their funded one to one care.

Care plans were in place and included information on people's care and health needs.

Complaints were managed appropriately.

Is the service well-led?

Requires Improvement

Kingsmead Lodge was not consistently well-led.

There was a lack of effective auditing systems in place to identify and measure the quality of the service delivered to people. Accurate records had not always been maintained.

People and staff spoke highly of the registered manager. Systems were in place to involve people in the running of the service.

Kingsmead Lodge

Detailed findings

Background to this inspection

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

The inspection of Kingsmead Lodge was undertaken on 4 and 7 August 2017 and was unannounced. The second day of the inspection was out of hours and we arrived at the service at 05.50am. This was because we wanted to speak with night staff and we received information of concern about the deployment of staff during peak times, such as early in the morning.

The inspection was prompted, in part, by a number of safeguarding concerns and quality concerns raised by partner agencies. Since January 2017 there have been nine separate safeguarding concerns raised. These safeguarding concerns are the subject of a police investigation and as a result this inspection did not examine the circumstances of these specific concerns.

However, the information of concern shared with the CQC about specific safeguarding concerns indicated potential concerns about the management of risk related to complex health conditions (such as Epilepsy, diabetes and dysphagia (difficulty swallowing)), deployment of suitably qualified and skilled staff, safe medicines management and care of percutaneous endoscopic gastrostomy (PEG) feeding tubes for people who were not able to take food and drink by mouth. Therefore we examined those risks in detail as part of this inspection.

The inspection on the 4 August 2017 was undertaken by two inspectors and a specialist nurse. On the 7 August 2017, the inspection team consisted of an inspector and inspection manager. Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the provider about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete 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 improvements they plan to make.

During the visit we spoke with three people who lived at the home. Due to the nature of people's complex needs, we were not always able to ask direct questions. However, we did chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, four registered nurses, one senior care staff member, four care assistants, the chef and a dietician who was directly employed by the provider. We also spoke with two area managers, the head of quality and an agency staff member responsible for activities. The nominated individual who represents the provider introduced themselves to the inspection team during the second day of our inspection.

We also spoke with seven relatives by telephone to gain their views of the care provided to their family members. We spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed medicines being administered to people.

We reviewed a range of records about people's care which included seven people's care plans. We also looked at four staff records which included information about their training, support and recruitment record. We read audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports and other documents relating the management of the service.

Requires Improvement

Is the service safe?

Our findings

Due to communication needs, not everyone was verbally able to tell us if they felt safe living at Kinsgmead Lodge. Observations demonstrated that people responded to permanent members of staff with smiles. However, some people told us they didn't always feel safe. One person told us they did not feel safe living at Kingsmead Lodge. They told us, "I don't feel safe here. There are too many agency staff which make me feel unsafe." Relatives had mixed opinions. One relative told us, "Oh yes. Totally feel confident leaving (person) at Kingsmead Lodge." Another relative told us, "It's scary, I don't feel they are safe." A third relative told us, "I'm beginning to have my doubts over their safety."

Our inspection was brought forward due to concerns raised by commissioners, the safeguarding authority, and external professionals about the safety of people's care and treatment. Specifically concerns had been raised about medication administration, management of people's health needs and ensuring safe administration of nutrition and hydration via PEG. Many of the concerns and allegations raised about Kingsmead Lodge were still being reviewed and investigated in order to safeguard individuals. However we used this information to review whether people were experiencing safe care and treatment.

The management of medicines was not consistently safe. Guidance produced by the National Institute for Health and Care Excellence (NICE) advises of the importance of the six 'rights' of administering medicines, which includes ensuring medicines are administered at the right time. On the first day of the inspection, we observed that medicines were administered later than prescribed. For example, the registered nurses were administering medicines at 10.00am, which should have been administered at 08.00am. We observed the registered nurse administering one person's pain relief at 10.30am. However, they inaccurately recorded on the medicine administration record (MAR chart) that the pain relief was administered at 08.00am. We checked the person's MAR chart at 12.30pm and found they had been administered another dose of pain relief. Guidance on the MAR chart reflected that the person should have a four hour gap between each administration of pain relief. This meant the person was administered two dosages of pain relief in a two hour period. Another person was observed being supported to have their medicines at 11.40am instead of 08.00am according to the MAR chart. The MAR chart was also signed inaccurately to indicate that the person was administered their medicines at 08.00am. We found this was a consistent theme across the MAR charts we reviewed. Nursing staff failed to record the actual times medicines were administered. Therefore, there was risk that medicines were not being administered in line with their prescribing instructions and time.

A number of people received their medicines covertly. Guidance by NICE describes covert medicines as giving people their medicines without them knowing. The guidance explains that 'The covert administration of medicines should only be used in exceptional circumstances when such a means of administration is judged necessary, in accordance with the Mental Capacity Act 2005. However, once a decision has been made to covertly administer a particular medicine (following an assessment of the capacity of the resident to make a decision regarding their medicines and a best interests meeting), it is also important to consider and plan how the medicine can be covertly administered, whether it is safe to do so and to ensure that need for continued covert administration is regularly reviewed (as capacity can fluctuate over time).' We found that covert medicines protocols were in place; however, these had not been consistently reviewed to ensure

that the continued use of covert medicines was required. For example, one person's covert medicines protocol was dated 25 April 2016 and had not yet been reviewed. On the first day of the inspection, one person was supported to have their medicines covertly in a nutritional supplement. The person had a few sips then refused the rest. The supplement with the medicine in was then left on the side and reused at lunch time. However, the manufacturer guidelines for the nutritional supplement advised that once made up, the drink should be refrigerated. We found that the supplement was not refrigerated and just left on the side until lunchtime. This could have an impact on the effectiveness of the medicine that was prepared in the drink. Best practice guidelines had not been followed to ensure administration of medicines was safe and protected people's rights.

The Commission are concerned about issues we have highlighted in relation to medicines as, between March and July 2017, the provider were made aware of at least two medicines-related concerns at Kingsmead Lodge that had been raised by the local authority as either quality and/or safeguarding matters.

The above evidence demonstrates that the management of medicines was not safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed examples where a registered nurse gave people their medicines safely. The registered nurse checked the instructions on people's MAR charts corresponded with the medicine directions on labels before administering to people and signed the MAR only after people had taken their medicines. The medicines trolley was locked at all times when unattended.

Staffing levels consisted of two registered nurses and seven care staff until 15.30pm. From 15.30pm, staffing levels consisted of six care staff and two registered nurses. Additional staff members included the chef, kitchen assistant, administrator, housekeeping and an agency staff member each day responsible for activities. A range of systems were in place to determine staffing levels required. The registered manager told us, "We operate on a ratio of three to one and when a person moves into the service we complete the 'Northwick Park Dependency Tool.' This helps us determine if our current staffing levels are sufficient to meet their needs. The dependency tool is then reviewed yearly. Primarily, staffing levels are based on people's level of mobility and funded care." Staff felt the impact of having regular agency staff was having a negative impact on people's quality of life and advised that people's social emotional and psychological needs were not always met. One staff member told us, "Recently it has been very difficult working here. There has been high use of agency staff and often agency staff haven't had any experience of learning disabilities. I've asked what training they've had and they've replied none. People don't respond well to different faces and it's not fair on them. I wouldn't say people are at risk as the permanent members of staff work really hard to ensure that doesn't happen. However, what has slipped is activities. We don't have time for activities." Another staff member told us, "We are very short staffed of permanent staff which means we are using too many agency staff which isn't good. Some people can react in different ways to agency staff. One person won't let any agency staff support them and one person who requires one to one, if they have agency staff they can shout and scream. It is very rare that they [person requiring one to one support] have agency staff, as we try and allocate a permanent member of staff."

Staff rotas confirmed that on nearly every shift there were agency staff members. The provider was taking steps to actively recruit staff; however, in the interim, agency staff were used to maintain staffing levels. Staff and people identified that the main impact of this was that people were not always familiar with agency staff, they often lacked experience of learning disability care and some people were not comfortable with being supported by agency staff which added pressure to permanent staff members. One staff member told us, "When you have agency staff, it's a greater pressure as you have to explain everything, check what they are doing alongside your own job." Another staff member told us, "It adds a lot of pressure. Sometime we

are late administering medicines as we are supporting the other agency nurse and we are juggling a lot." Relatives also confirmed that they had noticed a turnover in staff and high use of agency staff. One relative told us, "One of the main things is lack of staff. They are always using agency staff and I don't trust the agency staff due to a number of hiccups. Whenever agency nursing staff are on duty, I'll take (person) home with me." Another relative told us, "Like with all care homes, they are short of staff." The provider received a profile of the agency worker before they worked at Kingsmead Lodge. However, it was not always clear what consideration was given to the deployment of agency staff to ensure that they had the rights skills, training and competency to support people living at Kingsmead Lodge. We have identified this as an area of practice that needs improvement.

Observations throughout the inspection identified that people's basic care needs were met by the deployment of staff. However, we identified concerns with meeting people's social, emotional and psychological needs which we have discussed under the 'Responsive' section of the report.

A number of people living at Kingsmead Lodge were not able to eat, drink and take medicines orally. They had feeding tubes, either (PEG) or a balloon gastrostomy, in place to provide medicines and nutrition directly into their stomach. Permanent nursing staff we spoke with were knowledgeable about the management of supporting people using PEG and we observed them carry out their support safely. However, on one occasion, we observed a registered nurse pause a person's PEG feed pump to support them to taste some food but then forgot to restart the PEG feed pump. Inspectors brought this to the attention of the registered nurse who immediately restarted the pump. Throughout the rest of the inspection, we observed safe practice with the management of PEGs. Care staff told us that although they were not formally trained in the safe management of PEGs, through experience they had identified and learnt what to do in the event of a person's PEG not running. One staff member told us, "If a person's PEG is blocked, the alarm will go off or another sign could be that the clip on their PEG is unclipped. Any concerns, I would report them to the registered nurse." As Kingsmead Lodge regularly used agency staff and we found some discrepancies within documentation, we have discussed this and the associated risks in the 'Well-Led' section of this report.

Other aspects of risk management were being managed appropriately. Guidance produced by the epilepsy society advises that epilepsy can be more common in people living with a learning disability. Clear guidance and risk assessments were in place in relation to the management of people's epilepsy. Where people required emergency medicines to safely manage their epilepsy, sufficient stock was available and epileptic seizure monitoring charts were in place which recorded the time the seizure took place, description of the seizure, duration and treatment. Two people were prescribed two different types of medicines to safely manage their epilepsy concurrently. We were informed that this was because of a medicines storage issue at the day centre. This meant they were receiving different treatments for epilepsy seizures based on where the seizure occurred and not based on their medical needs. We brought this to the attention of the registered manager who confirmed that the GP was aware alongside the learning disability team from the local authority who would be reviewing this situation. However, documentation failed to reflect this. We have discussed this and the associated risks in the 'Well-Led' section of this report.

Regular maintenance and environmental checks had been completed. Fire evacuation and emergency procedures were displayed around the service. Staff and people had access to clear information to follow in the event of an emergency, including Personal Emergency Evacuation Procedures (PEEPS). PEEPS included individual information about people and things which need to be considered in the event of an emergency evacuation. An emergency contingency plan was in place that gave staff information of the action to take in emergency situations that included fire and floods. This meant the provider had plans in place to reduce risks to people who used the service in the event of emergency or untoward events. Where people required

assistance to move using a hoist, their records included details of the specific hoist and size of sling to be used, and we observed the sling to be in their bedroom.

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

Staff had the knowledge and confidence to identify safeguarding concerns and were aware of their responsibilities in reporting any concerns. Records confirmed that staff had received training in safeguarding. Staff were able to tell us what may constitute abuse, signs which may alert them to concerns and reporting procedures. One staff member told us, "I had safeguarding training in my induction. It was very useful and I learnt what to do if I had any concerns. If I noticed anything or witnessed anything, I would report those concerns immediately to the nurse in charge."

Requires Improvement

Is the service effective?

Our findings

People and their relatives had mixed opinions about the competency and skills of staff. One person told us, "Some staff are better than others." Relatives told us they felt confident in the skills and abilities of permanent members of staff but felt agency staff were not equipped to provide effective care to their loved ones. Although staff told us they felt supported and able to approach the registered manager, we found gaps in training and the oversight of nursing staff's clinical training was not clear.

External professionals, safeguarding teams and commissioners had raised concerns about the skills and knowledge of staff at Kingsmead Lodge and the impact this had on the effectiveness of people's care. Professionals from partner agencies had also raised concerns about inconsistent understanding and application of the Mental Capacity Act 2005 and its Code of Practice across other services operated by this provider. We considered these concerns in assessing the skills of staff deployed at Kingsmead Lodge and in reviewing how the MCA was applied to protect people's rights.

Guidance produced by Skills for Care advises on the importance of a 'strong skilled workforce.' A programme of mandatory training was in place which included fire, manual handling, infection control, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and safeguarding. Some staff had attended additional training which covered diabetes and profound and multiple learning disabilities training. Some people living at Kingsmead Lodge were living with epilepsy or were prescribed anti-epilepsy medicines. Staff told us that they had not attended epilepsy awareness training and nursing staff would be responsible for the administration of emergency medication. The training plan provided did not include epilepsy training as part of the core mandatory training alongside the training covered in people's induction. The registered manager confirmed that six care staff had received training on the administration of emergency epilepsy medication. This training had taken place on the 17 May 2016. However, for other staff members, there was a lack of training and support provided on how to support people living with epilepsy and general awareness of the condition.

For people living with epilepsy, they were dependent upon the competencies and skills of staff to receive effective care. One area of concern noted throughout the inspection, was that if people wished to access the community or go out and about, they would require support from staff who were qualified and skilled to administer emergency medicines in the event of them having a seizure outside of the service. People's care plans confirmed that two people were prescribed emergency medicines to administer in the event of a seizure. The staffing rotas we reviewed for the weeks commencing 19 June, 3 July and 17 July 2017 demonstrated that there were several days where there was no or only one staff member trained in administration of emergency epilepsy medicines alongside the registered nurses deployed at the home. This limited the opportunities for those two people living with epilepsy to go and out and about. We have discussed lack of activities and concerns with social isolation further in the 'Responsive' section of the report.

Ineffective systems were in place to check the suitability of agency staff and ensure that they had the right training and qualifications to support people living at Kingsmead Lodge. In the four weeks prior to our

inspection, 15 different agency staff had worked at Kingsmead Lodge. Before an agency staff member worked at Kingsmead Lodge, the registered manager was a sent a profile of the training they had completed, evidence of their DBS and confirmation that nurses had an up to date NMC pin. However, these profiles failed to include evidence that the staff member had received training in the specialist needs of people living at Kingsmead Lodge including epilepsy, learning disabilities or PEG management. We spoke to one agency nurse whose profile failed to state if they had PEG training. They told us that they hadn't received PEG training. We have discussed the lack of governance when accessing agency nurse support further in the 'Well-led' section of the report.

Guidance produced by the Nursing and Midwifery Council advises that ongoing hands on clinical training is vital to ensure registered nurses keep up to date with clinical practice and maintain their nursing registration. The registered manager told us that nurses attended a range of clinical training, for example they had recently attended gastrostomy training. The training matrix for registered nurses reflected that clinical training included catheterisation (however only two out of five nurses had completed this training), diabetes (two out of five had completed), epilepsy, profound and multiple learning disabilities and medication update. Training in midazolam (emergency medicines for epilepsy) had been provided but only two registered nurses had completed this training and were therefore skilled and competent to administer this medicine. However, three other registered nurses had not completed this training. The provider's internal quality visits had identified in July 2017 that training in care plan writing was to be organised but had failed to identify that not all nursing staff had completed clinical training to provide effective care.

The above evidence showed that staff had not always received appropriate support and training to enable them to carry out their duties they are employed to perform. The provider had not consistently ensured that staff deployed were suitably qualified, skilled and competent to meet people's care and treatment needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, staff told us they felt supported and able to approach the registered manager with any concerns. Staff received regular supervisions and a yearly appraisal. One staff member told us, "Supervisions are a good opportunity to express yourself and I do feel supported.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff confirmed they had received training on the Act and told us how they gained consent from people. One staff member told us, "As some people cannot verbally communicate, we monitor their body language and facial expressions. Often their body language will tell us if they are unhappy." Although staff understood the importance of consent, the provider was not consistently working within the principles of the MCA 2005.

We observed that methods of restraint were in use with the intention to keep people safe. This included bed rails, lap belts, leg straps and helmets. Appropriate applications had been made under the Deprivation of Liberty Safeguards. However, decision specific mental capacity assessments were not consistently in place For example, mental capacity assessments were not consistently in place for the use of bed rails. During the

inspection, we reviewed eight care plans and only found two completed mental capacity assessments. We discussed these concerns with an area manager who identified that they were reviewing all mental capacity assessments as they had identified that they were not always decision specific. The provider's monthly audits identified back in May 2017 that mental capacity assessments required reviewing and amending. Although mental capacity assessments were in the process of being reviewed, this meant that on the day of the inspection, the provider was unable to demonstrate that the restraints in place were used lawfully and in the best interest of the person. We have identified this as an area of practice that needs improvement.

Some people required total support in regard to their mobility. The premises and equipment was laid out appropriately to meet people's needs. People had specialist beds and mattresses to prevent the risk of skin pressure areas. There were tracking hoists in place to aid the transfer of people, for example from their bed to sitting chair or bath.

People required careful support around their nutritional and hydration needs. There was clear individual guidance about how to support people safely and effectively with eating and drinking. Some people needed specialist support with complex healthcare needs, including PEG feeding. This was required when people could not maintain adequate nutrition with oral intake. Guidance and information was readily available on the person's PEG regime which included advice on when staff should administer water flushes and at what time should an individual PEG regime commence. The menu was on display and the chef told us that the menu was rotated every four weeks. They told us, "I design the menu based on people's likes and dislikes. We always have fresh fruit and vegetables and make smoothies for people. Some people require their meals fortified and some people require their meals pureed. For those who require pureed meals, consideration is given to how it's presented. I don't mix the pureed meals and present each element of the pureed meals as I would a meal that isn't pureed." We observed this is in practice.

People's health needs were assessed and the provider employed various health professionals to support people with specific complex needs. This included a dietician and physiotherapists. The dietician had recently assessed people deemed at high risk and on the second day of our inspection was re-assessing people. They told us, "All of the staff are lovely and if I ever need to ask anything, there is someone who knows. They know their people well." A physiotherapist was employed by the provider to facilitate sessions to people assessed as needing support with this. On the first day of the inspection, they were holding one to one sessions with people using the service's hydrotherapy spa.

The management of diabetes was effective. People living with diabetes can have an increased risk of disability, pressure ulcer development and hospital re-admission. Diabetic care plans were in place which included guidance on the signs of high and low blood sugar and the steps for staff to take. For example, one person's care plan included guidance to take in the event of their blood sugar levels being too low. Documentation confirmed that people's blood sugar (if living with diabetes) was checked daily to ensure their levels were stable.

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff interacting with people living at Kingsmead Lodge in a manner which was kind, compassionate and caring. One relative told us, "The care the staff give is lovely. They are extremely kind and caring." Staff adapted their communication style to meet the needs of each person and it was clear that staff had spent considerable time getting to know people.

People were not always able to tell us about their experiences. We observed that people had good relationships with staff members and they were happy and comfortable in their presence. Staff had developed positive relationships with people. With pride, staff spoke to us about people's likes, dislikes and how they supported people. One staff member told us, "I'm the keyworker (keyworker is a link staff member for people and their relatives) for one person who adores shopping, make-up and being pampered. They love the cinema also along with the theatre. They are very comical." People's likes were also documented within their care plan alongside their dreams, aspirations and what mattered to them. For example one person's care plan identified that their appearance was important to them. Relatives confirmed that their loved ones had developed extremely positive relationships with the core staff team. One relative told us, "The permanent staff are excellent."

People's right to privacy and dignity was respected. People were assisted discreetly with their personal care needs in a way that respected their dignity. For example, staff knocked on people's bedroom doors before entering. Some people enjoyed having a rest in the afternoon and put signs on their bedroom door informing staff not to disturb them. Staff had helped people to dress in the way their care plan said they preferred and to have belongings with them that were of importance. Staff supported people to maintain their personal appearance and dress in accordance with their lifestyle choice. Staff members commented to people, "You look beautiful today. I love your hair." Staff had recently facilitated a shopping trip for a couple of people and one person showed us their new handbag they had purchased.

The atmosphere in Kingsmead Lodge was calm and relaxed. Staff described how the service had a homely atmosphere. One staff member told us, "We are one big family here." The registered manager told us, "I've been working here for 13 years and the people living here are my family. I want the best for them." Thought and consideration had gone into making the environment homely and friendly. One person had a passion for jigsaw puzzles. Throughout the service were jigsaw puzzles which they had completed and were now in frames on the wall to proudly display their work. In memory of one person who had sadly passed away, a sensory garden had been planted. The registered manager told us, "The sensory garden is great for activities. There are flowers in there which have a fragrance which people enjoy smelling."

People's bedrooms were spacious, in good decorative order and had been highly personalised, for example with photographs, sensory items and art. This helped to create a familiar, safe space for people. For example, staff told us about one person who enjoyed all things pink and girlie. This was clearly reflected in the décor of their bedroom. One relative told us how it was their loved one's birthday recently and staff prepared a party playing their loved one's favourite music. They told us, "It was a lovely day."

We observed numerous occasions of positive support provided by staff to people. Staff bent down to address people who used wheelchairs so they were at their own eye level and maintained good eye contact throughout their conversation. Staff spoke with people calmly and warmly and ensured they had everything they needed. We observed how staff interacted with people whilst waiting for an entertainer to arrive. Staff recognised the importance of touch. One person enjoyed holding staff members hand and staff happily reciprocated. Another person was enquiring about the Inspection team and a staff member spent time introducing us to the person. They then provided reassurance to the person who happily engaged in a hug with the staff member.

People were able to maintain relationships with those who mattered to them. The provider operated a restricted visiting time policy at mealtimes. However, at other times of the day, relatives were freely able to visit and a number of people went home for weekends and returned to Kingsmead Lodge at the beginning of the week. One relative told us, "I can visit at any time of the day, even the night if I wanted to."

For people living with a learning disability, communication is vital in ensuring that people can express themselves and make sense of the world around them. Some people were unable to fully express their needs verbally. Staff demonstrated a good knowledge of how people communicated. One staff member told us, "One person can shout and scream. That is there way of telling us something isn't right. It could mean they are not comfortable or in pain." Care plans included guidance on how people communicated. For example care plans considered 'how I communicate with you' and 'when I look at you it means' so staff could understand how to interpret people's non-verbal communication cues.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive support that met their needs and was personalised to their individual choices and preferences. One person told us, "I'm bored here. The activities are not for me." One relative told us, "The activities are terrible. It used to be great, they were always going out to night clubs and various events but now nothing."

Professionals from partner agencies had raised concerns about the responsiveness of staff to changes in people's health and care needs. They also raised concerns about the availability of person-centred and stimulating activities for people in order to enhance people's engagement and well-being.

At the last inspection we identified areas of improvement in relation to people not always having enough to do to give them stimulation and occupy them. Staff were also not available to support people to follow their interests or engage them in a meaningful activity. Recommendations were made and at this inspection, we found improvements had not been made.

Guidance produced by the Social Care Institute for Excellence (SCIE) advises that 'people who need a great deal of support to do things (because they have complex care needs) have the right to the same opportunities as everyone else. This involves doing things that have a purpose and are meaningful for them.' The provider had employed an activity coordinator; however they were not yet in post. In the interim, agency staff were coming in each day and allocated to activities. Staff confirmed that for a while, there were no activities taking place, so it was positive that an agency staff member was now allocated activities. One staff member told us, "Agency staff are now doing activities. However, people are not always responsive to agency staff and agency staff don't get to know people. I know they are trying to get the same agency staff, but it's not always possible." During the inspection, we observed a range of activities which included snakes and ladders, arts and crafts and sing alongs. Some relatives spoke highly of the activities. One relative told us, "(Person) has come on leaps and bounds since moving into Kingsmead Lodge and they enjoy the activities." Whereas other relatives felt the provision of activities were not meaningful and not based on people's likes or interests. One relative told us, "All they seem to do is play snakes and ladders which I feel doesn't promote their wellbeing." Another relative told us, "When (person) first moved in here, they had a vibrant social life, but now they are not getting enough stimulation."

Some people preferred to stay in their bedrooms due to personal preference or health reasons and did not engage in the group activities. Guidance produced by SCIE advises that social isolation and loneliness have a detrimental effect on health and wellbeing. People had individual social care plans in place which identified their likes and dislikes. For example, one person enjoyed watching TV in their bedroom. However, care plans failed to identify the risk of social isolation or how that risk could be mitigated. One person told us how they mostly spent all day in their bedroom as the activities were not for them. Activity records also identified a further three people who consistently did not engage with group activities. One person was receiving one to one care 24 hours a day. Activity records identified that they consistently stayed in their bedroom. Their social care plan noted that they enjoyed watching TV, going for short walks, DVDs and playing on their tablet device. However, the care plan failed to identify that they did not enjoy group

activities and there was no consideration as to whether they could be at risk of social isolation and how their one to one carer could mitigate that risk. The care plan was reviewed monthly but just stated 'no changes.' The care plan had not been reviewed in conjunction with activity records to ascertain if the care plan remained effective or whether it was no longer working. We found this was a consistent theme within the care plans we reviewed for people who stayed in their bedrooms. Care plans failed to identify and address the risk of social isolation.

Despite agency staff now undertaking activities, relatives felt that one agency staff member was not sufficient in meeting the complex care, emotional and psychological needs of people living with profound learning and physical disabilities. One relative told us, "The agency staff haven't got the skills to provide activities. Some of them are very good but others don't know how to communicate with people. Before there used to be two full time activity coordinators and that's when things worked. In July 2017 we had a meeting with the manager and area manager where we identified that one staff member for activities was not adequate. If they support people to go out or to escort them to appointments, there's no one available to lead on activities. They told us that there would be two staff leading on activities. However, in the recent 'resident's' meeting on the 9 August 2017 they advised that they would see how things would go with just one. I've actually employed someone myself to provide stimulation daily as otherwise (person) hasn't got an existence." Another relative told us about the meeting they had with the manager and area manager but advised that in a subsequent meeting they were disappointed to hear that their suggestions for activities and trips out had not been taken forward.

Staff told us that they did not have time to meet people's social, emotional and psychological needs. One staff member told us, "People used to have an amazing social life here. We were always going out and asking people each day what they would like to do. But now, no. We don't have time for activities. The impact of agency staff meant we are overseeing them and just supporting people with their basic care needs takes all of our time." Another staff member told us, "We don't have time for one to one activities with people." A third staff member told us, "I must say, there is not enough activities for people here." An additional restraint on staff's ability to support people to go out and about was that not all staff were trained in the emergency administration of medicines for people living with epilepsy. We have written about staff training in the 'Effective' section of this report.

A number of people were funded for one to one hours per week. The purpose of this funded one to one care was to enhance people's quality of life and enable them to access the local community or engage in hobbies or interests that they enjoyed. For example, one person was funded for five hours of one to one care a week whilst another person was funded for six hours a week. The provider was unable to demonstrate that people were receiving this funded care. One person was receiving one to one for 24 hours a day and documentation reflected that. However, for people receiving one to one care for six hours a week or five hours a week, we could not be assured that people were receiving that care. The area manager told us that people's funded one to one should be recorded on their weekly activity timetable. We found that people did not always have a weekly activity timetable in place and for those who did there was reference to an outing but not one to one care. For example, one person's weekly activity timetable noted that on a Thursday the activity was shopping and on a Saturday the activity was either an outing or activity of the day. This person was funded for six hours one to one care a week. Documentation failed to confirm that this person was receiving their funded six hours of one to one care a week and staff also confirmed that they were not getting their funded care. One staff member told us, "I take them shopping but that's for about two hours. They don't get the six hours funded care which they should get." Relatives also raised concerns that people were not getting their funded one to one care. One relative told us, "Due to poor staffing, I take (person) shopping and swimming. I don't mind as staff just don't have the time." Another relative told us, "I like to think they get their funded care per week." The daily notes between the period 5 July to 6 August 2017 for one person who should

receive funded one to one care for four hours a week made no reference to the person receiving that care or even accessing the local community. Another person's daily notes between the period 3 July to 6 August 2017 again made no reference to the person receiving their three hours of funded care a week. We also looked at daily allocations and activity records to ascertain if people received their funded one to one care and this did not evidence how staff were consistently allocated to deliver this.

The above examples demonstrate that provision of activities was not appropriate, did not meet people's needs nor did it reflect their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People had been assessed prior to moving into Kingsmead Lodge to make sure their needs could be met. Following the preadmission assessment, individualised care plans were devised. Care plans covered a range of areas including mental well-being, spiritual care, personal care, nutrition, communication and safety. Care plans considered the 'needs of the person, the long term aim and this is what we need to know and this is what we should do.' Information was available throughout people's care plans on their likes, dislikes and information on people that were important to them.

People had individual hospital passports in place which provided an overview of the person's needs and would aid hospital staff to also provide responsive care in the event of the person being admitted to hospital. For example, one person's hospital passport identified how they informed people if they were in pain.

Aspects of care plans were personalised and detailed, however, we found elements of people's care plans lacked clear and personalised information. On the second day of the inspection, we arrived at the service at 05.50am. Upon arrival, only one person was up and about. Staff clearly told us that this person was an early riser and they enjoyed getting up early. One staff member told us, "On the days that people go to day centre, night staff will support those people to get up and ready for day centre." During the inspection, a number of people still remained in bed at 07.00am. However, by 07.20am, a number of people were up and in their bedroom in their wheelchair watching TV or listening to music. These people were not due to attend day centre that day. Staff again confirmed that people were awake and wished to get up. One staff member told us, "We ask people if they are ready to get up or not. We are very flexible as some people enjoy a lie in." We observed that some people were still in bed at 09.30am. However, people's care plans did not consistently reflect whether people were early risers or what time they generally wished to get up. We have identified this as an area that needs improvement.

Care plans were meant to be reviewed monthly; however, we found some discrepancies within care plans and clinical guidance for staff to follow which we have discussed further in the 'Well-led' section of this report.

Relatives and staff felt communication within the service was good. Staff members confirmed there was a handover between shifts which enabled vital information to be shared with them. We observed a handover a between the night registered nurse and day registered nurse which was detailed and enabled the nurse coming onto shift to understand how people had been during the night. Relatives confirmed that they were informed promptly if there loved one was unwell or there had been a change in their care need. One relative told us, "If (person) doesn't feel well. They always contact me." Another relative told us, "If I mention anything it is done straight away."

Complaints were looked into and responded to in a good time. There was an accessible complaints policy in place (available in picture format and provided to people when they moved into the service) available for

both people living at the home and their relatives. There was a clear log of all complaints and the actions taken by the management team. Since the last inspection in January 2017, documentation reflected that the provider had received three complaints. Complaints had been responded to and resolved in line with the provider's policy and timeframe.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoke unanimously highly of the registered manager. People responded with smiles when the registered manager spoke to them and one staff member told us, "She is really caring. The past few months have been tough on her. She has even come in on weekends to do activities with people." One relative told us, "She has a heart of gold. I have nothing but praise for her." Another relative told us. "She's lovely." Whilst all feedback about the registered manager was very positive we found the leadership of the service was not effective in all areas.

Professionals from other agencies including commissioners, safeguarding authority and clinical commissioning groups had raised concerns about the accuracy and completeness of contemporaneous records related to people's care in order to evidence the care that has been delivered to them. Therefore it was not always clear to professionals whether appropriate care had been given in line with people's needs and plans of care. They also raised concerns about how the service responded pro-actively to changes in risk, safety and quality in order to continuously improve.

On the days of the inspection, a registered manager was in post who was also was a registered nurse. The service had five permanent registered nurses who covered both day and night shifts. The provider was also in the process of recruiting nurses and two staff members were awaiting to receive their NMC pin to practice as a registered nurse in the UK. The management team (registered manager and area manager) told us that the service tried to use the same nursing agency when they needed to cover shifts with agency nurses. They told us that when requesting agency staff (including nurses) they requested that staff had training in epilepsy, learning disabilities and PEG management. However, there was no oversight to ensure that the nurses attending the service and supporting people had current training in key subjects such as PEG management. We sampled a range of profiles for agency nurses that had worked in Kingsmead Lodge in the past four weeks. None of the profiles made reference to PEG management training or epilepsy or learning disability training. One agency profile listed training but failed to record the date when the agency worker had attended the training. The management team told us, "The agency profiles only include mandatory training which the agency worker has completed and not additional training such as PEG management." Although the provider requested agency staff with the necessary training and skills, they were unable to provide reassurance and evidence that agency nursing staff had the required skills and training to provide safe, effective and responsive care. The provider was responsive to our concerns and following our feedback agreed to review how they could assure themselves that agency nurses had the appropriate training and skills to care for people living at Kingsmead Lodge.

Guidance produced by the National Institute for Health and Care Excellence (NICE) advises that 'accurate record keeping forms the basis for planning peoples' care and treatment, obtaining feedback on their progress and suggesting actions for prevention and health promotion. Accurate records provide written evidence that a service has been delivered, and provides information for clinical management, resource management, self-evaluation, clinical audit and quality assurance.' During the inspection, we found a number of discrepancies within documentation, gaps in recording and care plans had not been consistently updated to reflect a change in a person's care need. For example, one person had been seen by the dietician

on 27 July 2017 as they were not eating or drinking. The dietician recommended for a food chart to be implemented and for staff to complete a MUST score (malnutrition universal screening tool). Their nutritional care plan dated 17 March 2014 had been reviewed in June and July 2017 but made no reference to the dietician's advice. This person was also now requiring thickening powder in the drinks to reduce the risk of choking. This also had not been reflected within their nutrition care plan. We found that a food chart was in place and staff were aware of the person's need to have thickening powder in their drink. However, for new staff members or agency staff, this guidance and information was not readily available.

Guidance produced by the Royal College of Nursing advises on the importance of robust catheter care. On the day of the inspection, one person had a catheter in place. Their care plan made reference to the catheter and that it should be changed every three months. Documentation reflected that the catheter was last changed in February 2017 and was due for another change in May 2017. However, we were unable to see evidence that the catheter had been changed since February 2017. Staff advised that the person's catheter had been changed during a hospital admission and this would be reflected on their hospital discharge summary. The most recent hospital discharge summary was from April 2017 and made no reference to their catheter being changed. Within their care plan we found a note dated from June 2017 which stated that the person had refused for their catheter to be changed and therefore it had remained in situ. However, it was not clear whether that reference was in relation to the catheter that had been inserted in February 2017 or a more recent insertion. The individual's catheter care plan had not been reviewed since May 2017 and made no reference to any history of the person refusing to have their catheter changed or what should be done in the event of them refusing. There was a lack of clinical oversight of this person's catheter. Documentation failed to evidence if the person's catheter was changed in hospital and if so, the date for when it should next be changed. We brought these concerns to the attention of the management team.

Management of pressure damage is an integral element of providing safe care to people living in nursing homes. Pressure damage is often preventable and requires on-going monitoring and nursing care input. We looked at the management of pressure damage throughout Kingsmead Lodge. People's risk of skin breakdown had been assessed using the Waterlow Score (tool for assessing skin breakdown). A number of people had been assessed at high risk of skin breakdown. However, where people's skin was beginning to break down, skin integrity care plans had not consistently been updated or reviewed to reflect a change in skin integrity and people's Waterlow score had not been reassessed. For example, one person's Waterlow score was calculated as 'high risk' in May 2017. Documentation from June 2017 reflected that their skin had broken down and input was requested from the tissue viability nurse (TVN). A skin integrity care plan was in place which was dated 8 June 2017; however, this had not been reviewed in light of their skin breakdown and recent input from the TVN. Therefore guidance from the TVN was not recorded on the care plan. Another person's skin was beginning to break down. They were seen by their GP in July 2017 due to a graze and the GP prescribed a topical cream. However, their skin integrity care plan had not been reviewed to reflect the change in need and heightened risk status. Staff had responded to people's change in need. However, care plans and risk assessments failed to reflect this action and ensure that robust guidance was in place for staff to follow.

Nurses provided care to a number of people who used various PEG systems for receiving nutrition, hydration and medicines. A range of guidance was in place which considered what to do in the event of a person's PEG becoming blocked or what should happen in the event of a PEG being accidentally pulled out. However, despite guidance in place, we found a range of discrepancies and omissions with recording around the general management of people's PEGs. For example, one person's care plan noted that the PEG should be advanced and rotated every week. This practice is the pushing in and rotating of the tube to help prevent further health complications such as part of the tube getting stuck. Documentation reflected that the PEG had not been rotated and advanced between the 16 April to 14 May 2017 and the 21 May 2017 to 4 June

2017. We found this was a consistent theme within documentation for people who required their PEG to be rotated and advanced. Although this did not necessarily mean that the appropriate rotation and advancing of PEG tubes was not being done, the records were not robust or complete to confirm what PEG management was being delivered to people. Another's person's care plan identified that the balloon attached to their PEG should be checked weekly. We asked a registered nurse to show us that weekly check and they confirmed that it was not being checked weekly. Although we could see improvements were beginning to take place within documentation and recording, a number of shortfalls had not been identified by the provider's internal quality assurance framework.

For people who required their nutrition and hydration via PEG, clear guidelines were in place which included a regime on when medicines should be administered, along with water and nutrition. However, documentation was not always clear and the provider was unable to demonstrate whether it was omissions in recording or whether people had not received their nutrition and hydration as prescribed. For example, guidance from the dietician advised that one person's feeding regime via their PEG should start at 09.30am. However, documentation reflected on a few days that the feeding regime had not started at that time. On the 23 June 2017, the person's daily notes made reference to them being supported to have water and medication at 06.00am and then reference to them going home in the early evening. However, there is no reference to staff supporting them to have their nutritional feed at 09.30am. On the 29 July 2017, daily notes made reference to them being supported to have water and medication and 07.00am but then nothing for the rest of the day. Staff informed us that the person also went home on this day. However, it is not clear if staff supported the person to have nutritional feed at 09.30am before they went home. Another person's care plan advised that as part of their PEG regime, a water flush (a water flush is to prevent blockages) should done at midnight every day. However, documentation failed to consistently reflect this water flush was taking place at midnight. Lack of consistent recording meant the provider could not fully demonstrate whether people had received the necessary care as planned.

Where people's care needs had changed or they were subject to review by healthcare professionals, documentation failed to evidence this. For example, one person was prescribed two medicines to treat their epilepsy in the event of a seizure. This meant that they would receive a different medicine to treat their seizure depending on if they were at day centre or Kingsmead Lodge. The registered manager told us that the GP was in the process of reviewing this and the local learning disability team were aware. However, documentation failed to reflect that action had been taken. Guidance produced by Disabled Living advises that people living with a learning disability are at heightened risk of experiencing constipation. Constipation assessments were in place yet these were not regularly reviewed to ensure that the management of constipation remained effective. For example, one person's protocol for managing constipation had not been reviewed since March 2017. The registered manager told us that the current medicine prescribed to treat and manage their constipation was not working and the GP was in the process of prescribing a more effective medicine. Their daily notes also identified that over a period of 5 days they had not opened their bowels. The registered manager identified that the current management of this person's constipation was not effective. However, documentation failed to evidence the action that been taken and when.

Systems were in place to assess and monitor the quality of the service. These included medication and infection control audits. The area manager completed a monthly audit and visit. During these visits they spoke with staff and people and sampled records relating to people's care and the management of the home. They then completed a document accordingly of any areas which required improvement and presented this to the registered manager. These monthly audits and visits had identified a number of shortfalls. For example, that meaningful weekly activity plans were not in place for everyone and that decision specific mental capacity assessments were not in place. Although some action had begun to address these shortfalls, there was still a need for improvement in these areas. The internal quality

assurance system had failed to identify a number of shortfalls which we found during this inspection. For example, the monthly audit and visit had failed to identify that staff were not recording the times medicines were actually administered and the risk that people were not receiving their medicines on time. Shortfalls had also not been identified in relation to lack of funded one to one care and omissions within documentation.

Feedback had been obtained from people and their relatives; however, where relatives had made suggestions, the provider was unable to demonstrate how these suggestions had been utilised to drive improvement and acted upon. For example, one relative had raised concerns in June 2016 as part of their satisfaction survey that there were not enough activities or trips out. Two relatives also told us that although they had attended a meeting with the manager and area manager, their suggestions and ideas on how activities could be improved, but had not yet been taken forward. One relative told us, "I provided lots of idea on trips out and activities but at residents' meetings I was sad to hear that they had not listened to my ideas or acted on them."

Documentation was in place for the recording of incidents and accidents. A flow chart was clearly displayed for staff to follow which outlined the provider's policy in recording and responding to incidents and accidents. From this flow chart and policy it was clear that the expectation was for information to be shared with West Sussex County Council and the Care Quality Commission (if required) and an investigation should be carried out and measures taken to prevent reoccurrence. However, from the incidents and accidents that we reviewed between January to July 2017, the provider's policy had not consistently been followed. Documentation failed to evidence what actions had been taken to reduce the risk of re-occurrence and the outcome. Following feedback from a recent visit from West Sussex County Council in August 2017, the area manager was in the process of reviewing all incidents and accidents to determine if any required a safeguarding referral.

Staff and the registered manager had a clear overview of people's needs; however, this was not always reflected within documentation. The above evidence shows that the systems or processes in place were not consistently effective. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to maintain securely an accurate and cotemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff identified that Kingsmead Lodge was experiencing a difficult period due to high use of agency staff and staff vacancies. However, despite this, staff spoke highly about working at Kingsmead Lodge. One staff member told us, "We are one big family here and we really care for people." Another staff member told us, "It's a lovely home." Relatives and staff spoke highly of the registered manager and felt she was trying her best. One relative told us, "I feel sorry for the manager. Her heart is the right place, but I don't feel she is supported by higher management." Relative's experience of Kingsmead Lodge varied, however, some relatives spoke very highly of the service and the care provided. One relative told us, "Staff have really engaged with (person). Before they moved into Kingsmead Lodge they had gone into a shell and weren't really communicating. But now they are happy and back to their old shelf." Another relative told us, "I would definitely recommend Kingsmead Lodge."

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users in relation to the provision of activities was not always appropriate for service users' needs or reflective of their preferences.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines was not safe.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems or processes in place to monitor quality and safety were not consistently effective. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to maintain securely an accurate and cotemporaneous record in respect of each service user.

The enforcement action we took:

We imposed a condition on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured that staff deployed were suitably qualified, skilled and competent to carry out their roles.

The enforcement action we took:

We imposed a condition on the provider's registration.