SHC Clemsfold Group Limited

Kingsmead Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	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 of Kingsmead Care Centre took place on 21 September 2017 and was unannounced.

Since the previous inspection of Kingsmead Care Centre in October 2016, services operated by the provider had been subject to a period of increased monitoring and support by commissioners. Kingsmead Care Centre had been the subject of one safeguarding concern about person-centred care delivery. As a result of concerns raised across the provider's 19 locations, the provider is currently subject to a police investigation. Our inspection did not examine specific incidents and 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 September 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 Care Centre provides accommodation and nursing care to people with a range of needs in two units, both of which are located in one building. Haven provides nursing care and accommodation for people with a learning disability, physical disability and/or acquired brain injury and other complex needs. The nursing home provides nursing care and accommodation for older people with a variety of healthcare needs and physical frailties including some people living with dementia. Kingsmead Care Centre is registered to provide nursing care and accommodation for up to nine people in Haven and up to 25 people in the nursing home. At the time of our inspection the home had no vacancies. All rooms are of single occupancy, including two double rooms in the nursing home. In Haven, there is a large community room which is utilised for activities and as a sitting and dining area. In the nursing home, there is a large sitting room with activities area and a separate dining room.

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

At the last inspection on 18 and 19 October 2016 the service was found to be complying with legal requirements and was given a rating of 'Good'. However, at this inspection we found the quality of care and safety had deteriorated and we identified breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found systems to assess and monitor the service were in place but these were not sufficiently robust as they had not identified what we highlighted at this inspection such as a lack of consistency and gaps within agency nurse training on specific subjects such as PEG management and learning disability training.

At the last inspection we spoke with the provider about the need to ensure all staff received training on

specific subjects relating to the needs of the people living at the home. Training opportunities had been provided since the last inspection however a significant amount of staff still needed to attend. At the last inspection in we found improvements were needed to ensure all staff received consistent supervision from their line manager. At this inspection we found improvements had been made and all staff were happy with the support they received and records confirmed this.

People's risks were assessed, identified and mostly managed appropriately. However, we found a lack of guidance available for staff regarding the support one person needed with their asthma. Other risk assessments were contained within people's care plans and were reviewed monthly or, as needed, following an incident or accident.

We found the activities and stimulation opportunities provided to people were inconsistent across the home. People had activity plans in place however on the day of the inspection there was a lack of personalised activities accessible for people living in the Haven Unit. We acknowledged the provider had recognised this gap. However, based on our observations this area required improvement to ensure activities offered are in line with all people's abilities, needs and their wishes.

Staff had been trained to recognise the signs of potential abuse and people told us they felt safe living at the home. Staffing levels were assessed based on people's needs using a dependency tool. There were enough suitable staff available to meet people's needs safely. Medicines were managed safely.

Staff understood how to gain people's consent to their care and treatment and had an understanding of the Mental Capacity Act 2005. People felt there was a good choice of food on offer and they were involved in menu planning at residents' meetings. People were supported to maintain good health and had access to a range of healthcare professionals and services.

Individual rooms were personalised in line with people's tastes and preferences. People were looked after by kind and caring staff who knew them well and how to meet their needs. People's personal histories, preferences, likes and dislikes were identified and included in their care plans. Relatives and friends could visit people freely and people were encouraged to maintain contact with them. Complaints were managed effectively and in line with the provider's policy.

People were supported to express their views and to be involved in making decisions about their care. They were treated with dignity and respect.

Staff spoke positively and valued the support they received from the management team. The care staff team understood their role and responsibilities.

The registered manager was 'hands on' in their approach and knew people living at the home well. They understood their role in working alongside external agencies such as the West Sussex safeguarding team and the Commission. The registered manager was open to making improvements regarding what we had identified at this inspection to ensure people received safe and effective care.

At this inspection we found the service was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

One aspect of the service was not safe.

There was no guidance or risk assessment available for staff who were supporting a person with their asthma care. Other risks to people were identified and assessments drawn up so that care staff knew how to care for people safely and mitigate any risks.

Staff were trained to recognise the signs of potential abuse and knew what action they should take if they suspected abuse was taking place. There was sufficient staff supporting people safely.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The staff team received regular training opportunities however not all staff had received training in specific subjects in relation to the needs of the people they were supporting such as in epilepsy and learning disabilities.

Staff received regular supervision and appraisals.

People were supported to have sufficient to eat and drink and consent to care and treatment was sought in line with legislation under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were supported by kind, friendly and caring staff who knew them well.

People were given opportunities to be involved with their own

care and to be as independent as possible.

Staff promoted people's dignity and respected their privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We observed a lack of personalised activity and stimulation offered to people living in the Haven part of the nursing home.

Each person had a care plan which provided details on their needs, preferences and wishes.

People and relatives we spoke with knew how to raise a concern and felt able to do so.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

Auditing systems were not always effective in measuring the quality of care provided to people.

The culture of the home was open, positive and friendly.

The staff team cared about the quality of the care they provided and understood their role and responsibilities. The registered manager worked alongside external agencies.

Kingsmead Care Centre

Detailed findings

Background to this inspection

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

The inspection of Kingsmead Care Centre was undertaken on 21 September 2017.

This inspection was prompted, in part, by partner agencies notifying CQC of safeguarding and quality concerns concern about this location related one person not receiving care in line with their assessed needs and funding arrangements. A number of safeguarding and quality concerns in relation to the provider, Sussex Health Care, are the subject of a police investigation and safeguarding enquiries although only two safeguarding and quality concerns relate to Kingsmead Care Centre. As a result this inspection did not examine the circumstances of the specific allegations made about the registered provider. However, the information of concern shared with the Commission indicated potential concerns about deployment of staff and delivery of person-centred care. Therefore we examined those risks in detail as part of this inspection.

The inspection was undertaken by two inspectors, a specialist nurse and an expert-by- experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience at this inspection had experience of adults with learning disabilities and other caring settings. The specialist nurse had the necessary skills and expertise to provide advice and feedback about clinical care of service users.

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 seven people who lived at the home and two relatives. Due to the nature of some 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 one registered nurse and one student nurse who also worked as a senior carer and one care assistant. We also spoke with the registered manager and area manager throughout the inspection. We spoke separately with the registered manager after the inspection over the telephone to gain her views on her role and responsibilities. The nominated individual who represents the provider introduced themselves to the inspection team during the inspection. The quality assurance manager and an additional area manager were also present for some of the inspection and were available to answer any questions the inspection team had.

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 four people's care plans. We also looked at three 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 home.

Kingsmead Care Centre was last inspected in October 2016 where we found the service to be meeting legal requirements and was rated 'good' overall.

Requires Improvement

Is the service safe?

Our findings

A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. During our inspection we found inconsistencies regarding how risks to people were managed by staff to keep people safe. We identified a gap in one person's care plan and associated risk assessment. The person was asthmatic and their Medication Administration Record (MAR) stated staff supported them with prescribed inhalers. The MAR also indicated the person used a device to support this function to ensure all asthmatic medicine dispensed is received by the person. There was no associated asthma care plan or assessment in place to describe the risks to the person if they did not receive their asthma related medicines. There was no care plan in place to describe the level of monitoring nursing staff and care staff had to provide to the person with this need. Whilst staff we spoke with knew people well the lack of assessed records meant the person may be at an increased risk of having their respiratory needs not being met consistently as the service deployed temporary agency staff to cover permanent vacancies. We fed this back to the registered manager who agreed this should have been in place. They took action and shortly after the inspection sent a completed asthma care plan to CQC which described how staff should support the person with this need.

We sampled other risk assessments which had been carried out about people's needs. They included step by step guidance on how people should be supported and monitored if they were diagnosed with epilepsy or risks associated with swallowing difficulties. There were three people living at the Haven unit who could not manage to eat, drink and take medicines orally. They required enternal feeding and had percutaneous endoscopic gastrostomy (PEG) feeding tubes. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and oesophagus. An agency nurse we spoke with was knowledgeable about the management of supporting people using PEG and we observed them carry out this support safely. Care plans and associated risk assessments provided detailed guidance specific to the individual for staff to refer to. We have discussed PEG related policies and procedures further in the Well-led section of this report.

We also found examples of risks being managed appropriately relating to the premises and equipment; these were monitored and checked to promote safety. Equipment and utilities were serviced in accordance with manufacturers' guidance to ensure they were safe to use. Gas and electrical safety was reviewed by contractors to ensure any risks were identified and addressed promptly. Fire equipment such as emergency lighting, extinguishers and alarms were tested regularly by the provider's maintenance engineer to ensure they were in good working order. Records confirmed that maintenance staff attended immediately when contacted by staff to repair damage, which may cause harm to people and others visiting the service. People were protected from environmental risks within the service such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing.

People told us they felt safe living in the home and we observed people were relaxed and comfortable. One person told us, "I'm satisfied. There is always someone (staff) if you want them". At the time of our inspection there were three care staff and one nurse supporting in the Haven unit and four care staff and one nurse

supporting the nursing home. During our inspection the nurse supporting the nursing home was the registered manager. Included in the nursing home staff team was a senior carer who was being supported by the provider to complete their nursing qualification. Sufficient staff were deployed during our inspection to ensure people's needs were being met in a timely manner. Not all people living at the home could communicate verbally with us. However, people we spoke with told us they received the correct support at the right time. One person said, "I have a call bell and someone comes." A second person told us, "I ring (call bell) and a carer comes straight away". A third person was happy with the care they received yet appreciated they shared the staff team with other people and said, "They may be busy with someone else, you have to be a bit patient". When staff were on leave the registered manager accessed agency staff to cover the shifts. One staff member told us, "We have agency but we have regular agency staff." The management team told us they had found it difficult to recruit nurses and used agency nurses to ensure people's clinical needs were being met. We have referred to the training needs of agency nurses within the Well-Led section of this report.

Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the registered manager or one of the senior nurses or the area manager in the first instance and failing that would refer to the whistleblowing policy for advice and guidance. One staff member told us, "If I had grandparents who needed care I would place them here". They added, "I have no hesitation if somebody was being mistreated it would need to be dealt with".

Accidents and incidents were reported appropriately and documents showed the action that had been taken afterwards by the staff team and the registered manager. This also included an analysis of any persons that had experienced a fall. The records showed that appropriate professionals had been contacted and subsequent support provided such as the introduction of specialist equipment. This helped to minimise the risk of future incidents or injury.

Medicines were managed safely by the home using an effective medicine administration system. We spoke with nurses who confidently discussed how they administered medicines to people. Nurses were knowledgeable as to the reasons why people had medicines prescribed to them, any known side effects and what to do in the event of any concerns. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. Tablets were dispensed from blister packs and medicines administered from bottles or boxes were stored and labelled correctly. Some medicines had to be stored in a refrigerator. Staff were vigilant at recording the temperature of the refrigerator daily. We observed that the Medication Administration Record (MAR) was completed on behalf of each person by the registered nurse on duty each time someone was supported to take their medicine. This evidenced that people received their medicines as prescribed. Guidance was provided for staff when administering "When required" (PRN) medicines.

Care staff were supported by the registered manager and other registered nurses using observations to assess their competency before performing their tasks independently within areas such as moving people safely. This also included nurses and more experienced staff supporting new staff on how to apply prescribed topical creams. Topical creams, such as skin barrier creams to prevent pressure wounds, are prescribed medicines which are often applied when a person receives their personal care. Support was provided from nurses and the registered manager to new care staff with the administration of topical creams. However, we identified there was no formal training for care staff undertaken to apply topical creams. Despite this care staff were able to tell us how they applied topical creams safely and effectively and if they had any concerns they would highlight them to one of the registered nurses. There was also robust

wound management plans in place for people when a need arose. For example, one person was admitted to the home with a pressure wound. Records showed how the staff team had referred the concern to a tissue viability nurse who changed the person's dressings daily. The treatment plan which included guidance for staff in place ensured the risk of the wound becoming worse or having an additional pressure wound was reduced on behalf of the person. During our inspection the registered manager and area manager told us they would consider introducing formal training for care staff on topical creams and referred us to the provider's comprehensive procedure on how to apply a topical cream.

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.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we identified not all staff had received supervision in line with the provider's policy. At this inspection supervisions and appraisals were provided to all the staff team. A system of supervision and appraisal is important in monitoring staff skills and knowledge. Staff told us and records confirmed they received supervision up to three times per year, sooner if needed and they were encouraged to discuss all matters relating to their role within these sessions. Items discussed were agreed and carried through to the next meeting. Staff also told us they did not have to wait for planned meetings as the registered manager was approachable and applied an 'open-door policy'. One staff member told us supervisions were routine and helpful and said, "Staff get to talk".

We had also discussed with the registered manager (and the previous area manager) at the last inspection about the need for existing staff to complete specific training in topics such as learning disability, dementia and acquired brain injury in order for staff to be able to provide appropriate and person-centred care to people with these needs. Since the last inspection the registered manager had taken action regarding this. They had used the provider's training academy and staff were able to tell us about the training they had completed and how they had been able to implement what they had learnt in practice when supporting people living at the home. However, some new and existing care staff supporting people with both a learning disability and a diagnosis of epilepsy still needed to complete training in both subject areas. Shortly after the inspection, the registered manager shared a list which included nine staff who needed to complete epilepsy training and seven staff who needed to complete learning disability training. We asked one staff member who had not attended learning disability training and who had been working in the home for a number of years whether they felt it would help them in their work and they said, "Yes". The registered manager told us they would be using the providers on line training academy and all staff were booked to attend. Nine people who lived at the home with a learning disability. In addition, four people had a diagnosis of epilepsy. Therefore, this was an area which needed to improve further to ensure all staff achieved the specific training relevant to people's needs to ensure they have the opportunity to gain the knowledge they need to carry out their role and responsibilities effectively. The gaps in learning disability training amongst the staff team may have influenced the lack of effective and appropriate activities offered to people living in the Haven unit which we have discussed further in the Responsive section of this report

People living in the Haven Unit had complex physical and learning needs. This included people who required support with PEG for food, hydration and medicines, had a learning disability and some people had a diagnosis of epilepsy. Some people in the nursing home were living with dementia. Permanent nursing staff had access to relevant clinical courses associated with the nursing care they provided such as palliative care and PEG management. At the time of our inspection a registered manager was in post who was also a registered nurse. There were three permanent nurses employed by the provider, this included the registered manager and two bank registered nurses. At the time of our inspection one or two agency nurses were being used to provide nursing care to people living at the home daily. The provider was in the process of supporting an existing member of staff to become a qualified nurse and undertaking a recruitment drive to employ further permanent nurses. We were told the home routinely used two different nursing agencies to supply agency nurses. The area manager and registered manager told us they aimed to have consistency

and used the same nurses and records supported this.

We asked the registered manager what checks they made to assess the skills, competency and training the agency nurses had achieved who provided us with training and experience profiles for agency nurses who were used by the home. However the training profiles we read did not confirm the agency nurses the home regularly used had attended training in those specific areas. We discussed this with the registered manager and area manager. They told us the records were not accurate and shortly after the inspection sent to us six revised training profiles. There were three people living at the Haven unit who could not manage to eat and drink and take medicines orally and had enteral feeding tubes either (PEG) or a balloon gastrostomy tube. Whilst some of the updated training profiles showed some agency nurses had attended PEG training routinely, they also provided details that some training courses had taken place after our inspection. For example, two agency nurse's completed PEG, epilepsy, and learning disability training after our inspection. A further two completed epilepsy and learning disability training after our inspection and two agency nurse's completed learning disability training after our inspection. One of the agency nurses had worked at the home since 2012. They worked six out of seven days in the Haven home the week of our inspection yet did not complete learning disability training until after our inspection. There was a lack of effective monitoring carried out to check all agency nurses had achieved essential training specific to the needs of the people they were regularly supporting. Accurate agency nurse training records were not readily available at the time of our inspection and some essential training took place after our visit. This meant there was an increased risk people may not always have received correct levels of care in accordance with their specific needs.

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. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff had attended other training courses such as safeguarding adults, health and safety and moving and handling and understood their role and responsibilities. Staff complimented the training they had attended and valued the support provided by the management team. New staff completed an induction programme. They shadowed experienced staff for at least three shifts and were paired with a senior member of staff until they were assessed as capable of working more independently. As part of the induction all new staff completed the Care Certificate (Skills for Care), covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards, candidates must prove that they have the ability to carry out their job to the required standard. Staff were encouraged to study for additional qualifications, such as diplomas in health and social care. Staff were also provided with staff meeting opportunities throughout the year. One staff member we spoke with said, "We have staff meetings every three months, we just had one", they added, "Staff feel comfortable to speak". The nursing staff also met regularly to discuss their role and responsibilities. At a meeting on 20 July 2017 topics such as care planning, fluid charts and a new safeguarding folder were discussed.

Consent to care and treatment was sought in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked that the home was working within the principles of the MCA and whether any conditions on

authorisations to deprive a person of their liberty were being met. Care records showed how consent from people had been obtained and capacity assessed thoroughly and where deemed necessary a DoLS application completed. The registered manager confirmed two people had an authorised DoLS in place and they were waiting on a further two renewal application decisions from the local authority. Training records confirmed staff had attended training in both MCA and DoLS. Staff were able to share some knowledge on the topic and provided assurances they were aware of its importance. One staff member told us mental capacity assessments took place on behalf of people when, "They cannot decide for themselves".

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs. There were allocated kitchen and domestic staff employed to prepare meals for people. One person in the nursing home said, "The food is good, it's improved with the new chef". Another person said, "The new chef is making an effort to talk to me and other people". Meal times were a busy period in both areas of the home and we observed staff support people to eat using a sensitive and discrete approach. All staff were aware of any specialist diets including any allergies people had and adjusted the menu accordingly. There were three people living at the home who could not manage to eat and drink orally and had enteral feeding tubes as discussed in other sections of this report. We observed nurses support people who received food and fluid this way with competence and flexibility.

People had access to health and medical professionals when they needed. GP's visited the home routinely and any changes to people's health needs were discussed and any actions to support people carried out. One person said, "I see the doctor every Friday". A relative told us, "They (staff) picked up [named person] had a water (urine) infection the other day and they sorted it out". Another relative said their family member saw a chiropodist and opticians regularly. The provider employed various health professionals to support people with specific complex needs. This included a dietician and physiotherapists. A dietician came to the home when a need was identified by the nursing team. We observed people receiving physiotherapy sessions on the day of our inspection. One person told us, "They have a visiting physiotherapist and they help me with walking".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed that people looked at ease in the company of staff and were comfortable when anyone in the staff team approached them. People in the nursing home confirmed their positive experiences of the staff team including the registered manager. One person said, "Oh yes the staff are very good". Another person said, "They look after me. I don't have a problem". A third person said, "I think they look out for people". A fourth person told us they were much happier with the care they were receiving now in comparison to the home they lived in before and said, "It's better here and I 'm happier with the care here. I am happy to see out my days here".

We observed positive support provided by staff to people. Staff bent down to address people at their own eye level and maintained good eye contact. Staff spoke with people calmly and warmly and ensured they had everything they needed such as drinks and snacks in between meals. A staff member told us they always checked, "Do they want to be in their room or do they want to get involved with an activity". This meant the staff member considered what the person wanted to do and how they wanted to spend their day.

People were provided with opportunities to talk to staff including their key workers and the registered manager about how they felt on a daily basis. A keyworker is a staff member who helps a person achieve their goals, helps create opportunities such as activities and may advocate on behalf of the person with their care plan. The registered manager told us the role was, "Somebody for the service user to speak with and get things done". They told us key worker meetings were not recorded within care records. Resident meeting opportunities were organised to take place every few months. A copy of the minutes to meetings were arranged in an accessible format which included pictorial for people who found reading words only difficult.

People were encouraged to be as independent as possible and to be involved with their own care by the staff. Staff described how they encouraged people to take part in their own personal care, enabled them to make choices and decisions about what they wore each day, how they wanted to spend their day, what time they wanted to get up and what time they wanted to go to bed. One staff member said, "We encourage them to do more things for themselves. They (people) may wash their face and arms as it promotes movement". They added, "We encourage them to hold their drinks, encourage walking if they can". Another staff member said, "Even if people find it hard to make choices we still involve them".

People were treated with dignity and respect. Staff were observed knocking on people's bedroom doors and waiting for a response before they entered. Staff talked to people whilst they were supporting them so they gained their consent and people knew what was happening. All staff members we spoke to told us how they would draw people's curtains before supporting them with personal care. A staff member told us, "We have to ask them what they really want". The registered manager told us how they, "Promoted privacy and dignity at all times which includes ensuring they (people) have access to professionals (health and social care) as well". They added they promoted a caring environment by, "Having a clear care plan so people (staff) know the needs and preferences of the service users". We asked the registered manager what they would do if a staff member was considered not caring, they said, "I would meet with the staff member to have a discussion about how they approach and look after that service user".

Requires Improvement

Is the service responsive?

Our findings

Personalised care that was responsive to people's needs was not always provided. During our inspection we observed people living in the Haven Unit were not consistently provided with activities which were meaningful and reflected all people's needs and preferences.

The hallways of the home were decorated with photographs of people participating in activities such as various seasonal themed events. The photographs captured people enjoying what they were doing and it added to a homely and personalised environment. Nine people lived in the Haven Unit. Each person had their own bedroom yet the majority remained in the communal activities room. On the day of our inspection one person who lived in Haven was accessing a day service outside of the home. Mostly people living at the Haven home were non-verbal therefore used other methods to communicate with others. Care records provided details of activity planners and daily notes which reflected how a person spent each day. Staff told us they worked in accordance with the individual activity plans in place. However, not all of the options were stimulating and suitable for the group of people they were offered to. For example, at 10:25am five people were watching television in the communal area. At 11:05am one person requested to play a sound bingo game. This is a game whereby the person was able to press the buttons on a tape recorder and see if anybody could guess the noise. One other person joined in but the game only lasted ten minutes. No other activity was offered to people before lunch. When we returned to Haven in the afternoon board games were placed on the communal table yet people were not engaged with them. Staff were not supporting or encouraging people to play with the games. We did not observe staff ask people if that is what they wanted to do or offer people an alternative activity.

We observed staff supporting one person who displayed self-injurious behaviour. Their care plan and associated risk assessments stated they should be provided with activities which were 'mentally stimulating. We read the person's activity planner which included suggested activities for each day of the week. On the day of our inspection, which was a Thursday it stated the person would be offered, dancing to the music of their favourite 'pop' singer in the morning and dancing and exercises and cooking in the afternoon. Out of the three separately suggested activities we were told staff had supported the person to listen to their favourite music in their bedroom. The other two activities were not offered during our observations. We read the person's activity monitoring form which was completed daily. In September, prior to our inspection, activity records showed they had participated in activities each day. However, on thirteen days the 'films/tv' option had been ticked by a staff member as being one of the activities offered. Records showed the person had not been taken out in September 2017 however had been out on a day trip in August 2017 yet according to the activity planner we read, the person was supposed to be offered a shopping trip every Wednesday. The same person was prescribed medicines when they became agitated such as pain relief in the form of paracetamol. We noted the person had become agitated and prescribed pain relief 14 times in September 2017 yet they had not been taken out of the home regularly and in accordance with their activity planner. This lack of varied stimulation may have influenced the person's behaviour and the amount of times they were administered pain relief. We read the person's care plan. There was a lack of written and consistent guidance for staff available, such as a Positive Behaviour Support (PBS) plan for this area of need. Positive Behaviour Support (PBS) guidelines contain strategies of how staff should support people to reduce

anxieties and manage behaviours displayed. We found further written guidance was required for all staff to know how they should respond and support the person when they became agitated prior to them administering paracetomol. We discussed this further with the registered manager and area manager. The registered manager confirmed the person's preferred activity was listening and dancing to their favourite music. They also clarified the person's medicines including their 'when required' medicines were continuously reviewed by a visiting GP. Shortly after the inspection the registered manager sent to the inspectors a revised guidance document to ensure nursing staff knew the steps they should take prior to the use of any pain relief.

The registered manager and area manager had already recognised activities offered to people in in the Haven Unit needed to improve. We were told that usually two activities co-ordinators, in addition to care and nursing staff were employed to support the two areas of the home. The registered manager told us the activities co-ordinator had recently left the Haven Unit in September 2017 which had impacted how activities were organised and facilitated. They told us a new activities co-ordinator had been recruited to join the staff team to improve how people spent their day. We also read the Haven Unit's resident meeting minutes in February and September 2017 where activities were discussed with people and what they liked to do and how they liked to spend their time. Whilst we appreciated the provider had taken steps to improve the activities offered to people this was an area which required developing further. A review was needed to ensure all people living in the Haven Unit were offered and provided with activities which were in line with their abilities, needs and their wishes to have a positive influence over their day and people's well-being.

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

Some people in the Nursing home were more able to vocalise their needs and choose how they spent their day. During our inspection the activities board in the nursing home stated, 'am. Sensory session, light exercise class' and 'pm karaoke'. We observed the activities co-ordinator in the nursing home facilitate sessions throughout the day with a few people who enjoyed group activities. We observed the activities coordinator offer flexibility with the plan and switch activities when people told them they would prefer to do something else. For example, the karaoke activity ended when people in the lounge requested to watch a film instead. We also observed staff chatting with people and going in and out of people's bedrooms who received their care in bed. We observed staff assisting them to walk down the corridor for exercise and a change of scenery, listen to music or switch their television on if they so wished. One person, who was very independent, told us, "I like the quizzes and the bingo. I go up to the top of the garden and back six times a day". People had choice in how they wanted to spend their day, one person told us they practised meditation in relation to their faith and said, "I prefer my own company and my world, it is my choice". A relative told us, "They encourage them (people) to sit outside, but it's up to them if they want to or not". Staff and people told us in the warmer months the home held parties in the gardens included BBQ's.

Each person had a care record which included a care plan, risk assessments and other information relevant to the person they had been written about. Care plans were reviewed monthly by registered nurses and included information provided at the point of assessment to present day needs. The registered manager told us people and their representatives were involved with reviewing their care plan as much as they were able. Relatives we spoke with confirmed this. Care plans provided staff with guidance on how to manage people's physical health and/or emotional needs, their goals and their aspirations. This included guidance on areas such as communication needs, continence needs, mobility needs and specific health information such as if the person had a diagnosis of epilepsy. Care plans provided details on how the people presented whilst having an epileptic seizure and how staff should respond accordingly. Pictorial images were used

throughout care plans to enable them to be more accessible for the individuals. Care plans also wrote about significant people in their lives, places they liked to visit and whether the person may have a religious belief or another passion or hobby. In addition, all people who required one had a communication passport attached to their wheelchair to ensure staff and other relevant persons were provided with a clear message about how the person communicated. Staff told us they found care plans easy to read and follow and effective working tools. One staff member told us all the staff knew people really well and said, "We get to know people's routines". They added, "When we induct new staff we tell them when a person likes to get up, go to bed and what they really like and what they really don't like".

Daily records were also completed about people by care staff and nurses during and at the end of their shift. This included information on how a person had spent their day, what kind of mood they were in and any other health monitoring checks. These daily records were referred to when staff handed over information to other staff when changing shifts to ensure any changes were communicated.

People and their relatives told us they had no current complaints and knew who to go to if they did. This included the registered manager. They told us when they raised any issues they were resolved. Complaints were looked into and responded to in a timely manner. There was an accessible complaints policy in place 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. There were no formal complaints open at the time of our inspection. One person said, "When (named staff) comes round they check if I have any problems or issues, but I haven't". A relative said they had no complaints and told us, "I would complain if there was something". A relative told us they raised a query about a broken washing machine once and an item of clothing washed at the incorrect temperature they said it was a, "One-off", and added, "They (staff) explained about it and said I'm sorry".

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they appreciated the care and support they received from staff at the Kingsmead Care Centre. However, we found some aspects of the service provided were not Well-Led. There were detailed care plans written on behalf of people using a form of percutaneous endoscopic gastrostomy (PEG) feeding tubes for their nutrition and medicines. The care plans and associated risk assessments were specific to the individual needs of the person. However, each care record referred the reader to a specific PEG policy and procedure. The balloon gastrostomy tube policy was located by the registered manager on the provider's intranet yet the registered manager was unable to locate the PEG current policy and procedure. Considering the reference to the specific PEG policy and procedures within people's care plans and the use of agency nurses we discussed this with the registered manager and area manager and the need for them to be available for nursing staff to access at all times. The registered manager sent to us the relevant PEG policy shortly after our inspection.

Systems to assess and monitor the service were in place and had highlighted issues which were being actioned by the registered manager. The area manager, who was relatively new to the service and provider, also visited the home monthly to assess the quality of care provided to people and provided the inspectors with written copies of the checks they had made since July 2017. This included, amongst other areas, checking whether people's care records and medicine records were accurate and up to date. However, the checks carried out were not sufficiently robust as they had not highlighted the areas we found during our inspection such as the gaps in agency nurse training profiles and the lack of an asthma care plan and guidance available for staff on behalf of one person. Checks had also failed to ensure sufficient improvements had been made to ensure all care staff had received training in epilepsy and learning disabilities which was an area we identified at the last inspection. This lack of governance and oversight may have placed people at risk from harm.

The provider had failed to apply learning from previous inspections of Kingsmead Care Centre and other locations operated by the provider. At the inspection of Kingsmead Care Centre a year prior we had raised that the provider needed to improve their needs-specific training for staff to ensure all staff had the appropriate knowledge and skills to understand the needs of service users including learning disabilities, dementia and acquired brain injury. At this inspection we found that there were still gaps in this training for new and existing staff. At other recent inspections of the provider's other locations, we raised concerns about the monitoring of agency staff skills, the provision of person-centred activities and proactive quality monitoring. Despite this, we found the same issues arising at Kingsmead Care Centre. This demonstrated that the provider had not effectively applied feedback and learning from other services to improve practices at Kingsmead Care Centre.

The above evidence shows there was a failure to consistently assess, monitor and mitigate the risks relating to the health, safety and welfare of all service users. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other checks carried out by the registered manager or other delegated staff on the care provided

to people and the home environment. This included monthly accident and incident audits. This was completed by the registered manager and checked whether the person received the correct care and treatment at the time and attending staff members completed the necessary records. In addition to 'service user meetings' which were carried out throughout the year, the registered manager routinely spoke with people and their relatives informally to gain their views on the care they received. One person told us, "I think [named registered manager] is marvellous. She's a warm caring person". Another person said, "She's always got a smile". A third person told us, "[Named manager] is good. They're very good here". Annual surveys were also sent to people and the responses we read were positive.

Staff were positive about working at Kingsmead Care Centre and we asked some staff members about the culture of the home and whether they thought the home was Well-led. One staff member said, "The home is well managed. [Named registered manager] knows the ins and outs of service users. [Named registered manager] is very well liked by service users; she greets them every day even if she is busy".

We spoke with the registered manager separately after the inspection and discussed their role and responsibilities. They were aware of the importance of continuing to notify the Commission of certain events and incidents within the home such as potential safeguarding incidents, deaths and other important incidents to comply with their registration requirements. This is important so the Commission have an awareness and oversight of these to ensure that appropriate actions are being taken on behalf of people living at the home. In addition to the registered manager role she was registered with a university to undertake a nurse mentoring role and since April 2017 they had supported two nurses with their practical skills.

The registered manager told us, "My staff team are excellent. I can always rely on them, there is give and take and they always cover when they can to cover a shift". They also told us they found the visits and support from senior managers who worked for the organisation valuable. This included their area manager and said, "[named area manager] is always there".

The registered manager offered a 'hands-on' approach when supporting the home. On the day of the inspection she was the registered nurse on duty supporting the nursing home. We identified the registered manager was allocated to shift duties throughout the week routinely. Although doing this occasionally can be useful for maintaining good supervision and communication with both people and the staff team, if it's happening regularly then it may impact a managers ability to perform their management duties. We discussed this both with the registered manager and the area manager. They both told us this was currently being discussed within their supervision sessions to ensure the home had the amount of nurses required.