London Residential Healthcare Limited

Kings Lodge Nursing Home

Inspection report

Main Road
Cutmill
Chidham
West Sussex
PO18 8PN

Tel: 01243573292
Website: www.lrh-homes.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Kings Lodge Nursing Home is a residential care home providing personal and nursing care to 67 older people with a variety of health needs at the time of inspection. One part of the home provides specialised care for people who were living with dementia. The service can support up to 77 people.

People's experience of using this service and what we found
Medicines were not always administered or stored in a safe way. New admissions to the home were not managed in line with government guidance. Some infection prevention and control systems were not sufficiently robust to protect people from unsafe care or treatment.

Care plans for some people with a learning disability did not provide detailed information or guidance for staff to ensure they received person-centred care.

People told us they felt safe living at the home. The home was open to visitors. A friend of one person was visiting the home and told us, "We were able to visit in the pod. It wasn't ideal, but at least I was able to see her again. It was so important that we could visit". Staffing levels were sufficient to meet people's needs and new staff were recruited safely.

People's needs were assessed before they came to live at the home. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
• Model of care and setting maximises people's choice, control and independence
Care records lacked information for staff as to how people's independence could be promoted, or how to support people to have choice and control of their lives.
Right care:
• Care is person-centred and promotes people's dignity, privacy and human rights
Staff knew people well and provided personalised care. However, records did not show how staff should promote people's dignity and privacy or protect their human rights.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives
There was no evidence to show how the home promoted inclusion in order for people to feel empowered.

The registered manager was not aware of the principles of Right support, right care, right culture. On the second day of inspection, they told us they had accessed this strategy and would be reviewing the care, including records, that people living with a learning disability or autism received.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Good (published 3 November 2018).

Why we inspected
We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection. The provider has taken some action to mitigate the concerns
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kings Lodge Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to the safe administration and management of medicines, infection prevention and control, and governance. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Kings Lodge Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by three inspectors, one of whom was a medicines inspector, 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.

Service and service type
Kings Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service, four relatives and a friend of one person at the service, about their experience of the care provided. We spoke with 11 members of staff including the registered managers, deputy manager, two registered nurses, chef, three care staff and two activities co-ordinators.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at memory assessment records, self-administration medication documents, and care plans relating to medication and people living with a learning disability.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Preventing and controlling infection

● Medicines were not always stored safely and securely. Processes for the safe administration of medicines were not always followed.

● On the ground floor, thickeners for drinks were stored openly in some people's rooms, which was against the provider's policy and NHS guidance. If not stored and administered in line with prescribed recommendations, people were at risk of asphyxiation or choking, since they had free access to their thickeners and could use them unsafely. During the inspection, the registered manager removed the thickeners into secure storage.

● We observed one person was given their medicines which were left in a pot for them to self-administer. We asked this person about their medicines being left out and they said, "I'll take them later. No, I don't know what they are for, I've forgotten". Staff could not be assured the person had taken their medicines in a timely way or disposed of them. There was no risk assessment documented for this. We raised this with the registered manager who undertook a risk assessment. However, this risk assessment lacked detail to ensure the person had capacity and would be safe to self-administer their medicines.

● Whilst observing a registered nurse administering medicines to people on the ground floor, we saw the Medication Administration Record (MAR) folder was left open on top of the medicines trolley in the hall. The provider's policy stated that medical information for people should be stored securely where it cannot be accessed by unauthorised persons. At the time of our observation, external contractors were walking around the building checking the fire alarm system, and could easily have accessed the MAR folder and confidential information.

● A denaturing kit for medicines requiring more stringent control was awaiting collection. Out of date or unwanted medicines of this type must be fully denatured prior to disposal so they cannot be retrieved, recovered or reused. This was a large denaturing kit that could not fit into the cabinet. Staff told us that the kit was not locked away for the required 24 hours to ensure denaturing had fully occurred as required, nor was it placed in the pharmaceutical waste pending collection.

● The service did not have a consistent process to ensure timely access, secure handover and retention of keys by senior staff on duty.

● Oxygen cylinders are a potential fire and explosion hazard. One person required oxygen to assist with their breathing. Signage on their bedroom door stated that oxygen was in use, but cylinders in situ were not made secure, nor were staff aware of how to secure or move oxygen cylinders safely. This was contrary to the provider's policy, and an example of unsafe practice. By the second day of inspection, the oxygen cylinders had been secured as required and staff had been updated on the safe moving of these.

● We were not assured that the provider was admitting people safely to the service.

The provider's policy stated that only people who had been double vaccinated against COVID-19 and tested

negative were to be admitted to the home. People would then need to re-test and isolate for 14 days on admission. The registered manager told us this policy was not up-to-date and people were no longer required to isolate. Current government guidance, 'Admission and care of residents in a care home during COVID-19', (updated 17 August 2021) states that people do not need to isolate subject to certain conditions being met. One condition is the person undertakes a Polymerase Chain Reaction (PCR) test before admission (within 72 hours), a PCR test on the day of admission (day 0) and a further PCR test seven days following admission (day 7).
The registered manager was not aware of the latest government advice. Two people had been admitted to the home after the government guidance was issued, but did not complete PCR tests on the day of admission, or on the seventh day. Additionally, government guidance is that people should complete a daily Lateral Flow Device (LFD) test every day for seven days; this was not done. This put people at risk of the spread of infection.
● A staff member did not use appropriate Personal Protective Equipment (PPE) when dealing with soiled laundry. The provider's Infection Prevention and Control (IPC) policy stated that care staff should wear disposable gloves and aprons when handling soiled linen. We saw one staff member place soiled linen into a red linen basket in a bathroom, and that they were not wearing an apron or gloves. When we asked them why, they explained they had removed the gloves and apron they were wearing whilst in the person's bedroom. A member of the management team assured us this was not normal practice and the issue would be addressed with the staff member.
● Some areas of the home were not cleaned to a high standard. Two shared bathrooms had not been cleaned thoroughly, and in one there were debris and hair in the bath and on the bath seat. The side of the bath was unclean. In the first floor dining room, some chairs were not clean and food remnants were present on the sides and seats of several chairs. We shared this concern with the management team during feedback at the end of the inspection, and they assured us these issues would be rectified.

The provider had failed to ensure some medicines were stored or disposed of safely. Processes for the safe administration of medicines were not always followed. People were not protected from the risk of infection. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were somewhat assured that the provider was using PPE effectively and safely.
Apart from the incident we observed with one staff member not using PPE appropriately when moving soiled linen, PPE was used effectively to safeguard staff and people using the service.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
Apart from some areas of the home not being cleaned to a high standard, the use of premises, space and hygiene practice promoted safety.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.
A comprehensive policy guided staff on how to manage risks relating to COVID-19. The registered manager acknowledged their admissions procedure was different to the provider's policy, which had not been updated, nor was this in line with government guidance. There were no specific COVID-19 risk assessments for people living with a learning disability.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the

current guidance. A relative said, "During the worst of Covid, I know they kept each floor separate to reduce the risk of infection. Then they started visits in the pod, so we could visit long before other homes I know had started".

We have also signposted the provider to resources to develop their approach.

● We asked people about their prescribed medicines and what they were. Many people could not tell us about their medicines in detail, but did say they could ask staff for pain relief and that this would be given.
● Observations and records showed that people received their medicines as prescribed and that stock was well managed.
● People were supported to take their medicines in a way that met their needs.
● Weekly medicines audits were completed and included an overview of medicines use. The management team completed quarterly audits which had a clinical focus. Staff competency to administer medicines had been completed.
● After the inspection, we received documents to show the person did have capacity in relation to self-administering their medicines. A risk assessment was also sent to us to show how risks were managed and mitigated.

Assessing risk, safety monitoring and management
● Risks to people were identified, assessed and managed safely, with guidance provided to staff which was followed.
● The registered manager told us that risk assessments were started as soon as a person was admitted to the home. They said, "We try and finish the initial care plan, including any risk assessments, within 72 hours".
● Assessments included risks associated with people's health conditions. However, one person's risk assessment in relation to an infection risk that was blood borne, did not identify the potential risks to staff. One staff member did not fully understand the nature of the health condition and how it should be managed. This is an area in need of improvement. We discussed this issue with the registered manager who told us they would review and update the risk assessment. There was no impact to the person, and staff were supporting the person safely.
● Risk assessments relating to Legionella, fire safety, and the evacuation of people in an emergency, were completed as required. Two maintenance staff oversaw the premises and rectified any problems, or external contractors were brought in. We observed fire alarm testing being undertaken during the inspection.

Systems and processes to safeguard people from the risk of abuse
● People were safe living at Kings Lodge Nursing Home. One person said, "I can't grumble. I'm safe here and comfortable".
● Staff had completed training in safeguarding adults. One staff member explained the different types of abuse they might encounter, such as physical, verbal, psychological or institutional abuse. They added they would report any suspected abuse to the registered manager who would then make a safeguarding referral to the local authority and inform the person's next of kin. Another staff member told us, "I've completed safeguarding training. All our training is on e-learning. I've done safeguarding for children as well".
● The registered manager understood their responsibilities with regard to reporting any alleged or actual abuse, and to notify any safeguarding incidents to the local authority and CQC.

Staffing and recruitment
● Staffing levels were sufficient to meet people's care and support needs.

● People were generally happy with staff and spoke positively about them. One person explained, "They help me into my chair, and it takes two of them. I can't get back on my own. Sometimes I have to wait for the staff to help me back to bed". A relative said, "Staff are consistent. People see the same familiar faces and that's important".
● Staff felt there were enough staff on duty. One staff member told us, "Yes, we have enough staff. Recently we had one extra staff on at night and [named registered manager] keeps helping. All the managers try and help us". Another staff member said, "How busy we are can be unpredictable and I try not to rush people".
● The registered manager said there were no problems with recruitment of staff currently, and that agency staff were only used as a last resort. Some staff were accommodated on site in separate housing next door to the home.
● New staff were recruited safely. Staff files we reviewed showed that Disclosure and Barring checks had been completed; these relate to a person's good character and whether they have a criminal record. Potential staff had their employment histories verified, identity checks completed and two references were obtained. Registered nurses had up-to-date Personal Registration Numbers (PIN) to show they had been validated with the Nursing and Midwifery Council.

Learning lessons when things go wrong
● Lessons were learned when things went wrong.
● Senior staff met weekly to discuss clinical risks and any issues, which were used for reflective learning and what could be done differently.
● Staff were familiar with the reporting process for any medicines incidents. Learning from these was shared with staff who felt the home had an open culture and a supportive management team.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care and support needs were assessed before they came to live at Kings Lodge Nursing Home.
- People's preferences on how they wished staff to support them was recorded. Some people's relatives had provided this information on behalf of their loved ones. For example, one person could become extremely anxious if they did not receive their medicines at a particular time, so staff made sure these were administered according to the person's routine.
- The registered manager told us they kept up to date with current guidance through information sharing between managers, from the provider and through CQC news bulletins.

Staff support: induction, training, skills and experience

- Staff were supported through an organised induction programme, and ongoing training.
- People felt that staff were equipped to undertake their caring responsibilities. One person said, "There are nurses and carers here. I fell recently and the nurse was very good. He kept checking me over, he was very caring. I didn't need a doctor".
- One staff member described her induction as, "Gradual. We concentrate on one part at a time. The majority of training was through e-Learning, but some is face to face, like fire training and moving and handling. Someone from the company [provider] delivers this".
- Staff completed training in a range of areas such as infection control, safeguarding, wound management, first aid, and dementia awareness. Staff had access to training on their mobile phones which also flagged up when any training was required or needed to be refreshed.
- Staff received supervisions every couple of months with their line managers. One staff member felt supported by senior staff and added, "We can just go to them and they're very supportive. We have staff meetings too, maybe twice a year".

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported with their dietary needs and encouraged to eat healthily. One person said, "The food is reasonable", and a relative told us, "The food's very good". Another person said, "I enjoy my meals. They're very good. I've got curry today".
- We observed that drinks were freely available to people throughout the day and snacks were also provided. Drinks were within people's reach.
- Meals were served individually and people's choices were marked on a menu sheet, so staff knew which meal was to be served. Portion sizes were generous. In the dining room, we observed people ate independently. One person did not eat very much and staff were overheard encouraging them to eat a little more. People who stayed in bed either ate their meals independently, or were assisted by a member of staff

who sat next to them.
● The chef demonstrated a clear understanding of people's dietary needs. They had completed training in modified diets and gave examples of soft diets and what foods to avoid for people living with diabetes.
● Food choices and suggestions were shared during residents' meetings and the chef could change menus accordingly.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The home worked with a variety of health professionals to provide care that met people's health and support needs. One person said, "I haven't needed to see a doctor. If there was a problem, staff will call the doctor for me".
● Another person required a liquified diet following recommendations made by a speech and language therapist. Their care plan showed they enjoyed smoothies, as they had difficulty swallowing.
● The registered manager told us they worked closely with the Hospital Avoidance Team, and were proactive in the management of people's long-term health conditions.
● During an outbreak of COVID-19 at the home, access to medical support was provided through video calls. The registered manager said, "Now GPs will come and see people when it's really necessary. If people had something like cellulitis or a skin condition, the GP will come and visit".
● People received support through one GP practice, so health advice and support was provided consistently.

Adapting service, design, decoration to meet people's needs
● The home had been designed and decorated to provide a homely and comfortable environment.
● For people living with dementia, their bedroom doors were each a different bright colour, with the room number clearly displayed, and looked like front doors. A storage cupboard door resembled a telephone kiosk. At the end of corridors, there were 'shop fronts' showing signs for a baker and confectioner. Colours were used to good effect and helped people to orientate themselves around the home. On the second floor, a library area had been created, with a range of books for people to browse and a comfy armchair to relax on.
● Some rooms were personalised with people's ornaments and photos used in decoration. Other rooms appeared stark, but it is acknowledged that relatives and friends have been unable to visit people in their rooms when the home was closed due to COVID-19.

Ensuring consent to care and treatment in line with law 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● People received care and treatment in accordance with the MCA and legal guidance.

● We observed that two people had 'gates' across their bedroom doors which were to prevent people from entering their rooms, not to stop them from leaving. One person could be verbally aggressive if people came to their room other than staff, and another person could become very upset if people entered uninvited. The gates had been placed with people's permission.

● Where people might lack capacity to make specific decisions, assessments had been completed. For some, their ability to understand decision-making processes had been evaluated by staff with mini memory assessments. These would identify whether a full capacity assessment was needed.

● DoLS had been applied for as needed and authorisations sought from the local authority. Where conditions to DoLS had been imposed, these were complied with. Where decisions were taken in people's best interests, these were documented and appropriate. One person needed bed rails with bumpers whilst they were in bed. The person lacked capacity to understand why bed rails were needed or that they were a form of restraint. The decision to use bed rails had been taken appropriately and in their best interests.

● Where relatives or representatives had the power to take decisions on behalf of people, Lasting Power of Attorney documents for health and welfare or property and finances were kept on file.

● Staff had completed training on mental capacity. One staff member explained, "Everyone has capacity, we go from there. We don't assume because someone has dementia that the person doesn't have capacity. They might be able to make some decisions, not others".

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People received care in line with their preferences, and their diverse needs were catered for.
- One person said, "It's very good here. I think I've been very happy these past six months. Staff are good if they're not too busy". A relative told us about the initial assessment the registered manager had completed before their loved one was admitted to the home. They explained, "He worked with the family to learn what exactly my relative likes to do and what he doesn't like. The family were all involved in the care planning. It took a while for him to settle in and the staff to get used to care for his needs, but gradually his care got better and better. He's happy, so are we; being here is like being part of a club really".
- Staff confirmed they had completed training in equality and diversity. One staff member said this was about treating everyone equally and added, "One person did not like male carers at first, so was only cared for by female staff. Then he changed his mind and doesn't mind anymore, and that was okay". Another staff member told us that people's spiritual needs were acknowledged. For example, if people wanted to attend church or have a member of the clergy visit them in the home, this could be arranged.
- During a conversation with one relative, the maintenance man came into the lounge to check one person's wheelchair was functioning properly after a recent service. The person and their relative indicated the wheelchair was working well. The relative said afterwards, "[Named maintenance staff member] has always been so helpful and always speaks to my relative by name. In fact all the staff, including housekeeping, know his name and talk to him, which is so important. I don't think I've seen that in other care homes".
- We observed people were cared for by kind and patient staff, who took time to spend and chat with them.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- People were involved in all aspects of their care.
- One person said, "Staff are very good and I get on well with them. I have a couple of friends". Their relative told us, "I've always been very satisfied. [Named person] has routines and staff work hard to keep to them. Even during the pandemic, they tried hard to keep everything in place for him. They always keep me updated and involved with his care".
- We observed people talking with staff who supported them according to their preferences. One person liked to know which staff were on duty, so their names were written down for them to refer to.
- We asked staff how they supported people to express their views. One staff member said, "You sit and talk with them. You have to choose the right time with people, for example, people might be more relaxed in the morning. If people don't want to talk, then I'll leave it. We also talk with the family". Another staff member

commented, "We do try and encourage independence and the majority of people can do things with support".

● We observed staff supporting people in the dining room at lunchtime. The majority of staff were supporting people in a respectful and encouraging manner. However, we observed one staff member was not so considerate. For example, we saw a member of staff patting one person on the back when they had a coughing fit whilst eating. This member of staff was concerned and asked another member of staff about this person's cough. The second member of staff responded, in front of the person, "He coughs because he puts too much in his mouth". This comment did not respect the person's dignity. We shared this concern with the management team during feedback at the end of the inspection, and they assured us this was unacceptable behaviour and would be addressed.

● This was an isolated incident. Our observations showed that staff treated people with dignity and respect. When people received personal care, staff attended to them in their bedrooms, behind closed doors. One person said, "I like to have my door closed at night once I'm asleep and the night staff do this for me".

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received personalised care that was responsive to their needs.
- We observed people were relaxed in the company of staff. Some people chose to spend time in their rooms and staff stopped by to have a chat and check people were comfortable.
- One person said, "About once a week, I like to drink a glass of brandy in warm milk. Staff make that for me and I really enjoy it".
- Staff understood the concept of personalised care and one staff member explained this as, "Treating everyone as an individual".
- Care plans included information about people's lives, their families, their likes and dislikes. Some information was in paper format and some had been transferred to an electronic planning system. The registered manager explained they were still in the process of moving over fully to electronic care plans.
- We asked people whether they were involved in planning their care, but some people were unsure about this. However, one person said, "I don't mind who helps me. I've lost my inhibitions in here. It doesn't matter who helps me". Relatives confirmed they had been consulted and informed of any changes within care plans.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were met.
- For example, there was an 'activities planner' on display in one part of the home, which showed the activities people could choose to participate in, and a picture of that activity. However, the planner was written in green, on a purple background, so was difficult to read.
- We observed that some people found it hard to hear what staff had to say as their mouths were hidden by masks. However, staff respectively spoke more loudly to assist and repeated any requests, making sure people had understood what they were trying to communicate.
- One person had a portable whiteboard which they carried around with them. This whiteboard had information on it which was important to the person and helped provide structure to their day.
- The registered manager said that they could produce information in any accessible format according to people's needs and when required.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
● Activities were planned according to people's wishes and preferences.
● When asked if they had enough to do during the day, one person said, "It's not too bad. Some days are okay and others not. I like watching TV, making cakes, making things. I might go out for a meal, but they don't let me out on my own". We observed people making cakes and one of the activities co-ordinators checked with people whether they want to join in with this or not. Cake mixes were used and people were encouraged to help measure, mix and spoon the mixture into paper cases. People were not rushed and appeared to enjoy the session. The cakes were then taken to the kitchen to be cooked and later people were seen decorating the cakes. The cakes were then shared with others in the afternoon with a hot drink.
● Three co-ordinators organised a variety of activities for people. The registered manager said, "We used to plan events, but now we do what people want. We do have entertainers and we had a memory walk which helped raised funds for our sensory room".
● A relative told us that during the outbreak of COVID-19 at the home, they were in frequent contact with the home by phone, and by email. They said, "Staff were brilliant, and kept me in touch".
● The home had a social media page which was open to anyone to view. The registered manager told us they had obtained the consent of people and their families to share photos. We discussed the risks of having an open page online which could be open to sabotage or negative comments, and the difficulties of monitoring this. The registered manager told us they would review this in light of our comments.

Improving care quality in response to complaints or concerns
● Complaints were recorded and actions taken to respond.
● Complaints were resolved to people's satisfaction and used to make improvements when needed.

End of life care and support
● People were supported at the end of their lives to have a comfortable, pain-free death. No-one was receiving end of life care at the time of the inspection.
● People's wishes were recorded and complied with as they reached the end of their lives.
● Some people had 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. DNACPR is when resuscitation would be considered not to be in the person's best interests if they went into cardiac arrest.
● Staff had completed end of life training, and some had received additional training through a local hospice.
● The registered manager told us they had plans to use 'ReSPECT' forms in the future. The ReSPECT process creates personalised recommendations for people's clinical care and treatment in any future emergency when they may be unable to make or express choices. People's preferences and any clinical information is recorded following conversations between them and their families with health and home staff.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care;

- People did not always receive personalised care that was in line with best practice. 'Right support, right care, right culture' is a strategy produced by CQC which providers supporting people living with a learning disability and/or autism are expected to follow.
- The management team had not heard of this strategy nor were they aware of the contents, so were unable to demonstrate how people were supported in line with this guidance. One of the registered managers told us they would access the document to understand what was needed.
- There was little written evidence to show how people living with a learning disability and/or autism lived a life that reflected their particular needs and preferences. For example, two care plans we reviewed lacked detail and information with regard to people's abilities and social skills. One person's behaviour plan included the triggers which might pre-empt a challenging behaviour. However, an analysis of their behaviours to understand what could precipitate any incident, was not used to understand how a behaviour might be changed towards a positive outcome. In addition, there was no dedicated COVID-19 risk assessment for this person and people living with a learning disability are at high risk.
- After the inspection, the registered manager sent us updated copies of these two care plans. One plan referred to impulsive behaviours and that staff should monitor any behavioural changes. There was no information as to how staff might understand why this person could display behaviours perceived as challenging and how best to support them in a positive, meaningful way.
- A range of audits identified any issues that required actions and were used to drive improvement. However, issues we found at this inspection with regard to the cleanliness of some parts of the home had not been picked-up through the audits.

The provider had failed to ensure that care plans for people living with a learning disability were personalised in line with CQC guidance under Right support, right care, right culture. Audits were not effective in identifying issues found at this inspection. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some information about people's needs was recorded in a personalised way, but was not always easy to access. For example, some information from people's care plans had been transferred to an electronic system, whilst other information was in paper format. This made it difficult to retrieve for the inspection team and for support staff who might need it. The registered manager told us they were working hard to

transfer everything into the electronic care planning system, then all information would be kept in one place.
● Incidents and accidents were reported and monitored by the registered manager. Falls were monitored and included a review of people's medicines to identify whether there was any causation link. Since more people sustained falls during the afternoon, staffing levels had been increased to provide a higher level of support for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their responsibilities under duty of candour. They said, "If something goes wrong, say a safeguarding or an incident, we inform the families and share the learning; we send an apology and learn lessons".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
● The registered managers demonstrated a clear understanding of their roles and responsibilities. There are two registered managers currently, but one is now a regional manager for the provider and is in the process of handing-over to the other registered manager.
● All notifications that were required to be sent to us by law had been completed and received.
● However, as part of registration, a provider is required to notify us of the 'service user bands' they intend to use, in order for us to be assured people's particular needs can be met by the provider. If a provider admits people to the home, confident that they can meet their needs, but as an exception to the service user bands registered, they can do so. The provider would then need to prove to us that they have assessed these people's needs and feel confident these can be met. Even though it may not be necessary to update the service user bands, a provider must amend the statement of purpose. CQC guidance on 'Service user bands' states, 'If in an exceptional one-off circumstance you want to provide a service to someone whose presenting need is outside your service user bands, you must still update your statement of purpose to describe the change in specialist needs that the service is now meeting. You must notify CQC of this update but don't need to add the additional service user band unless you intend to offer services to other people with that specialist need. In this one-off scenario we will not usually add the service user band to your location but will seek reassurance that you can meet the person's specialist needs.' The registered manager informed us they had sought permission to admit two people whose needs were outside of the registered service user bands. However, the provider did not update the statement of purpose to reflect this. We discussed this issue with the registered manager at inspection. If it is the provider's intention to consider admitting people with a learning disability in the future, then this service user band will need to be added to the registration. This is an area in need of addressing.
● The management team completed daily walks around the home to observe care and chat with people and staff.
● People and their relatives knew who the various members of the management team were. One person told us, "It's well run. You have to pay for the best care, but it's very good here". A relative said, "I've got no criticisms about the place. Before the pandemic I could eat here. The staff are very good, although there have been quite a few changes recently".
● 'Ten at ten' meetings occurred three times a week. These were opportunities for nurses and senior care staff, housekeeping, catering and other staff to meet informally to discuss any concerns and share information. Clinical risk meetings were held weekly. Topics such as menus, weight loss, behavioural issues, accidents and incidents were reviewed and discussed. Staff also used social media to keep in touch with each other. One staff member explained, "If you forget something, you can message. We don't include the person's name, just room numbers".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and staff were involved in all aspects of the service.

● A relative told us they had been asked on two or three occasions for their feedback about the home, all of which was positive. Their family member told us, "There's lots of things I like here; I'm very content. There are two staff on duty who I really like today".

● Another relative said, "I feel what's good here is the way the place is set out. There are rails everywhere for people to use and I've seen them used. I like the wide corridors and layout, but it's the staff who make it good here. They find a way of communicating with people here".

● Residents' meetings were organised and suggestions were listened to and acted upon. For example, if people requested a particular meal, this could be included on the menu.

● Staff felt supported in their work. One staff member said, "I just love my job. I go home exhausted but I know I've done good. I look forward to coming to work and on my days off I may come in and help out. We get on pretty well as a team".

● Staff explained there was a two-stage training system, online and face-to-face. Training was made equitable for staff whose first language was not English, allowing the online training to be taken in their spoken language.

Working in partnership with others

● The service worked in partnership with others.

● The registered manager was part of a social media group in the Chichester area including other care home managers. This forum was used to discuss any concerns and share ideas.

● The home worked with a wide range of health and social care professionals, such as the local medical practice, speech and language therapists, and community matrons.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always stored or managed safely. People were not admitted to the home in line with government guidance. Infection prevention and control systems were not robust. People were not protected against the risks of unsafe care and treatment. Regulation 12 (1) (2)

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 provider had failed to ensure that care plans for people living with a learning disability were personalised in line with CQC guidance under Right support, right care, right culture. Audits were not effective in identifying issues found at this inspection. Regulation 17 (1) (2)