Meridian Healthcare Limited

Kingsfield 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Our inspection of Kingsfield care Centre took place on 4 and 6 December 2017 and was unannounced.

At the last inspection on 1, 2 and 5 December 2016 we asked the provider to take action to make improvements around person centred care, consent, safe care and treatment, safeguarding, meeting people's nutritional and hydration needs, staffing and good governance. These actions had not been fully completed at this inspection. We found continued and breaches regarding meeting people's nutritional and hydration needs, safe care and treatment, person centred care, consent and good governance.

The service remains in special measures. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be relating to the same question at each of these inspections for us to continue to place services in special measures. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Kingsfield Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Kingsfield Care Centre accommodates up to 54 people in one adapted building. At the time of our inspection there were 29 people living at the service.

The registered manager had left the service in October 2017. There had been five registered managers in post since the service registered in 2010 and other managers had left the service prior to registering with the Care Quality Commission. 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 time of our inspection the service was being managed by the deputy manager with support from the area director and three local registered managers from the provider's other services. We were concerned at the lack of sustained management at the service.

Safeguarding processes were in place and staff had been trained to recognise signs of abuse. Accidents and incidents were monitored, analysed and actions taken as a result. However, specific assessments were not always in place to mitigate risks to people.

Sufficient staff were deployed to keep people safe and training was in place to equip them with the required skills for their role. Safe recruitment processes were in place. People told us staff were kind and caring. Staff knew people well and some good relationships had developed. Although we saw some caring interactions from staff we also saw a lack of quality interaction from other staff. Staff respected people's privacy and dignity.

Medicines were not always managed safely as the staff member administering medicines on the day of our

inspection left the medicines trolley unsecured during the medicines round.

The service was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, better systems needed to be in place regarding covert medicines and best interest decisions around consent.

Complaints were recorded with actions seen to be taken. People told us they knew how to complain if required and information on how to complain was displayed at the service.

Food and fluid charts were not completed in a timely manner. Dietician referrals were made where people were deemed at nutritional risk. However, we saw some fluids as prescribed by the dieticians were not offered to people or documented on food/fluid charts. The mealtime experience was noisy and we saw little evidence of staff organisation over this period.

Care records were in place. However, these did not always reflect people's current care needs accurately. We also saw care provided did not always reflect people's documented needs.

Communal areas were noisy, with two televisions and the radio playing.

A range of activities were on offer and people could choose if they participated in these.

Staff meetings were in place which discussed a range of service related topics. Although the service had organised resident/relative meetings during the year, no relatives had attended these. We saw an annual resident/relative feedback survey had been conducted with results analysed.

A range of quality assurance audits were in place to monitor and drive improvements at the service. However, these systems and processes had not identified issues we found at inspection which were continued breaches from the inspections in July 2016 and December 2016. The service had submitted action plans following these inspections. We would have expected these actions to have ensured the service was no longer in breach of Regulations.

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

The service was not always safe.

Medicines administration was not always managed safely.

Detailed risk assessments and management plans for specific needs were not always in place.

Staff were recruited safely to ensure they were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive the required nutritional support as prescribed by health care professionals.

Staff had received training to equip them for their role.

The service was working within the legal requirements of the Mental capacity Act 2005. However, best interest processes were not always followed around support and care delivery.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were caring and respected their privacy and dignity.

We saw some caring interventions and staff knew people well. However, we saw a lack of quality interactions in some instances.

The atmosphere in the communal area was not calm or relaxing due to the distracting level of noise from a number of sources.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support in line with their care plans.

A range of activities were in place.

Complaints were investigated and people told us they knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

Continued breaches found at consecutive inspections had not been addressed through the quality assurance and governance systems.

There was no registered manager in post. The service had had not had a consistent registered manager in position for a sustained period of time.

The deputy manager was open and accepted improvements were required at the service.

Kingsfield Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 6 December 2017 and was unannounced.

The inspection team comprised three adult social care inspectors 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 used on this occasion had experience in older people and dementia care.

Prior to the inspection we reviewed information we held about the service, including notifications received from the provider and information from the local authority safeguarding and commissioning teams. No concerns were raised from the local authority. As part of the inspection we ask the provider to complete a provider information form (PIR). This is a document which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we used a number of different methods to help us understand the experiences of people who used the service. We spoke with seven people who used the service, five relatives/visitors, two staff members, the deputy manager, the area director and the cook. We observed care and support in the communal areas of the home. On this occasion we did not use the Short Observational Framework for Inspection (SOFI). People or their relatives were able to speak with us so we gained an understanding of people's experience through speaking with people, informal observations and reviewing records. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at six people's care records, some in detail and others to check for specific information, medication records and other records which related to the management of the service such as training records and policies and procedures.

On 6 December 2017 we spoke with four care staff and three ancillary staff on the telephone. We also asked the deputy manager to send us some information regarding a person's food and fluid chart and other people's falls risk assessments which they did in a timely manner.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Kingsfield Care Centre and felt well looked after. Comments included, "I prefer it here than the last place lived in" and, "I feel a lot safer than when I lived at home as there are people around me who can help me." People who lived at Kingsfield Care Centre and visitors seemed relaxed and comfortable in the company of staff.

However, one relative we spoke with commented, "I don't feel my [relative] is always safe as [relative] slips down the chair and has nearly fallen onto the floor; [relative] doesn't have any communication so I advocate on relative's] behalf. I have mentioned this on several occasions and they have now acquired a reclining chair in the lounge for [relative]" On the day of our inspection, we observed the person sitting in the reclining chair. The chair was not placed in a reclined position to mitigate the risk of the person slipping down the chair. At lunchtime we observed the same person sitting in their wheelchair at a dining table. Their relative was present and asked staff to move their relative into an upright position as they were sliding down the seat. Three staff members assisted the person to sit in an upright position. We were concerned if staff would have reacted if the relative was not present to highlight that the person was slipping down the chair.

Risk assessments were in place which considered falls, choking, skin integrity and mobility. These were regularly reviewed. The risk assessments included the hazards, control measures and a risk rating. These provided staff with guidance and assistance in mitigating risk.

However, we observed during the inspection three people who were mobile were not wearing shoes or slippers and were just wearing socks. The majority of the communal areas had laminate flooring which could pose a slip hazard for people not wearing shoes. We had raised this as a concern at the last inspection in December 2016.

We saw falls risks assessments were in place for all three people just wearing socks. Only one person had a falls risk assessment specific to them refusing to wear slippers and the other two were general falls assessments which included the information. Since one of these people had been identified in the risk assessment as having recent falls, we would expect a falls assessment and care plan in place for this specific risk. This meant the service had failed to maintain complete and accurate records.

This was a breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed one of these people being supported to the table for their teatime meal. We saw they were leaving wet footprint marks on the floor. A staff member saw we were looking at the person's feet and told us, "It's wrote in [person's] plan that [person] only wears socks." The staff had not noticed the person had wet feet. We pointed out to the staff member that the person was wearing wet socks which increased the risk of them slipping on the floor. At this point the area director who was in the dining room asked the staff member to change the person's socks and confirmed the person had been incontinent. The area director then asked the cleaner to mop the wet floor. We were concerned that it was only through our intervention

that actions had been taken and staff would have otherwise sat the person at the table for their meal.

This was a continued breach of Regulation 12, Health and Social care Act 2018 (Regulated Activity) Regulations 2014.

We found medicines were stored securely and the temperature of the medicines room and medicines fridge was checked every day. This helped to make sure medicines were stored correctly. If medicines are not stored at the correct temperature they may not work the way they are meant to.

When medicines were prescribed to be given 'as required' there was guidance in place to help staff make sure these medicines were used consistently. One person we spoke with confirmed they received their medication and could ask for pain relief if they felt they needed it.

Some people were prescribed medicines which had to be taken at a particular time in relation to food. We saw there were suitable arrangements in place to enable this to happen.

Some people had medicines where the amount they needed to take varied, sometimes on a daily basis. The dose was determined by the results of a blood test carried out by an external health care professional. There was a system of recording in place to make sure people received the correct dose. These medicines were dispended in boxes and we checked two people's medicines to see if the stock balance was the same as the record sheet. In one case we found a discrepancy of one tablet, 28 had been received, 17 had been signed for as administered which should have left a stock balance of 11 tablets. However, there were only 10 tablets in the box. We discussed this feedback with the deputy manager and area director. Following the inspection the provider's area director informed us the tablet had been found in a box in the medicines cupboard.

The senior care worker told us when people required medicines by injection, for example insulin, this was administered by the district nurses.

With the exception of one person who had an inhaler which they liked to keep with them no one who used the service managed their own medicines.

We looked at the medication administration records (MARs) and found for the most part these were well completed. There were photographs of people to help with identification when medicines were being administered and the MARs contained information about known allergies.

Staff responsible for supporting people with their medicines had received training. Checks were carried out to make sure they were following the correct procedures. We observed a senior care worker administering morning medicines to people in the large lounge/dining room. They talked with people about their medicines and encouraged them to take them. However, when they went to support people with their medicines they repeatedly left the medicines trolley unlocked with the doors open. This was a risk because some of the people who used the service were living with dementia and were walking around near the trolley. This was raised as a concern at the previous inspection in December 2016 when we recommended staff were given protected time to administer medicines to reduce the risk of interruptions and to ensure the medication trolley was not left unattended.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The senior care worker told us when people were prescribed creams and lotions they were recorded on separate charts, Topical Medication Administration Records (TMARs). They said these charts were kept in

people's rooms. We looked in one person's bedroom and found they had a number of creams prescribed. There was no TMAR in place to guide staff on the application of these creams or to show they had been applied. We brought this to the attention of the deputy manager and the area director during the feedback meeting at the end of the inspection and they told us they would take action to remedy this.

Medicine audits were done at monthly intervals. For medicines classified as controlled drugs stock checks were done and recorded at least twice a day at shift handovers. In addition, the service operated a 'resident of the day' system whereby senior staff checked the care plans and medicines for the named person. The deputy manager told us any issues identified during these checks were addressed with individual staff members in supervision meetings.

The area director told us the provider had processes in place to support services when their audits identified improvements were needed. This was based on the provider's 'Supporting Improvements in medicines management – Medicines Matters' document. However, when we looked at the way the home managed covert (hidden) medicines we found they were not following this guidance and this had not been identified in the audits. This is addressed later in the inspection report.

Where staff were assisting people to move we saw people were handled safely. Staff took their time ensuring people were at ease through every stage of moving and handling. People were treated in a kind and caring way throughout moving and handling manoeuvres. For example, one person was agitated when staff came to assist them to mobilise. We saw staff provided gentle and constant reassurance and explanation to the person.

At our last inspection we had concerns about staff using the same sling for all people that required hoist assistance and the service was in breach of Regulations. At this inspection we saw improvements had been made and the service was no longer in breach of Regulations. Staff documented in people's care records the size and type of sling required for each person. We saw staff used different slings for people when using the hoist. We spoke with the deputy manager after the inspection who confirmed staff used individual slings for people to reduce the chance of cross infection as well as to ensure safe moving and handling.

We saw wheelchairs were in good condition and were being used correctly by care staff. However, we noted wheelchairs were being stored in the smoking room which meant they smelt strongly of smoke. This had also been identified at the previous inspection and had not been addressed by the provider.

Safeguarding processes were in place. Staff had received safeguarding training and told us they had been taught to recognise signs of abuse. We saw appropriate safeguarding referrals had been made to the local authority and the Care Quality Commission and investigated.

The service held small amounts of personal money for people who used the service. This was typically money left by people's relatives to pay for hairdressing and other additional services. The money was held securely, receipts were issued when money was deposited and for any money spent on people's behalf. All transactions were recorded. The deputy manager carried out random checks and told us staff from the provider's head office also made periodic checks to make sure people's money was being managed properly. This helped to protect people from the risk of financial abuse.

At our last inspection we had concerns about the recording, analysis and actions from accidents and incidents and the service was in breach of Regulations. As part of our inspection we looked at accidents and incidents and found improvements had been made which meant the service was no longer in breach of Regulations. We saw accidents and incidents were recorded appropriately on specific forms with the

information then transferred onto the corporate database. We saw these had been audited and analysed to check for any trends and to drive service improvements. Incidents investigation reports were completed for serious incidents, with care plans reviewed following incidents. We saw actions in place to help reduce risk following incidents. For example, one person had managed to leave the building using a faulty fire escape. This was reported to the local authority and the Care Quality Commission, the person's care plan had been reviewed and repairs made to the faulty doors. We checked and found these actions had been done.

Most staff had received face to face falls training and some staff had been made 'falls champions'. We saw separate falls meetings were held on a regular basis which included looking at hazards, risks, analysis of falls and the use of assistive technology to mitigate the risk of falls. We saw falls were also discussed during staff meetings. This showed the service had made improvements in the analysis of these incidents to mitigate risks to people living at the service.

During this inspection we found staffing levels were appropriate to people's needs and our review of the staff rotas confirmed this. The deputy manager told us the usual staffing levels were one senior care staff and five care staff. On the day of inspection one care staff member had phoned in sick and the deputy manager arranged for other staff members to cover their shift. The deputy manager was not included in the numbers. Overnight there were three staff on duty, one of whom was a senior care staff member. In addition to care staff the home employed separate staff for housekeeping, catering and maintenance. There was also an activities co-ordinator who worked 20 hours each week; this was usually 20 hours during the day. However although most staff confirmed sufficient staff were currently deployed, some staff told us too many staff were deployed on occasions and not enough deployed on other occasions. Comments included, "Now I feel there is enough staff in the mornings. Staffing has improved", "When staff turn in there's enough staff. Also depends on the day and the needs of the residents", "Not enough staff at night. Staff come and go", "Overstaffed sometimes and under others. Lately we've been okay," and, "Not enough staff every day; some days there's not enough and sometimes too many."

The deputy manager told us they had recently recruited three staff although they still had staff vacancies, equivalent to 99 hours during the day and 33 hours at night time. They told us they currently used agency staff if they were unable to achieve sufficient staff numbers through regular staff working extra shifts.

We checked three staff files to ensure safe recruitment practices had been undertaken. The records showed all the required checks had been completed before the new staff had started work. This included two written references and Disclosure and Barring Service (DBS) checks were obtained prior to employment. Applications were in place along with the applicant's work history and we saw there were no employment gaps which required exploring. We also saw appropriate disciplinary processes were in place. This helped ensure people were protected from the risk of being cared for by staff who were unsuitable to work in a care setting.

We found people had personal emergency evacuation plans (PEEPs) in place. PEEPs provide additional information on accessibility and means of escape for people with limited mobility or understanding.

On arrival we found the home had a malodour in many parts of the building. Many of the armchairs in the lounge were malodorous. We spoke with the deputy manager and the area director who told us the service could order replacement chairs if required. However, during the inspection we found the building malodour improved and was only present in a small number of areas such as the lounge.

During our inspection, we looked around the building and found communal areas to be clean and tidy. The area director told us the reception area had been refurbished since our last inspection and we saw this

looked clean and smart. We saw a maintenance person was employed at the service and the service was well maintained. Appropriate safety checks such as fire, gas and water checks were carried out and documentation of these was in place. We saw water temperatures were within acceptable limits and this was confirmed when we checked water temperatures in different locations in the building. This had been a concern at our previous inspection. Regular servicing of equipment such as hoists, fire extinguishers and electrical equipment was carried out.

Staff wore aprons and gloves and we saw sanitising stations throughout the service. At the last inspection we were concerned about a lack of toilet rolls, hand towels and bins in people's en-suite bathroom and a lack of bins in communal bathrooms and toilets. At this inspection we saw this had been addressed.

However, we saw in the laundry room the washing machine and dryer were placed next to each other which created a risk that clean clothes could easily come into contact with soiled items. We did not see any system in place to prevent cross contamination.

Similar concerns were identified during our previous inspection in December 2016.

This is the third consecutive inspection where the provider had been in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had been awarded a level 5 for food hygiene by the Food Standards Agency which is the highest rating possible.

Requires Improvement

Is the service effective?

Our findings

People and the relatives we spoke with all felt the staff knew them and were able to meet their needs. One person said, "The staff are a mixed bunch and treat me well. I don't have any complaints." Another person told us, "I have to use the standing hoist which I don't like and this can get me agitated and shout. The staff are very good me with me and calm me down. They know what they are doing."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The deputy manager had a list of the DoLS applications which had been made and this showed when the authorisations were due to expire. We saw applications for renewals had been submitted well in advance of the expiry date, although some authorisation responses from the local authority were still outstanding. When DoLS authorisations had been granted with conditions we saw these conditions had been complied with.

We saw staff training was in place around MCA and DoLS. Staff we spoke with had a good understanding of the Act and what impact this had on people living at the service who had DoLS in place.

A Lasting Power of Attorney is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and financial affairs or health and welfare.

The deputy manager had a list of those who had Lasting Power of Attorney (LPA) for people who used the service. However, we found the list was incomplete. It is important this information is available so that staff know who has the authority to make decisions for people and what decisions they can make.

Two people who used the service were having their medicines administered covertly. Covert medicines are medicines that are given without the person's knowledge, for example, disguised in food. Covert medicines should only be given when the person is deemed to lack capacity and when administering covert medicines has been assessed as being the least restrictive option in that person's best interests.

In one person's records we found a letter from a GP dated December 2015 giving the home permission to administer their medicines covertly and if necessary to crush tablets. There was no evidence the best interest decision making process had been followed and no evidence of consultation with the person's relatives or pharmacist. There was no evidence to show the decision had been reviewed. The person had a medicines care plan in place but this did not include details of which medicines could be administered covertly or in what format. An application had been made for a DOLs authorisation and was awaiting authorisation from the local authority; the previous DoLS had expired on 8 November 2017. There was no information on the DoLS application about covert medicines.

Similar concerns were identified during our previous inspection in December 2016.

This is the third consecutive inspection where the provider had been in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we had concerns about care staff and kitchen staff's knowledge about people's dietary needs and people's dietary requirements not being followed. At this inspection the cook was able to tell us about people's dietary likes and dislikes as well as specific dietary requirements such as supplements. Staff we spoke with were also able to tell us about people's nutritional requirements. We saw the cook had information in the kitchen with information relating to this. At the time of inspection special diets were catered for; four people were on a soft diet, two on a puree diet and a diabetic. The cook explained that all meals were cooked from fresh and those who required meals fortified would have added cream, butter, cheese and full fat milk. The cook stated they had received no specific training around fortification but understood what to do. The cook told us staff kept them up to date with any changes and had contacted the SALT team on occasions for advice on a person's individual dietary needs. The cook explained that milkshakes were offered to people who required additional fortification which had added milk powder and ice cream. We saw one person's SALT assessment completed on 6 November 2017 had requested they be offered two milk shakes daily or two milky drinks. We saw staff offered people hot drinks of tea or coffee mid-morning and afternoon. However we did not observe anyone having or being offered a milk shake or any hot milky drinks. We checked the person's fluid charts which only showed hot drinks had been offered. There was no mention of milky drinks or milk shakes being given. The cook told us snacks offered in the afternoon were homemade cakes or biscuits. However, we saw only biscuits were on offer in the afternoon.

Where people were nutritionally at risk, we saw their weight was monitored and a malnutrition universal screening tool (MUST) had been completed. However one person's MUST tool information about their weight loss did not correlate with the information documented on their Waterlow score. The primary aim of the Waterlow tool is to assist staff to assess risk of a person developing a pressure ulcer. The Waterlow tool consists of seven items: build/weight, height, visual assessment of the skin, sex/age, continence, mobility, and appetite, and special risk factors, divided into tissue malnutrition, neurological deficit, major surgery/trauma, and medication. Both of these had been completed on 17 November 2017. We saw this person was classed as at risk nutritionally and had been referred to the dietician so would expect these tools to be accurate and completed correctly.

At breakfast time people were offered a choice of cereals, porridge, toast with jam or marmalade and hot and cold drinks. We observed people were offered a choice of three meals at lunch time. Staff showed people a plate of each meal to assist them choose which they preferred.

We observed that meals times were rushed, chaotic and staff appeared to have no clear direction. This meant some people were waiting for main meals whilst others were eating their dessert. The dining room was noisy due to the radio and television playing at the same time. We saw staff were removing people's

plates before they had finished their meal. We saw four different staff members interacting with a person whilst they were eating their meal. The person looked bemused and ended up shouting and telling the staff to leave them alone. Some plate guards were in use to assist people to eat independently but not given to other people who we saw would have benefitted by them. We saw some people required assistance from staff with their meal. Although most staff assisted with patience and kindness and sat next to people to assist them, they did not explain the individual components of the meal to people. We also saw some staff did not communicate with people as they were assisting them with their meals.

We saw staff moved one person from the table to the lounge area due to an altercation. Once sitting in an armchair, the person became sleepy. A member of staff placed the person's plate of food on a low small table in front of them. It would have been difficult for the person to eat comfortably in that position. We observed staff made two attempts to encourage them to eat their meal but did not sit the person at a different table where it would have been easy for them to reach their food. The plate was then removed without them having finished their meal. This meant the person had not received appropriate support to ensure they ate well.

Another person who was asleep in a chair in the lounge area at the start of the lunch period had been assessed by the SALT team for a soft diet and for their fluid intake to be documented. We saw initially a normal plate of food rather than a soft diet was placed in front of them where they were sitting. This meant the person was given a meal that was not consistent with the recommendations from the SALT team and placed the person at risk of choking or aspiration from the incorrect preparation of their food. Staff assisted the person to a dining table after about ten minutes, where they were given assistance to consume a soft diet. We saw a full beaker of juice with a lid and spout was placed in front of them. A staff member came to sit with them and assisted them to consume a few mouthfuls of juice. However, we saw staff did not communicate with the person whilst supporting them. We saw the beaker was left half full when the staff member left to do another task and another staff member removed the beaker after a few minutes. This meant the person had not received enough support to ensure they drank the full amount in the beaker. However, we saw later that afternoon the staff member was completing the fluid chart and told us the person had drunk a full beaker of juice. They told us, "But I helped [person] drink." We spoke with the staff member and they agreed the person had only consumed half of the beaker of juice.

Food and fluid charts were in place for those assessed at nutritional risk. We saw people had a target of an amount of daily fluid to be taken each day and these were mostly attained. The deputy manager told us staff should complete these after each meal or intake of fluid. However, we saw staff completing all the food and fluid charts for the day at 15:10. We asked one staff member how they could remember at that time what each person had consumed since they had got up that morning. They told us staff observed and remembered. However, when we spoke with the staff member, they incorrectly remembered one person's fluid intake at the lunchtime period. We had observed and documented this at the time. The deputy manager and area manager told us this was an isolated incident and would speak with the staff concerned. They confirmed the staff members received supervision following our inspection. However we remained concerned that food and fluid charts were not completed accurately and in a timely manner.

Similar concerns were raised at our inspection in December 2016.

This is the third consecutive inspection where the service had been in breach of Regulation 14, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were also concerned our observations of the late completion of food and fluid charts meant complete and contemporaneous records were not being completed in respect of each person living at the service.

This is the third consecutive inspection where the service has been in breach of Regulation 17, Health and Social Care Act 2018 (Regulated Activity) Regulations 2014.

Staff and the deputy manager told us handovers were conducted at the start of each shift and a daily 'flash' meeting took place where any concerns were discussed. We saw these took place. Staff told us these were a valuable tool for keeping informed about people, their healthcare needs and any service updates. The deputy manager told us they also received support from managers from other services within the group.

At the last inspection, the service was in breach of Regulations regarding ensuring people's medical needs were met. At this inspection we saw improvements had been made and the service was no longer in breach of Regulations. Care records showed people had access to a range of health and social care professionals such as GP's, district nurses, dieticians, opticians and dentists. For example, we saw the service referred people at nutritional risk to the speech and language therapy (SALT) team. Two of the people we spoke with said they knew their GP and felt comfortable asking the staff to call the GP if they felt unwell. Where required, appropriate equipment such as crash mats, hoists and bed sensors were in use. We saw people had been assessed for equipment appropriately.

The home was also taking part in a trial of a digital health system. This had been designed so staff could consult a variety of healthcare professionals via video link if concerned about a person's health and receive speedy advice, potentially avoiding unnecessary hospital admissions. The deputy manager told us this was proving beneficial and gave examples of how they were using the system to good effect. This showed the service was working with other organisations to deliver effective care, support and treatment.

We saw pre-admission assessments of people's care and support needs in people's care records. However, we saw no evidence of hospital passports in people's care records. Hospital passports give key information about the person and their required care and support in case of hospital admission.

During the inspection we saw people were given choices and staff asked for people's consent prior to carrying out care and support. We saw in care records that people and/or their relatives had been involved in care reviews and we saw letters had been sent to relatives, inviting them to take part in people's care reviews.

At our last inspection the service was in breach of Regulations in relation to staff training. At this inspection we saw sufficient improvements had been made for the service to be no longer in breach of Regulations. A structured training plan in place along with an up to date training matrix. This showed the training staff had completed and when refreshers were due. We found most staff had completed the required training. This meant people received care and support from staff that had knowledge and skills in the required areas. Where some staff had not updated their required training we saw this was being managed by the deputy manager through the disciplinary process.

We looked at whether staff had received specific training to meet the needs of the people at the home; for example, we found that many people living at Kingsfield Care Centre were living with dementia. We could see from the training matrix that most staff had completed dementia training, person centred approaches to dementia care and understanding and resolving behaviours that challenge. One staff member told us, "The dementia training has taught me a lot. It's not just about respecting people but also understanding how our behaviours and approaches have an impact on the individual. We have to ensure that care is centred around the individual according to their needs and delivered in the kindest way."

The service had introduced champions to promote topics such as falls, dignity and dementia. We saw the

falls team had met to look at ways to reduce risk and the incidence of falls within the service. The deputy manager told us this had been effective in reducing the number of falls.

There was a structured supervision and appraisal system in place. Staff received individual supervision from the deputy manager. Annual appraisals were completed with staff which covered topics such as competencies, handling infection, value based behaviours, objectives, goals and development. Staff who administered medication had been observed doing this to demonstrate they were competent, assessments were present for the relevant staff. A matrix was in place which demonstrated when supervisions were planned and had taken place.

We saw people were encouraged to furnish their bedrooms with personal possessions such as ornaments, pictures and photographs. Memory boxes were attached to the wall outside each person's bedroom which contained small items of importance to them such as photographs and postcards. Staff told us they used these to promote conversation with people. We found the service was brightly decorated and saw photographs displayed in the communal areas of people and events they had taken part in. The service had an enclosed patio area that people could access safely and freely. During our inspection we saw one person spent time walking around this area. This meant the design of the service had incorporated the needs of people who enjoyed spending time outside whilst maintaining a safe environment.

Requires Improvement

Is the service caring?

Our findings

People we spoke with said they were all well cared for and well looked after. Some of the comments included, "All the girls are brilliant. They know me and are very good. They look after me. I can talk to them", "The staff call me by my first name. They are all friendly. I can ask any of them to help me and they do help" and, "The staff are very good; they have time to listen to me. I get upset easy and they reassure me it is good to cry sometimes. This makes me feel better and without them to talk to I would be very sad."

The relatives/visitors we spoke with were highly complimentary of the staff and felt their loved ones were well looked after. One relative commented, "It is not easy for the staff as a lot of the residents are very difficult to manage."

Most staff we spoke with were enthusiastic about their roles and told us they enjoyed working with the people living at Kingsfield Care Centre and gained satisfaction from their roles. Comments included, "I love interacting with the residents. I enjoy my job", "I love it and the residents. You can have a laugh with them" and, "I love the way we look after them. By caring for them you're giving them the interaction they need. I go in on my days off."

Staff had good knowledge about people and we saw some positive relationships had developed between staff and people living at Kingsfield Care Centre. However, we also saw some examples where staff did not ensure quality interaction with people. For example, when we were observing in the conservatory, staff came in regularly to check if the two people sitting there were okay. However, apart from, "Are you ok?" and other pleasantries, staff did not engage either in meaningful conversation or quality interaction with the people. We also saw another staff member assisting a person with a few sips of drink at the table at lunchtime. We observed the staff member did not engage with the person or offer encouragement and left the beaker on the table after a few mouthfuls had been taken.

Throughout our inspection we saw that staff were kind and compassionate in the way they provided care and we observed some instances where staff engaged with people and reassured them when providing assistance. For example, we observed one staff member offering a person reassurance when they became confused and were accusing people of taking bags of money. It was clear they knew the person well and took appropriate action to help calm them.

We saw staff knocked on people's doors before entering bedrooms and respected when people wished to spend time by themselves. This showed staff respected people's right to privacy. Staff gave us examples of how they respected people's dignity; for example, asking discretely if they needed the toilet, covering them with a towel and ensuring curtains were closed when providing personal care.

We were concerned about the high levels of distracting noise during the morning and at mealtimes. This did not facilitate a calming atmosphere. For example, we observed for a while in the conservatory during the morning. At the time, the television was switched on with the volume turned up high and at the same time there was loud music coming from the music activity taking place in the lounge area since the CD player was

located by the conservatory door. It was also possible to hear the television playing in the lounge area. This created a confusing sensory overload and it was unpleasant to be in this environment. There were two people sitting in the conservatory at the time, one of whom was trying to watch the television but unable to hear properly due to the noise coming from the music playing and the other television.

We recommend the service accesses and implements best practice guidelines regarding noise levels and the impact upon people living with dementia.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We did not see any evidence of discrimination during our inspection and people were treated with respect.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed and care plans were in place to show how people should be supported to ensure they received safe and effective care which met their individual needs. We saw people's care records documented preferences such as likes and dislikes. Staff reviewed care plans and risk assessments monthly. We saw evidence of people's representatives being invited to care reviews. One relative we spoke with told us they had been involved with planning their relative's care.

However, care records did not always reflect people's current needs. For example, one person had returned from hospital with a pressure sore. The person's care review stated 'care staff need to ensure regular two hour pressure relief and moisture hygiene are met.' The skin integrity plan had not been updated to reflect the person's changing needs or a specific plan written to manage pressure care. There were no charts in place to demonstrate pressure relief had been given. We asked the deputy manager whether the individual was receiving pressure care and how this was evidenced; they were unable to demonstrate this. Following our inspection we raised a safeguarding alert about this to the local authority.

We saw another person's MUST tool had been updated on 17 November 2017. This indicated the person had no weight loss greater than 5% over the last three to six months. The person's Waterlow assessment completed by the same staff member on 17 November 2017 indicated more than 10%weight loss in the past three to six months. This meant the two assessment tools did not correlate. We checked the person's weight chart. Some date information was recorded and other dates were missing so it was difficult to assess if the person had lost more or less than 5% over the period. This meant there was incomplete or inaccurate documentation about the person's weight. However, we saw the SALT team had reassessed the person on 20 November 2017 and their advice was reflected in the care records.

We saw another person displaying behaviour which challenges during our inspection. Staff told us how they dealt with this through redirection. However, there were no care records in place for this or to guide staff about triggers/action to take. We saw the person had a risk assessment in place for 'risk of isolation due to agitation.' This assessment instructed care staff to 'use distraction techniques.' However, there were no details of what these might be other than 'sometimes talking about life story helps.'

The same person's nutritional care plan dated 17 February 2017 stated they should have two milky drinks a day or homemade milkshakes. We reviewed their fluid intake charts for five days from 29 November 2017 to 3 December 2017. These showed mainly tea and juice consumed. The only exception was one drink of coffee with cream at 2pm on 3 Dec 2017. We asked a staff member about the person getting two milky drinks a day. They replied that the person had milk in their tea. The fluid chart did show the person was getting adequate fluids, more than their 1337mls target every day. However, we were concerned the person was not receiving milky drinks as indicated on their nutritional care plan.

Another person's care records stated 'requires glasses' in their admission information and their communication care plan, safe environment care plan and personal care details stated, '[Person] to wear

glasses daily', '[Person's name] needs to have [person's] glasses on every day,' and, 'wears glasses for distance and reading.' We did not see the person wearing their glasses at any point during the inspection or staff noting the person was not wearing these.

The same person's care plan, reviewed on 17 November 2017 said they were to be 'helped to the toilet every two hours.' We did not observe this to happen during the morning of the inspection when we were observing within clear eyesight of the person. We also saw this person's nutritional care plan, reviewed on 17 November 2017, stated they should have two milky drinks or milk shakes daily. We reviewed their fluid charts from 1 December 2017 to 3 December which only documented tea or juice had been consumed. We did not see any milky drink offered during our inspection on 4 December 2017.

These examples showed people did not always receive care in line with their plans of care. One staff member told us, "Don't get time to read care plans."

This is the third consecutive inspection where the service had been in breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities programme on the wall displaying what activities were happening each week. An activities co-ordinator worked 20 hours per week. Activities in the home included armchair aerobics, painting, baking and hand massage. During the inspection we observed people taking part in a 'sing-along' and a group game during the morning and playing dominoes in the afternoon. Some people chose not to participate in the activities and their wishes were respected. People told us they enjoyed the activities on offer although one person told us they would like more organised activities to be offered.

We saw the service used a range of assistive technology to assist with care and support, such as a digital health system and bed monitoring sensors.

Information about the service's complaints procedure was displayed in the reception area. The complaints records showed complaints were dealt with in line with the provider's policy. Complaints were investigated and the complainant responded to in writing. We saw compliments were also recorded so that the service knew where they were meeting and/or exceeding people's expectations. One person told us, "I would go to the staff and if that didn't work I would ask to speak to the manager."

The deputy manager told us no-one at the home was receiving end of life care at this time. We saw care records reflected people's end of life wishes.

We asked the deputy manager if anyone living at the service required assistance with accessible information; for example, if anyone living at the service had a sight, speech or hearing impairment. They told us nobody currently living at the service was registered blind. They said they made referrals to the GP if a person required a hearing aid or to the GP or opticians if they were concerned about a person's sight. We saw regular visits from the GP and opticians were made. The deputy manager told us they had not been asked for information about the service in large print but was sure they would be able to access this if required. During the inspection we saw staff spoke with people clearly and at eye level to assist with communication. However, we did see one person's care record clearly stated they should wear their glasses at all times and this did not happen throughout our inspection.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in position at Kingsfield Care Centre. The previous registered manager had left in October 2017 and the service was currently being managed by the deputy manager. The deputy manager was supported by a regional director who was present during our inspection and managers from two other services within the group. Although we saw the service was receiving management support, the deputy manager expressed concerns and told us, "I've been put in the position. I need more support. I get overwhelmed." However, they told us the area manager would visit if they rang for assistance and was accessible to them via the telephone when required.

We were concerned there had been no consistent manager in place at the home for a sustained period of time. The service had registered in 2010. During this period, five registered managers had been appointed and subsequently left the service and other managers had left prior to completing the registration process. These concerns were reflected in relatives' comments from the June 2017 survey which included, 'Very hard to rate management due to the poor management cover over the last 18 months...lack of stable managers has reflected in the morale of the seniors and care workers.' The area director told us they had plans to develop the service and appoint a new manager.

The majority of the people we spoke with who lived at Kingsfield Care Centre didn't know staff names although two people told us they knew who the deputy manager was. They told us they would approach staff if they had any concerns. The relatives/visitors we spoke with were aware the registered manager had left and told us there was an acting manager who they felt was approachable.

Staff we spoke with were mostly positive about their role and the management team. Comments included, "I find [deputy manager] approachable. I can go in (the office) whenever I need anything. Staff morale is really good. Staff all work together really well", "Staff get on well and work together as a team", "I feel able to raise concerns with the management team. Most staff work well together. Staff pull their weight" and, "I feel supported. Feel I could approach [deputy manager]. It used to be tense; it's better now. We all work together." However, one staff member told us they did not feel supported in their role.

We saw the deputy manager conducted a daily walk around of the service and was a visible presence in the home. We found them open about the improvement path the service was on and accepted improvements were still required.

We saw people living in the home and their relatives were asked for their opinion of the service through an annual quality survey. We saw the results for the June 2017 survey had been analysed and a rating generated. We saw responses were generally positive. However, when we reviewed the ratings for 'management' in the relative feedback response, this showed a 20% excellent rating and a 0% poor rating. When we looked at the actual figures in the document, these showed a 20% very poor response and 0% excellent response. This corresponded with the comments about relative concerns about sustained management. We did not see any actions identified as a result of the survey results or how this information was fed back to people or their relatives.

A range of audits and quality assurance processes were in place with actions and analysis to drive service improvements. These included maintenance checks, daily medicines audits, call bell audits and care plan audits. However, the issues we found at inspection had not been identified during these processes, such as covert medicines, nutrition and hydration charts, care plans and consent. This meant systems were not sufficiently effective. We had also identified these concerns at our last two inspections.

We saw the service had worked with the local authority and was supported by the provider's internal quality team to drive improvements with the service. However, we were concerned about the repeated breaches found at this inspection. Robust governance and quality assurance processes should have ensured the service was compliant with Regulations. Several of the breaches we found during our inspection were third time breaches.

This is the third consecutive inspection where the service has been in breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff meetings were held regularly and these were well attended. We reviewed the minutes from the meetings and saw discussion items included falls, health and safety, keyworker roles, reviews, person centred care, memory boxes, dignity, nutrition and mental capacity. Staff told us they felt able to voice any concerns during these meetings.

We saw the service had organised relatives meetings throughout the year to involved them with the service. However, we saw no relatives had attended these meetings.