Care Quality Commission

Care Uk Community Partnerships Ltd

Kingsfield Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection was carried out on 10 and 14 September 2015 and was unannounced.

At our previous inspection on 10 December 2014, we found a breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. The breach was in relation to staff training.

The registered manager sent us an action plan on 26 January 2015 showing how and when the regulation would be met. At this inspection, improvements had been made, the registered manager had completed all the actions they needed to take to meet the regulation.

The home provided accommodation, nursing and personal care for older people some of whom may be

Summary of findings

living with dementia. The accommodation was provided over three floors. A lift was available to take people between floors. There were 82 people living in the home when we inspected.

There was a registered manager employed at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The registered manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

Details were recorded in people's care plans and assessments about how nursing staff should monitor people's health. However, the care and treatment people received did not always follow their assessed needs. Effective arrangements were not in place to review care plans to ensure staff responded appropriately and in good time to changes in people's planned care.

There were two systems in use to record the care people had received. This reduced the effectiveness of the systems used and created inconsistent processes for recording information for staff to follow. We have made a recommendation about this.

People felt safe and staff understood their responsibilities in balancing people's rights against protecting people from harm. Staff had received training about protecting people from abuse. The management team had access to and understood the safeguarding policies of the local authority and followed the safeguarding processes. The registered manager followed the homes stated aims and referred people to other homes when they could no longer meet people's needs safely.

The registered manager and care staff used their experience and knowledge of people's needs to assess how they planned people's care to maintain their safety. Risks were assessed and management plans implemented by staff to protect people from harm.

There were policies and a procedure in place for the safe administration of medicines. Nurses followed these policies and had been trained to administer medicines safely. People had access to GPs and their health and wellbeing was supported by nursing staff. Prompt referrals were made for access to medical care if people became unwell.

Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected. People and their relatives described a home that was welcoming and friendly. We observed staff providing friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered.

The registered manager involved people in planning their care by assessing their needs when they first moved in and then by asking people if they were happy with the care they received. People's capacity to make day to day decisions was assessed and their best interest was taken into account if people were unable to make informed choices. People had been asked about who they were and about their life experiences.

Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again. The risk in the home was assessed and the steps to be taken to minimise them were understood by staff.

Managers ensured that they had planned for foreseeable emergencies, so that should they happen people's care needs would continue to be met. The premises and equipment in the home were well maintained.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the home. The registered manager ensured that they employed enough staff to meet people's assessed needs. Staffing levels were kept under review as people's needs changed.

Staff understood the challenges people faced living with dementia. Staff had received training and induction when

Summary of findings

they started working at the home and the training continued to be updated. Nurses were registered with their professional body and undertook the training required to maintain their registration. Staff supported people to maintain their health by ensuring people had enough to eat and drink.

If people complained they were listened to and the registered manager responded to complaints appropriately. The actions taken were fed back to people.

People felt that the home was well led. They told us that managers were approachable and listened to their views.

The registered manager of the home and other senior managers provided good leadership. The provider and registered manager developed business plans to improve the home. This was reflected in the positive feedback given about staff by the people who experienced care from them.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

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 safe.

People experienced care that made them feel safe. Staff knew what they should do to identify and raise safeguarding concerns. The registered manager acted on safeguarding concerns and notified the appropriate agencies.

There was sufficient staff to meet people's needs. The provider used safe recruitment procedures and risks were assessed. Medicines were managed and administered safely by nursing staff.

Incidents and accidents were recorded and monitored to reduce risk. The premises and equipment were maintained to protected people from harm and minimise the risk of accidents.

Good

Is the service effective?
The service was effective.

People were cared for by staff who knew their needs well. Staff understood their responsibility to help people maintain their health and wellbeing by working with other health and social care professional. Nurses and care staff encouraged people to eat and drink.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

Staff received an induction and training and were supported to carry out their roles. Nurses continued their professional development. The Mental Capacity Act and Deprivation of Liberty Safeguards was followed by staff.

Good

Is the service caring?
The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect.

Good

Is the service responsive?
The service was not always responsive.

People were not always provided with care based on their needs assessments and changes in people's needs were not always implemented.

Requires improvement

Summary of findings

Information about people was updated often, but care plan reviews were not always effective. People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about and the registered manager listened to people's concerns. Complaints were responded to and the registered manager tried to resolved complaints to peoples' satisfaction.

Is the service well-led?

Requires improvement

The service was not always well led.

Two systems were in place to record the care people received which were complicated and unclear.

There were structures in place to monitor and review the risks that may present themselves as the service was delivered and actions were taken to keep people safe from harm.

The provider and registered manager promoted person centred values within the home. People were asked their views about the quality of all aspects of the home.

Staff were informed and enthusiastic about delivering quality care. They were supported to do this on a day to day basis by leaders within the home.

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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 10 and 14 September 2015 and was unannounced. The inspection team consisted of four inspectors, a nurse specialist and one expert by experience. The expert-by-experience had a background in caring for elderly people and understood how this type of home worked.

Prior to this inspection we received information of concern relating to care at night, poor choices of food, poor interactions with people by staff and poor pressure area management. Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the home, which the provider is required to tell us by law.

We spoke with four people and six relatives about their experience of the home. We spoke with eleven staff including the registered manager, deputy manager, one senior care worker, three nurses, four care workers and a member of the cleaning team to gain their views about the home. We spoke to the Kent County Council commissioning team about the home. We observed the care provided to people who were unable to tell us about their experiences. We asked a health and social care professional for their views of the home.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at eight people's care files, eleven staff record files, the staff training programme, the staff rota and medicine records.

Good

Is the service safe?

Our findings

We observed safe care at Kingsfield Care Centre. People who could express their views about the service did not have any concerns about their safety. Relatives felt that their family members were safe and gave us examples of how staff responded appropriately to their relatives when they did have concerns.

Staff followed the provider's policy about safeguarding people and this was up to date with current practice. Staff were trained and had access to information so they understood how abuse could occur. Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place. Staff spoke confidently about their understanding of keeping people safe. Staff gave us examples of the tell-tale signs they would look out for that would cause them concern. For example bruising. Staff understood that they could blow-the-whistle to care managers or others about their concerns if they needed to. Staff were aware that people living with dementia may not always be able to recognise risk or communicate their needs.

Any concerns raised were recorded and the registered manager understood how to protect people by reporting concerns they had to the local authority and protecting people from harm.

People had been assessed to see if they were at any risk from falls or not eating and drinking enough. If they were at risk, the steps staff needed to follow to keep people safe were well documented in people's care plan files. Additional risks assessments instructed staff how to promote people's safety. Staff understood the risks people living with dementia faced and we observed staff made sure they intervened when needed.

Our observation and discussion with staff showed that staffing deployment was based on an analysis of the levels of care people needed. How staff would be deployed was discussed before shifts started so that the skills staff had could be matched to the people they would care for. Staff responded to people quickly when they needed care which reduced the risk of people falling or becoming upset. There were enough staff available to walk with people using their walking frames if they were at risks of falls. Staff moving people using a hoist did not do this on their own, they did this in two's to protect themselves and people they were moving.

Risks were minimised and safe working practices were followed by staff. Incidents and accidents were investigated by the registered manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. We saw risked assessments were updated after Incidents.

People were cared for in a safe environment. Equipment was serviced and staff were trained how to use it. The premises were designed for people's needs, with signage that was easy to understand. The premises were maintained to protect people's safety. There were adaptations within the premises like ramps and handrails to reduce the risk of people falling or tripping. Equipment was provided for those who could not weight bear so that they could be moved safely.

There were enough staff to ensure the care people received was safe and they were protected from foreseeable risks. Staffing levels were planned to meet people's needs. In addition to the registered manager and deputy manager, four qualified nurses and a senior carer there were fifteen staff available to deliver care during the day. At night, three nurses managed seven staff delivering care. The rota showed that staffing levels were consistent and that systems were in place to cover staff absences. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were available to people.

People were protected from the risks associated with the management of medicines. Nursing staff followed the provider's policy on the administration of medicines. People who could not make certain decisions because they were living with dementia received medicines after a best interest assessment. The registered manager checked staff competence by observing staff administering medicines, ensuring staff followed the medicines policy. Medicines were stored safely in lockable storage available for stocks of medicines and access was restricted to trained staff. Medicine's in storage and ready for administration in the lockable medicine trolleys was accounted for and recorded. Staff administering medicines did this uninterrupted, as other staff were on hand to meet people's

Good

Is the service safe?

needs. Staff knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

The medication administration record (MAR) sheets showed that people received their medicines at the right times. The system of MAR records allowed for the checking of medicines, which showed that the medicine had been administered and signed for by the staff on shift. Medicines were correctly booked in to the home by a trained nurse and this was done in line with the home's procedures and policy. This ensured the medicines were available to administer to people as prescribed and required by their doctor. Medicines were stored at the correct temperatures which were recorded.

The provider had policies about protecting people from the risk of foreseeable emergencies, such as power failure so that safe care could continue. The registered manager had an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time. People who faced additional risks if they needed to evacuate had an emergency evacuation plan written to meet their needs. Staff received training in how to respond to emergencies and fire practice drills were in operation. Therefore people could be evacuated safely.

People were protected from the risk of receiving care from unsuitable staff. Staff had been through an interview and selection process. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Applicants for jobs had completed applications and been interviewed for roles within the home. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. Nursing staff told us their registration with the Nursing and Midwifery Council were checked and we saw these were recorded. All new staff had been checked against the disclosure and barring home (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

Good

Is the service effective?

Our findings

At our previous inspection in December 2014 we identified breaches of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some staff had not attended training that related to their job roles and people's needs.

We asked the provider to take action to make improvements. The provider sent us an action plan telling us what actions they would take so that the regulations would be met.

Training levels had improved significantly since our last inspection. The provider had systems in place to ensure staff received regular training, could achieve recognised qualifications and were supported to improve their practice. Nursing staff told us they had opportunities to continue their professional development and they were managed by an appointed clinical lead nurse. Core training was planned to enable staff to meet the needs of the people they supported and cared for. For example, staff received dementia awareness training and gained knowledge of other conditions. Core knowledge training levels were now at 85% and the levels of diabetes trained staff had risen from less than 50% to 90%. Training records confirmed staff had attended training courses and these records were audited by the registered manager. This provided staff with the knowledge and skills to understand people's needs and help people maintain their health and wellbeing.

Staff told us that training had improved in the last year, they spoke about the training they received and how it equipped them with the skills to deliver care effectively. They told us about their induction into their roles. Nursing staff were supervised by the deputy manager who is also a registered nurse and qualified to clinically supervise other nurses. This included monitoring nurses for their continuing professional development and competencies.

Staff had received training in relation to caring for people with behaviours that may cause harm to themselves or others. The home had a zero tolerance policy to verbal and physical abuse. People living with dementia could become frustrated or anxious, often without obvious cause. However, we observed staff reacting well to people who were anxious to reduce the risk of challenging behaviours developing. Referrals to the community mental health team were made so that staff could follow guidance from other health and social care professionals.

New staff inductions followed nationally recognised standards in social care. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately. Agency staff profiles were available showing their training skills and experience. This meant that people received care from staff with the right competence, training and skills.

Staff were provided with one to one supervision meetings as well as staff meetings and annual appraisal. There had been sixty six supervisions over the last three months. These were planned in advance by the registered manager and fully recorded. Staff told us that in meetings or supervisions they could bring up any concerns they had. Supervision records confirmed staff were able to discuss any concerns they had regarding people living at the home.

Records of unannounced night checks carried out by the registered manager showed that night staff were carrying out care effectively. We saw that during the night checks staff received supervisions and there were records confirming that night staff were reminded of the disciplinary consequences if they slept on shift.

Care plans included eating and drinking assessments and gave clear instructions to staff on how to assist people with eating. People at risk of dehydration or malnutrition were appropriately assessed. People who were at risk of choking had also been assessed. Daily records showed food and fluid intake was monitored and recorded. Care plans detailed people's food preferences.

People spoke positively about the food, one person said, "I have no complaints about the food. I'm eating here more than I've eaten in my life. I'm never hungry". Menus were displayed for people. Staff asked people for their choice of meal at breakfast. We observed lunch being served in the dining areas. People were offered a choice and people were not rushed to finish their meals. Staff in the dining rooms knew people's names and preferences and we observed that they gave individual attention to people when needed.

People were weighed regularly and when necessary what people ate and drank was recorded so that their health

Good

Is the service effective?

could be monitored by staff. We saw records of this taking place. People's requirements for diabetic or soft diets were recorded so that staff were aware of people's needs. This protected people from becoming unwell or choking.

Nursing staff were knowledgeable about pressure area management and this was well managed. Everybody had access to a doctor, and people's experience of this was good. Care plans gave information to staff about how to provide care in a range of areas. Care plans showed when dressings needed changing and nursing staff kept to the schedule for this. This ensured that people had access to appropriate medical help which included preventing pressure areas developing on people's skin.

People's mental capacity had been assessed and taken into consideration when planning their care needs. The Mental Capacity Act 2005 (MCA) contains five key principles that must be followed when assessing people's capacity to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Good

Is the service caring?

Our findings

We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. People praised staff, one said, "The care here is very good, they are always there for you and I feel comfortable". People said they could have a laugh with staff. One person said, "Staff here are second to none, always laughing and joking and I'm not a nuisance to them".

Relatives told us that staff kept them informed and listened to them. One relative said, "Mum has vascular dementia and has been here three years, there are no problems at all it's been superb". We observed that staff were welcoming and friendly towards people's relatives who were visiting. A relative told us that they were pleased with the communication they received from the staff in the home.

We observed staff providing care in a compassionate and friendly way. People were relaxed when staff spoke to them. Nursing staff spoke calmly to people when administering medicines which put people at ease. People who refused their medicines were treated with dignity and they were offered the medicines again. People's choices were respected.

People were able to personalise their rooms as they wished. They were able bring personal items with them. Memorabilia boxes and pictures outside people's rooms demonstrated that best practice was followed in relation to assisting people with memory loss to identify their rooms. We observed that staff knocked on people's doors before entering to give care. Staff described the steps they took to preserve people's privacy and dignity in the home. People were able to state whether they preferred to be cared for by all male or all female staff and this was recorded in their care plans and respected by staff.

People were treated with dignity and respect by staff. Staff members were able to describe ways in which people's dignity was preserved, such as making sure people closed toilet doors and by ensuring that doors were closed when providing personal care in bathrooms. Staff explained that all information held about the people who lived at the home was confidential and would not be discussed outside to protect people's privacy. At lunch time staff were focused on the people they were supporting and we observed staff speaking to people as individuals.

People described that staff were attentive to their needs. We observed staff speaking to people with a soft tone; they did not rush people. For example, staff asked people's views and opinions and for consent before they delivered care. A nurse showed considerable skill at redirecting people's attention before they became disorientated or anxious.

People were encouraged to be as independent as possible. People indicated that, where appropriate, staff encouraged them to do things for themselves and stay independent. For example, when bathing, care plans described what areas people would wash themselves and which areas staff needed to help with. People told us that staff were good at respecting their privacy and dignity.

People and their relatives had been asked about their views and experiences of using the home. We found that the registered manager used a range of methods to collect feedback from people. There were residents and relatives meetings at which people had been kept updated about new developments in the home. Relatives told us they attended meetings and gave their views. At a recent meeting food and drink had been discussed and this resulted in a self-service breakfast area being set up so that people could help themselves. We found that the results of the surveys/questionnaires were analysed by the provider. Information about people's comments and opinions of the home, plus the providers responses were made available to people and their relatives. This kept people involved and up to date with developments and events within the home and showed they could influence decisions the provider had made.

Information about people was kept securely in the office and the access was restricted to senior staff. When staff completed paperwork they kept this confidential.

Requires improvement

Is the service responsive?

Our findings

People were encouraged to discuss issues they may have about their care. People told us that if they needed to talk to staff or with the registered manager they were listened to. People described to us how the registered manager had responded to changes in their needs.

One person told us, "They look after me very well and I have no complaints, I would talk to people if I had concerns but I don't have any". Others were impressed with the assistance they got, one said, "The physio is coming very shortly, she comes twice a week. The doctor made a referral and next thing I knew the physio was here".

Responses to people's long term health needs were not always well managed to protect people from harm. People's needs had been fully assessed, but nursing staff had not always delivered care according to people's assessed needs. For example, a person's health assessment stated that they were at high risks of hypertension and that their blood pressure should be taken each month. Records showed that the person's blood pressure had only been taken three times between July 2014 and July 2015. We spoke to the nurse in charge and they confirmed that the person's blood pressure had not been taken monthly as stated in their care plan.

Care plan reviews were not effective in picking up issues in relation to people's care. We saw that the persons care plan was last reviewed on 31 August 2015. The review had not picked up the issues relating to the person's long term health issue and blood pressure monitoring, which indicated that the care plan reviews were not fit for purpose.

The registered manager had not always responded to requests made by external health and social care professionals or people's request for changes to their care, which put people at risks of harm. The person's family had asked for the DNAR to be withdrawn. We found correspondence in a person's care plan from the Canterbury and Coast Clinical Commission Group dated 30 July 2015, requesting the immediate withdrawal of the persons 'do not resuscitate form' (DNAR). However, we found that a photocopied 'do not resuscitate form dated 28 February 2015 was still in the persons care file. We noted that nurses could refer to a quick reference list of people who either had a DNAR or did not have a DNAR. This person was shown on this list as having a DNAR in place, which was incorrect. Had the person fallen ill in an emergency after 30 July 2015, they may not have received the most appropriate care or treatment.

These were breaches of regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans had been developed on an individual basis. Before people moved into the home an assessment of their needs had been completed to confirm that the home was suited to the person's needs. After people moved into the home they and their families where appropriate, were involved in discussing and planning the care and support they received. We saw that assessments were detailed and care plans reflected people's needs. For example, medical histories and safe moving and handling assessments were translated into areas of nursing care needed and details about numbers of staff and types of equipment needed for safe care.

Referrals were made to others services to ensure people's needs continued to be met. If people's behaviours presented a risk to others, the registered manager worked with the local care management team and continuing care team to enable people to move to other care settings where people's needs could be appropriately and safely managed.

People's life histories and likes and dislikes had been recorded in their care plans. This assisted staff with the planning of activities for people. Care was personalised and responsive to people's needs. Comments in care plans showed this process was on-going to help ensure people received the support they wanted. Family members were kept up to date with any changes to their relative's needs.

Nursing staff took the lead in liaising with other health and social care professionals when people's needs changed. Records of multi-disciplinary team input had been documented in care plans for Speech and Language Therapist, Continence nurses and District Nurses. These gave guidance to staff in response to changes in people's health or treatment plans.

The activities people could get involved in were advertised within the home. People told us they sometimes participated in activities. One person told us they were

Requires improvement

Is the service responsive?

researching talking books with the activities coordinator. Staff told us activities were organised and included arts and crafts, senior exercises and movies. An art session took place on the ground floor during our inspection.

All people spoken with said they were happy to raise any concerns. There was a policy about dealing with complaints that the staff and registered manager followed. This ensured that complaints were responded to appropriately. There had been seven recent complaints, these had been responded to in writing by the registered manager and fully recorded. The registered manager investigated people's complaints and had apologised to people if necessary. Complaints that could not be resolved by the registered manager were escalated to others within the organisation like the regional director. Records showed that the registered manager and regional director had met with people to try and resolve complaints and they communicated to people what actions they had taken to improve people's experiences.

The registered manager always tried to improve people's experiences of the home by asking for and responding to feedback. Nineteen people had attended the August residents meeting. Discussions included menu choices, people's satisfaction with their care and also things they would like changed. Relatives told us they also attended meetings and they felt they were listened to by the registered manager. One relative said, "The registered manager is very approachable." There was a comments book in the reception of the home. We saw that people had sent thank you cards for the care their loved ones had received at the home and recorded compliments about the home. These included 'The care is excellent' and 'We are pleased with the one to one care our Mum has been offered at the home'.

Requires improvement

Is the service well-led?

Our findings

People told us the home was well led. The registered manager held a bi-monthly "surgery" for staff to discuss any issues with her. She also held similar sessions for relatives. Staff and relatives told us that the manager was approachable and that she had an "open door" policy. Staff told us they felt able to raise any issues with the manager and felt confident that these would be addressed. Staff commented that they were proud of the improvements that had been made in the home over the last year.

The care recording systems in the home were confusing and difficult to audit. This had the potential to put people at risk. The provider had introduced a computerised care planning system but staff told us this was unreliable as the system sometimes went offline or was interrupted. Also, not all staff could access the system, for example agency staff. Therefore, hand written copies of care plans and other information was also being used. A nurse in charge said, "They (paper care plans) are only recorded in handwritten notes when agency staff are on duty or if the computer crashes." When we looked at the computerised system we found sporadic gaps in the records of people's care, both for day shifts and night shifts. However, we found that some of the gaps could be attributed to the care being recorded on the paper system. This meant that staff would need to look in different places to find the information they needed and it was unclear to us if all of the information had been recorded. Another example we saw was that incidents recorded on the computerised system had not been investigated and completed, but found these had been finished off as paper based forms, which had been completed. These were stored in the office and were not available for staff to read on either the computerised or paper based care plans. Therefore, staff delivering care could not see all of the information they needed.

We found it very difficult to follow people's care and in some instances staff were not sure where to record or look for information as it was not in people's care plans. In one case we could only find two records of a person's daily catheter wash out, one on the computer and one in the hand written care plan. The nurse in charge showed us that these were recorded in another place, which illustrated that staff delivering care were not sure which system to use. Records indicated that some people had mental capacity assessments and applications had been made to the local authority for deprivation of liberty (DoLS) under the mental capacity act legislation. We found out of date DoLS information that had expired in people's paper based care plans, with no obvious reference of renewal. When we spoke with nursing staff in day-to-day charge of people's care they were not sure if the DoLS applications had been completed. However, we later found comprehensive and up to date DoLS applications in the registered manager's office. This meant that there was a disconnect between what was recorded in people's paper based care plans, computerised care plans and the information staff should be aware of when delivering care.

We have recommended that the registered manager and provider research published guidance about effective care recording systems.

The registered manager had been in post for about one year. They had experience of managing homes for people living with dementia and had relevant qualifications for their role. The deputy manager had been at the home since 2010, was a qualified nurse to teaching standard. The deputy manager was responsible for the learning and development of nursing staff. Together they demonstrated to us they had the skills and experience to provide good leadership at Kingsfield Care Centre.

The nurses in charge met with the registered manager or deputy manager at a daily meeting to discuss any problems or issues in the home. Nurses told us that these discussions were effective and any issues raised were promptly addressed.

The aims and objectives of the home were set out and the registered manager of the home was able to follow these. For example, providing people living with dementia with care and support through a skilled and knowledgeable staff team. Staff received training and development to enable this to be achieved. The registered manager had a clear understanding of what the home could provide to people in the way of care and meeting their dementia needs. This was an important consideration and demonstrated the people were respected by the registered manager and provider.

Staff told us they enjoyed their jobs. Staff felt they were listened to as part of a team, they were positive about the management team in the home. Staff spoke about the importance of the support they got from senior staff, especially when they needed to respond to incidents in the

Requires improvement

Is the service well-led?

home. They told us that the registered manager was approachable. The registered manager ensured that staff received consistent training, supervision and appraisal so that they understood their roles and could gain more skills. For example, staff told us about situations where they had applied their learning to real life situations in the home. Also, we checked staff records which showed when staff had been given guidance about improving their work practices. This was driving the promotion of better working practices within the home.

There were a range of policies and procedures governing how the home needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the home.

Health and safety audits within the home were regular, responsive and in depth. For example, a recent weekly bedrail audit had identified some issues around people's bedrails. We checked the reporting of this and found that the repairs had been carried out promptly and signed off as complete. The registered manager had implemented ongoing audits of care plans and training and staff supervisions. This was having the effect of raising standards of care within the home which people had noticed.

Maintenance staff ensured that repairs were carried out quickly and safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected from water borne illnesses. The maintenance team kept records of checks they made to ensure the safety of people's bedframes, other equipment and that people's mattresses were suitable. This ensured that people were protected from environmental risks and faulty equipment. The registered manager produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The registered manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the home. This ensured that people could raise issues about their safety and the right actions would be taken. Senior managers at head office were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not always being delivered in safe ways and did not follow people's assessed needs, risk assessment or wishes. Arrangements were not always in place to respond appropriately and in good time to people's changing needs.