Four Seasons (Bamford) Limited

Kingswood Care Home

Inspection report

Wotton Road
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Ratings

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

Overall summary

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced. When we last inspected the service in May 2013 we found there were two breaches of legal requirements. These were in respect of care records and the quality monitoring systems that were in place. We checked again in December 2013 and found that improvements had been made to meet the relevant requirements. Kingswood Care Home provides residential and nursing care for up to 47 older people. At the time of our inspection there were 34 people in residence. The home had two units, one for people with personal care needs and the other unit being for people with nursing care needs. All bedrooms were for single occupancy and the majority of rooms had en-suite facilities. One side of the home is a converted older house and the other part is purpose built.

Summary of findings

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The registered manager and staff team were knowledgeable about safeguarding issues and protected people from harm. However, medicines were not being administered to people following safe work practices and this increased the risks of an error being made. Other risks were assessed and appropriate management plans were in place. Where significant changes in one person's moving and handling needs had occurred a new moving and handling plan had not been devised. Staffing numbers on each shift did not always meet people's care and support needs.

Staff were provided with regular training and were supported by their colleagues to do their jobs. People were not satisfied with the quality of the food and drink they were provided with and the catering staff were not satisfied with the quality of food items purchased. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

The relationships between staff and people who lived in the home were good and staff spoke well about the people they were looking after. Relatives talked about caring and friendly staff. People's privacy and dignity was maintained and where there were examples of this not being so, the registered manager had taken the appropriate action. People were involved in making decisions about how they were looked after, and families were included where this had been agreed upon.

People received care and support that met their specific needs. They were encouraged to express their views and opinions; the staff listened to them and acted upon any concerns to improve the service.

Some aspects of the homes management needed to be improved to ensure there was strong leadership for the staff team. The quality of service provision and care was monitored however this needed to be improved to ensure that shortfalls were identified and addressed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take 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?

Inadequate

The service was not safe.

People told us they felt safe and staff were there to help them stay safe. However they may be at risk because medicines were not always administered safely. Staff were not using safe work practices.

Staffing levels were based upon numbers of people and did not relate to their care and support needs. There were insufficient staff to be able to support people at the times they needed help.

Staff were aware of their responsibilities to safeguard people and to report any concerns. Safe recruitment procedures were followed at all times to ensure only suitable staff were employed.

Risk assessment were completed where risks had been identified. However these were not reviewed when significant changes had occurred.

Is the service effective?

Requires Improvement

The service was not fully effective.

People were looked after by staff who received training and had the necessary knowledge and skills. The staff were well supported by the staff team.

People were supported to eat and drink but the quality of food provided was not always good. Meals and drinks were often served cold. Where people were at risk of poor nutrition or dehydration, there were measures in place to monitor and manage the risk.

Staff sought consent from people before helping them and where people lacked capacity, they followed best interest processes. People's rights were properly recognised, respected and promoted. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

People were supported to access healthcare services and to maintain good health.

Is the service caring?

Good

The service was caring.

People were treated with kindness and the staff treated them with respect. Their privacy and individual needs were respected.

People were positive about the way they were looked after and were at ease with the staff.

People were encouraged to be as independent as possible but staff provided the support people needed.

Summary of findings

People were looked after in the way that they wanted and the staff took account of their personal choices and preferences. People were involved in making decisions about their care and support.

Is the service responsive?

Requires Improvement

The service was not fully responsive for each person.

People may not be responded to appropriately by staff because their care planning documentation did not always contain up to date information. Care plans were difficult to follow and some contained misleading information.

There was usually a programme of activities for people however this stopped because of staff absences and was being restarted.

People told us staff generally responded to any comments they made and that concerns they had were dealt with.

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

People, relatives and staff felt that the registered manager needed to be more visible within the main parts of the home and provide opportunities to listen to their view's.

Regular audits and checks were carried out to monitor the quality of the service however these need to be more robust in order to identify those shortfalls we have identified.

Kingswood Care Home

Detailed findings

Background to this inspection

The last inspection of Kingswood Care Home was completed in May 2013. At that time we found breaches in two regulations. This was in respect of the quality of care records and the homes quality monitoring procedures. When we checked again in December 2013 improvements had been made.

The inspection team consisted of two inspectors and one 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. Their area of expertise included dementia care and nursing home care.

Prior to the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We contacted two GP services, the Continuing Health Care healthcare professionals and the local authority quality assurance team as part of the pre-inspection planning process. During the inspection we spoke with 15 people who lived in Kingswood Care Home, seven relatives and 16 staff members (including the registered and deputy managers). We looked at six care records, four staff personnel files and the training records, staff duty rotas and other records relating to the management of the home.

Not every person was able to express their views verbally. We therefore undertook a Short Observational Framework for Inspection session (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home.

Inadequate

Is the service safe?

Our findings

People told us they felt safe in the home and said, "There is always someone around who can help you", "I am treated very well and I could not ask for a better place to live", and "We do not have to worry about a thing. Everything is done for us and we are kept very safe". One person said that some of the care assistants were less experienced and they didn't have as much confidence in them but "no-one is rude, or shouts at us".

None of the people living in Kingswood Care Home were able to look after their own medicines although a couple of people kept their inhalers in their bedrooms. All other medicines were looked after and administered by staff at the prescribed times. Nurses administered medicines to those people who were funded to receive nursing care. A senior care assistant who had received safe medicines administration training administered medicines to those people who were funded for residential care.

We watched whilst people were being given their morning medicines. The pharmacy provided printed medicines administration record (MAR) charts for staff to complete when people had taken their medicines. The nurse initially took medicines from the blister packs without referring to the MAR. We challenged them over their practice as this increased the risks of an error being made. For the rest of the medicine round the nurse signed the MAR chart before administering the medicines, this again was not good practice. In one instance, the nurse signed the MAR and then checked the person's heart rate before administering one medicine. If the heart rate had been too slow, the medicine would not have been administered and the MAR would have been incorrectly completed.

Two people were prescribed oxygen therapy to be delivered via concentrator units. These units are provided for people who need to have oxygen therapy for substantial parts of the day and night, or 24 hours per day. The home had a supply of oxygen cylinders in case of any medical emergency or equipment failure. On the first day of our inspection these were stored in the corner of the clinical room but were inaccessible because of other items stored in front. Immediate action was taken to ensure that the cylinders were accessible.

Where people were prescribed creams or ointments, a topical medicines record was kept in their bedroom and the treatment was applied by the care staff. Appropriate records had been kept to show the application of these preparations however they were not checked by the nursing staff. The records included a body map to show care staff where particular preparations had to be applied.

Designated members of nursing staff were tasked with re-ordering medicines every four weeks to ensure that people's medicines were always available . When new supplies were delivered they were checked against the MAR charts and the prescriptions to ensure they were correct. The nurse signed in how many medicines were received. Where additional medicines or medicine changes were made outside of this, the GP faxed new prescriptions to the pharmacist who then delivered the medicines. In this instance the nurses did not see the new prescriptions.

Medicines were kept safely in a locked room that was well ventilated. Although the room temperatures were not checked the nurse was aware that the room temperature should not exceed 25°C. A medicines refrigerator was available. The temperature of the refrigerator was checked on a daily basis and was within safe limits. Suitable arrangements were in place for storing controlled drugs, which need additional security. Records showed that these medicines had been looked after safely.

These were breaches in parts of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

On a monthly basis the dependency score of each person was reviewed and rated as high, medium or low needs. However, these scores were not used to calculate the staffing numbers. The registered manager explained that a new system was to be introduced that calculated the number of staff required on each shift. Shifts were covered with a mix of management, ancillary staff, nurses and care staff. A nurse was on duty for every shift including weekends and overnight.There was little turnover of staff and minimal use of agency staff. People were therefore looked after by staff who were familiar with their needs and preferences. Staff felt that staffing levels were not adequate, this was a view shared by a number of the people we spoke with and relatives. Staff told us that some shifts had been worked with less staff because of last minute sickness and made the following comments - "There never seems to be enough staff and everyone works so hard" and "There is no time to be able to sit and chat with people". Due to recent extended periods of leave by

Inadequate

Is the service safe?

activity staff, people were left with only minimal support to meet their social care needs. All these comments were discussed with the registered manager who stated current staffing levels were appropriate, but "once we have more staff in post we will be increasing staffing numbers per shift".

We received negative comments from a number of people about the length of time call bells can take to be responded to. During the course of the inspection one call bell went unanswered for over 30 minutes. Staff told us that most of the people needed two staff to help them move about therefore there was not always sufficient staff available to answer call bells. This conflicts with what the registered manager said when they reported that their observations showed call bells were generally answered within two to five minutes.

This was a breach in regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Staff had good awareness of safeguarding issues and told us they would report any concerns they had about people's safety to the registered or deputy manager or the nurse on duty. Staff were able to tell us what constituted abuse and how they might recognise if a person was being harmed. They were less clear that harmful interactions between people who lived in the home could be classed as abuse or that they could report directly to Gloucestershire County Council safeguarding team or the Care Quality Commission. In the PIR the registered manager told us the safeguarding training was mandatory for all staff and was delivered via an e-learning programme and a workbook that had to be completed. The registered and deputy managers had previously completed safeguarding adults training with the local authority and had a good understanding of safeguarding issues. The registered manager was able to talk about actions that had been taken in the past when safeguarding concerns had been raised in respect of one individual.

Staff files were checked to ensure that safe recruitment procedures had been followed to prevent unsuitable staff being employed. Since our last inspection there had been very little staff turnover. Each file contained an application form, two written references and evidence of the person's identity. Appropriate pre-employment checks had been undertaken but an interview assessment had not been recorded in all instances and one person's reference had been provided by a family member. Criminal Records Bureau (CRB) checks, now called Disclosure and Barring Service (DBS) checks had been carried out for all staff.

Risks assessments were completed for each person in respect of the likelihood of falls, use of bed rails, moving and handling tasks, continence, risks of malnutrition and the likelihood of developing pressure ulcers. Where a person needed the staff to support or assist them with moving or transferring from one place to another a personal handling profile was devised. These set out the equipment required and the number of care staff to undertake any task. We saw other person-specific risk assessments that had been completed in respect of the risks of choking and the risks of epileptic seizures.

A fire risk assessment was in place and arrangements had already been made for this to be reviewed on 13 October 2014. Personal emergency evacuation plans (PEEP's) had been prepared for each person: these detailed what support the person would require in the event of a fire.

Checks of the fire alarm system, fire fighting equipment, fire doors, hot and cold water temperatures had been completed regularly and records were maintained. The registered manager checked and signed that these checks had been completed. The hoisting equipment, specialist baths, passenger lift and call bell system had been serviced and maintained in good working order. Catering staff checked fridge and freezer temperatures, hot food temperatures, food storage and kitchen cleaning schedules.

Requires Improvement

Is the service effective?

Our findings

People told us the staff were good at their jobs and were able to look after them in the way they liked. They said, "The staff know how I like things to be done", "They are good at their jobs", "I was in a very bad way when I moved in. The staff have helped me get better and I am now hoping to go home with home-help support" and "I could not ask for better care even though I do grumble at the girls a lot. They understand it is difficult for me".

Two visitors made the following comments: "Our relative was very poorly when they moved in but perked up the minute they arrived here. I think they were lonely" and "We cannot fault the way our relative is looked after. The staff are excellent with them".

Staff received on-going individual meetings with their supervisors every two months. There were plans in place to introduce an annual appraisal for each staff member. Three staff said they did not have regular meetings with a senior member of staff. We saw records in staff files where these meetings had taken place . There were mixed views from the staff about how they were supported in their roles and training and development needs were identified. Staff were provided with a programme of training. New staff completed an induction training programme at the start of their employment and we saw the completed records of two care staff. This programme included moving and handling, fire awareness and safeguarding adults training. Nurses and senior care staff had completed comprehensive medicines training in both 2013 and 2014. Records showed staff had completed basic life support training and first aid awareness training in 2013/2014. Five newer care staff had not completed moving and handling training but were not leading on moving and handling tasks. Most training was completed on-line; staff did not feel this was adequate. The registered manager said there were plans to provide more face to face training. First aid at work and fire warden training dates were already scheduled for dates in November 2014.

When we spoke with the registered manager about additional training on top of the training that all staff had to complete, it was always the same two people who were being considered for attending this. This may be to the detriment of other nurses and care staff.

Training records indicated that 14 of the 35 care assistants had a national vocational qualification (NVQ) in care at level two. Ten care staff were signed up for the diploma in health and social care training (replaced the NVQ) to commence that week. Staff had completed various training to include; fire safety, equality and diversity, deprivation of liberty, care of substances hazardous to health (COSHH), food hygiene, moving and handling, infection control and safeguarding. A computerised record was completed to help ensure that staff updated their training when required and staff said they were "chased" when their refresher training was due.

The registered manager had an adequate knowledge of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and safeguarding adults and demonstrated a good understanding of issues relevant to all these areas. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

Mental capacity assessments had been completed for all aspects of care and daily living for each person on admission. The assessments were reviewed after any changes in the person's needs. One example we looked at showed the person had been assessed to have full mental capacity and wished to be involved in all decisions about their care. A DoLS assessment had been completed but a DoLS authorisation was not required. Another person's capacity assessment had recorded the person lacked capacity to make major decisions but could make simple decisions when alert. A relative had enduring power of attorney and was involved in making decisions in the person's best interest. A 'best interest' record had been completed in respect of their end of life care needs. The relative had known the person's wishes and was able to contribute to the decision. A GP had signed a Do Not Resuscitate record and the relative and a member of staff had also signed the record. The registered manager talked about an occasion when advocacy services had been used when there was a difference in opinion between family members who both lived in the home.

Requires Improvement

Is the service effective?

Staff told us they had completed on-line safeguarding, MCA and DoLS training. Records showed that all but four of the whole staff team had completed safeguarding and DoLS training. However, some staff found it difficult to explain to us what safeguarding meant and were unsure about MCA 2005 and DoLS. MCA training was scheduled to take place on 16 October 2014 and a group of key staff had been identified to attend this. One staff member was able to tell us what safeguarding people meant and why a person would need to have a DoLS in place. They knew when a person's lacked mental capacity assessment that best interest decisions had to be recorded. A senior care assistant had completed dementia link training and intended to provide all staff with dementia care training but this had not yet been scheduled to take place.

People had signed their consent to have their photograph taken for identification purposes, activity events in the home and wound care (where appropriate). Staff were clear about which people lacked the capacity to make decisions but added that most of them were able to make day-to-day choices. Staff told us, they always asked for peoples consent before they commenced any personal care task or were going to help them move to another area of the home.

We completed a Short Observational Framework for Inspection (SOFI) during the lunchtime. People were served individually with their choice of food. The two staff in the dining room were attentive to the nine people there. People talked to the staff and to each other and were helped when required in a calm and respectful way. Staff asked people how they were and helped them cut up their food when needed. They had time to enjoy each course and hot and cold drinks were offered. One person had the sun in their eyes and staff asked if they wanted the curtain closed. Another person wanted to leave the room as they felt unwell and staff discreetly helped them. One person did not eat much of the main course but ate a large portion of dessert. The staff were aware they preferred desserts and told us the person had already eaten a cooked breakfast that day so were not concerned. A member of staff told us food charts were only kept when people had lost weight. Some of the glasses and beakers that were in use were stained and scratched.

People had very mixed views about the meals they were served and improvements need to be made. Some people told us they enjoyed their meals. One person told us there was not enough food sometimes, but they could have more food if they liked. A significant number of people told us food and drinks (tea and coffee) were frequently served cold. Another person told us the food was "so so" and sometimes, "The meat was difficult to chew". Other comments we received included: "We are served peasant food – the quality is not very good", "Some days the food is good and other days it is not", "The portions can be very small, there is just not enough" and "You get to see the menu if you ask, there is a choice of dinners".

A recent food quality survey had been completed by 16 people but there was no indication why the survey had only been completed by less than half of those in residence. The majority had rated the choice of meals, presentation and taste of food as 'good' or 'alright'. Three people had rated the taste of food as poor (this is the view of almost 25% of those people who responded). The registered manager did not have a plan in place to survey a larger number of people, or a plan to improve the quality of the food served. The chef told us the quality of food purchased could be improved. The four weekly menus provided a variety of food and choice for each meal. They were changed four times a year. The chef was in the process of changing over to the autumn menus and had taken pictures of some of the meals to assist people in making choices. The chef talked to all new people about the food they liked. A board in the kitchen displayed people's names and their specific dietary requirements for example soft consistency diets, vegetarian or diabetic. One person who required a fortified diet was not referred to on the board, however the chef said they generally fortified all meals for older people.

People's nutritional needs were assessed monthly using a Malnutrition Universal Screening Tool (MUST). An oral assessment was completed monthly to look at people's teeth, dentures, lips and speech and any dental examinations were recorded. Nutritional care plan reviews included any GP advice, for example including fortified foods for people with weight loss. Weekly weights were recorded for those at risk, however some were incorrectly charted on a graph without calibrations. Reviews that used the graph may not identify weight loss and people at risk. There were risk assessments for those people at risk from choking. One person's care plan recorded their drinks needed to be thickened in order to prevent choking. Food charts were maintained where people's food intake needed to be monitored.

Requires Improvement

Is the service effective?

Expected outcomes were recorded for those people with diabetes where they needed assistance from the staff with their diet. The Diabetic Society Protocol had been followed so that blood glucose monitoring was reduced from monthly to whenever people felt unwell. A review of one care plan recorded that diabetes was well controlled with tablets; however the person was not taking tablets. We informed the deputy manager about the incorrect record. Each person was registered with one of two local GP practices. One of the GP's visited on a fortnightly basis and saw those people the nurses had identified as needing a GP visit. Nurses also requested home visits whenever people were unwell or when people asked to see the doctor. We asked both GP surgeries for their views and opinions about how their patients were looked after. They told us "Staff do a tremendous job in often challenging circumstances", "Kingswood in my opinion is the place I would want my family to be looked after. It is a pleasure to be the doctor visiting this home as it is well organised" and "I know whenever I have contacted the care home for information they have always been efficient and forthcoming. I have not received any complaints or heard any concerns from patients or their relatives regarding the home".

Arrangements were in place for people to receive support from visiting opticians, dentists and chiropodists. The home worked alongside community and hospital social workers, occupational therapists and physiotherapists in order to make sure people were well looked after.

Good

Is the service caring?

Our findings

People told us "The staff are very compassionate", "They are all pretty good and generally kind, I've got no grumbles" and "I am treated with dignity and respect and my disability is respected". One person referred to an event the previous week when they had been upset. They said, "When I cried, the carers comforted me. They do if I am lonely". We asked one person if the staff asked them if they were happy with the care and support provided and they replied "Yes". Another person said, "Sometimes the staff are too busy to listen to me". One person told us that previously a member of care staff had been very short-tempered with them and made them feel a nuisance, but the senior staff had taken the appropriate action and that member of staff no longer worked in the home.

Visitors told us that their relatives were well cared for. "I cannot fault the way the staff look after my relative. They can be difficult but the staff are always friendly and patient" and "The staff are so loving and kind". One other visitor said, "The staff need the patience of a saint to do this job, but they always do it with a smile on their face". Visitors said there were no restrictions on visiting and they were able to visit at any reasonable time.

Within information provided prior to the inspection, the registered manager told us that each person had a key worker to "act as their friend and champion". This person was a member of the care team who took a social interest in that person, developing a good knowledge of them and building up a trusting relationship. Staff were able to tell us about the people they were a keyworker for.

Feedback we received from one of the GP surgeries we contacted stated that "The staff are very caring and really think about what would be appropriate for people who live in the home". Staff understood how people chose to be looked after. Staff were able to tell us about the people they were looking after. They spoke about individuals in a kind and respectful manner. We heard staff addressing people in an appropriate manner. The majority of people were called by their first name and this preference had been recorded in their care plan. Staff received training in equality and diversity and this enabled them to provide support that took account of individuals' specific wishes. One staff member told us that treating people with respect and dignity was important to them and was "How you would treat your Mum".

We observed a person being supported to eat and drink and the care staff supporting them spoke gently and encouragingly to them throughout the meal time. We observed numerous examples of positive and meaningful interactions for people. We saw people being encouraged to make choices about their daytime activities, making a choice about what meal to have and what they would like to eat. When we asked a person if the staff had found out what they liked to do, they said "no, not really, not recently".

Requires Improvement

Is the service responsive?

Our findings

People told us "I am looked after the way I like", "The staff know how they have to look after me", "I am very settled here and the staff come and help me when I need support" and "I was asked lots of questions about how I wanted to be looked after but I just lets the girls do what they need to".

One visitor said, "My relative is very obsessed with cleanliness and always gets the staff to clean her things. They are very patient with her and do as she asks". Other relatives said, "very well looked after and we enjoy visiting the home".

Before admission to the home people's care needs were assessed to ensure the staff had the appropriate skills to meet their needs and essential nursing equipment was available. These assessments were reviewed on an annual basis, or more often if needed. The assessments were used to develop the plans of care for each person. The plans included people's likes and dislikes and what was important to that person. Plans provided details about people's personal care needs, their mobility, the support they needed with eating and drinking, any wound care management and their night time requirements.

The care plans were not easy to follow and there were many examples where the information recorded was either misleading, meaningless or absent. For one person, in their care plan there was three references to decisions about resuscitation in the event of sudden illness. One record stated they wished to be resuscitated and the other two stated they didn't. Another person's psychological and emotional needs plan stated 'to meet and maintain XX psychological needs' – there was no information about how this was to be achieved or what actions the staff had to take. For a third person, who had had a sudden change in their mobility needs, a new moving and handling support plan had not been devised. We discussed with the registered manager some inappropriate comments that had been made in one person's daily notes.

In all the plans we looked at it was difficult to distinguish between the care plan and what was an evaluation of that plan. Where the evaluations had recorded a change in needs, the out of date information in the care plan had not been discontinued. Care plan reviews were carried out on a monthly basis with the aim of ensuring that the care and support provided was in line with people's individual needs. One person said, "They have a 'resident of the day' system here and so each month my care is gone through and the staff make sure I am ok". This system had just been implemented and was still to be fully embedded. This involved the nurse or senior care assistant reviewing all aspects of care for that individual and included laundry, cleaning and catering services as well as care and support staff.

This was a breach of regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what actions we have told the provider to take at the back of the report.

We spent time with the full time activity person whose aim was to ensure that all people enjoyed social interaction and hobbies every day. Two volunteers helped with hobbies one afternoon each week however one other member of the activities team had not been available for some time. Activity boards advised people of planned events and also displayed pictures of people enjoying hobbies and staff fund raising events. We were told there was on a £12 budget per month for providing activities for people. The staff team worked hard to supplement this meagre amount and completed fund raising events to enable people to pursue their interests and hobbies. The staff team should be commended for this.

People had a variety of social needs and the activity team and care staff worked hard to meet everyone's needs. Some people were unable to recall what happened but others told us about events that had taken place. One person said they liked to do their knitting, and another liked to read the newspaper. One person said the previous week an entertainer had visited and there was a sing-song, with drums and tambourines and about 10 people had joined in. One person said they would like someone to read to them.

Some liked one to one conversations and this was achieved a couple of days each week. Monthly art classes were provided plus knit and natter sessions, reminiscence, skittles and exercise groups. The staff team had set up a "tuck shop" and people could buy toiletries and food items and there was a trolley to take round to people who were room bound, so they could see what they could buy. Board games and films were used at the weekends when no activity staff on duty. The activity person told us there were no cultural differences to cater for but people enjoyed

Requires Improvement

Is the service responsive?

regular worship in the home. During the warmer weather there had been trips away from the home to see the local duck pond and visit a garden centre. Festivals throughout the year were celebrated and preparations were starting to celebrate Halloween and bonfire night. In the summer the home had held a fete and BBQ.

Activity records were kept and information about individuals was transferred to their care plans. Staff recorded what activities people had completed and whether they enjoyed the activity. We looked at an example where a person had listened to a compact disc book, listened to music, had a one to one conversation, sat in the garden and had 'mind song' therapy in one week. This person told us they liked doing exercises to music.

The Kingswood Care Home newsletter for October 2014 advertised a 'relatives and friends cheese and wine meeting and raffle' in November 2014. Previous 'resident and relative' meetings had not resulted in any relatives attending therefore the registered manager was trying a new approach. Residents and relatives meetings were planned every two months and minutes were recorded.

People told us that if they had any concerns they felt able to raise these with the care staff. One person said, "Oh yes, I tell the staff". Another said, "They sorts things out for me, but I try not to grumble too much".

Requires Improvement

Is the service well-led?

Our findings

People made the following comments when we asked them what it was like to live in the home: "We don't have to worry about a thing everything is done for us", "I don't see the manager so I am not sure who you mean", "I have been in the home for a long time but I don't know the managers name" and "You hardly ever see her".

Relatives said, "There are never any relatives meetings. We would come along if we knew one was happening" and "I am not aware that there has ever been a meeting while my relative has been here". The second relative added "I visit every couple of days so I have very good communication with the staff team and I am asked how I think things are going".

Staff felt that their day-to-day leadership was provided by the deputy manager. Staff felt that the registered manager was approachable but not 'visible'. The registered manager's office was located at the far end of the home therefore they were not as present within the home as they could be. The registered manager was unsure whether there were plans to move the office to the front of the home. Despite this, the registered manager did have a good grasp of all the issues relating to people's care and the staff team.

The registered manager was supported by the deputy manager, the area manager and an administrator to ensure the home was well run. A 'flash' meeting was held each morning to enable the registered manager or nurse in charge to communicate with heads of department and senior staff. We saw that information was discussed and where action was required, staff were identified as responsible for the action. The 'resident of the day' was identified and which member of staff was completing their monthly review with them.

Staff meetings were held regularly. Records were kept of a general staff meeting held in April 2014 and a nurse and senior carers meeting in July 2014. The registered manager attended a meeting with other home managers and the area manager in August 2014. Some staff said, "They had not attended a staff meeting for a long time". Information was displayed in the reception area about the next staff meeting scheduled for that week and taking place at 2pm and 7pm. This enabled both day and night staff to attend one of the meetings. Other staff said that in meetings they were generally "talked to" rather than encouraged to provide feedback about how things were going or make suggestions about meeting people's needs differently.

Each month the registered manager sent the area manager a report on any accidents and incidents, any health and safety issues, complaints, staffing issues and issues regarding people's care. These measures ensured the provider was aware of how both services were being run.

The registered and deputy managers were aware of when notifications had to be sent in to CQC. A notification is information about important events which had happened in the home the service is required to send us by law. CQC used information sent to us through the notification process to monitor the service and to check how any events had been handled. So far in 2014 the home have notified us of 10 expected deaths, one unexpected death, one fall in which the person sustained a bony injury and one notification about the boiler breakdown.

All accidents and incidents were entered on to an electronic record system. At the end of each month the registered manager followed up on each report and can analyse the number of falls or the number of events for a particular person. All accidents and incidents were analysed to identify triggers or trends so that preventative action could be taken.

All policies and procedures were reviewed and amended where needed on an annual or bi-annual basis. We noted that the safeguarding adults policy (adult protection) had been due for review in March 2014 and the whistleblowing policy was dated June 2006 and had not been reviewed more recently.

A customer satisfaction survey was last undertaken and reported on in February 2013. The registered manager said this year's survey forms had just been sent out from head office and the results would be analysed and an action plan devised to improve outcomes for people where shortfalls were identified.

The home had a programme of audits and quality checks. These were completed in respect of medicines, nutrition, health and safety and care documentation. Quality monitoring visits were completed on a monthly basis by

Requires Improvement

Is the service well-led?

the area manager and the last one had been completed on 15 September 2014. Any improvements required were recorded on the remedial action plan and followed up at the next visit.

The complaints procedure was displayed on noticeboards in the home and stated that all formal complaints would be acknowledged, investigated and responded to. Information was also given to people about the procedure in the service user guide given to people and their relatives. The home had received two formal complaints in the last 12 months and records evidenced the actions that had been taken. Other verbal complaints had been reported to head office. The complaints were about a variety of issues the registered manager would use information from any complaints to review their practice.

We asked the registered manager what their aims were for the service and where they planned to make improvements. We were told that the main aim was to improve the environment. Works has already been carried out in the kitchen and bathrooms and the redecoration of some communal area's and bedrooms. Parts of the home and the grounds were in need of significant repair. The roof needed to be repaired over the kitchen and dining room. Carpets needed to be replaced and the glass roofed corridors needed to be sealed to stop rain damage. The registered manager was waiting to hear whether Kingswood Care Home was next in line in the provider's refurbishment programme.

In their provider information return (PIR) the registered manager told us they had plans to introduce staff appraisals in order to improve staff development and to put in place a team of champions. These champions would lead in areas covering all aspects of care. The registered manager's vision also included further embedding of the resident of the day initiative.

We recommend that the registered provider prioritise their commitment to providing a comfortable environment at Kingswood Care Home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use the service were not protected against the risks associated with the unsafe use or management of medicines because unsafe administration practices were being used. Staff were not checking medicine charts before administering medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person must take appropriate steps to ensure that, at all times there are sufficient numbers of suitably qualified, skilled and experienced staff, to meet people's needs. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment, arising from a lack of proper information about them, by means of keeping accurate records. Regulation 20 (1) (a).