Care UK Community Partnerships Ltd

Kingsfield Care Centre

Inspection report

Jubilee Way
Faversham
Kent
Kent
ME13 8GD

Tel: 01795535550
Website: www.careuk.com/care-homes/kingsfield-faversham

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on the 26 and 29 September 2017. The first day of the inspection was unannounced and the second was announced.

The service provided modern, purpose built accommodation. Staff provided personal and nursing care for up to 90 older people. The accommodation spanned three floors and offered various room size options for people. Bedrooms had on-suite facilities. There were plenty of communal areas and lifts were available for people to travel between floors. There were 56 people living in the service when we inspected, 39 people were accommodated in part of the service which was designed for people who needed nursing care or were living with developed dementia. The other parts of the service provided residential accommodation and nursing care to 17 people living with non-complex dementia. Nursing staff and care staff assisted people to manage chronic and longer-term health issues associated with ageing or after an accident or illness.

We carried out our last announced comprehensive inspection of this service on 25, 26 and 27 July 2016. Breaches of legal requirements were found. Accurate and complete records were not being kept, staff were not deployed in sufficient numbers and staff had not been receiving supervision. We also made a recommendation about the levels of staff training for end of life care. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches of Regulation 17 and Regulation 18 of the Health and Social Care Act Regulated Activities Regulations 2014, Good Governance and Fit and proper persons employed. The provider sent us an action plan, this told us they had already taken action and were now meeting the regulation. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kingsfield Care Centre on our website at www.cqc.org.uk.

There was not a registered manager employed at the service. The person who had been registered left the service on 15 September 2017. 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. However, the provider was in the process of employing a manager. At the time of this inspection the service was being managed by the deputy manager (Acting manager).

At this inspection we found that some improvements had been made. Staff had been keeping up to date and accurate records of the care provided to people. Recruitment of new nursing and care staff had taken place, but the new staff had only just started their induction. However, the majority of people who gave us feedback about the service told us their experiences of the care and the management continued to be poor. Concerns remained about the stability of the management structures in the service and the consistent deployment of regular qualified nursing staff. At the time of this inspection the local authority in Kent had issued a safeguarding and poor practice warning against Kingfield Care Centre. This meant that the service still required improvement. We have made a recommendation about this.

The provider understood the challenges and issues faced by the service and had taken steps to improve people's experiences of the care. However, the provider needed to do more to improve the outcomes for people in the service.

Staff received training that related to the needs of the people they were caring for. During the inspection all three of the nurses leading the day staff were agency nurses. The acting manager told us that five new nurses had been recruited and four new nurses had started their induction on the first day of our inspection.

The provider had a system in place to assess people's needs and to work out the required staffing levels. However, we could not fully assess the staffing levels impact on the service because the provider was still in the process of recruiting and training staff and there were 24 vacant rooms in the service, which was not running at full capacity.

The leadership in the services had not been stable. People, their relatives and external health and social care professionals could not always tell us that they experienced well-led safe care.

Staff supervisions had improved, but were not consistent having been affected by large movements of staff out of and into the service. We could not fully assess if the current management structure in the service could effectively sustain staff meetings and supervisions with a designated line manager to discuss their work performance. We have made a recommendation about this.

There were systems in place to monitor the quality of the service, which included gaining the views of people and their relatives. People felt confident to raise a concern or complaint, but were not always sure their concerns would be acted on.

All staff understood their responsibilities to protect people from harm and were encouraged and supported to raise any concerns.

Records about the care people had received were now up to date and completed.

Agency nursing staff had the skills and experience to advise care staff and to meet people's needs. The acting manager provided nurses with clinical training and development.

The provider and acting manager had contingency plans in place to reduce the impact on people's care from foreseeable emergencies. Equipment and the environment were maintained, checked and tested to minimise the risks of potential harm.

There were policies in place for the safe administration of medicines. Nurses and accredited staff were trained in the safe administration of medicines, gained people's consent before giving a person their medicines and appropriate records were kept.

People's care plans and risk assessments contained information about their personal history and support needs that enabled staff to support them safely. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced.

The environment was clean and some of the design features benefitted people living with dementia including themed areas and signage. The service planned to make further provision to improve outcomes for people living with dementia.

People had their health and nutritional needs assessed and monitored and referrals were made to health professionals when their needs changed. People were offered a choice at mealtimes which took into consideration their dietary requirements.

New staff received an induction which included shadowing existing staff. They were provided with a regular programme of training in areas essential to their role. Staff had received training in the Mental Capacity Act 2005 and understood its main principles. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The acting manager had submitted and monitored DoLS applications so that people were not deprived of their liberty unlawfully.

Staff communicated with people in a kind manner and treated them with compassion, dignity and respect. Staff had developed positive and valued relationships with people and their family members.

A plan of care was developed for each person to guide staff on how to support people's individual needs. Information had been gained about people's likes, and what was important to them. These were regularly reviewed so that they contained the right information for staff to be able to support people.

People were offered a range of activities which included sensory activities that took into consideration the needs of people living with dementia.

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.

People, their relatives and external health and social care professionals voiced concerns about staffing in the service.

Systems were in place to manage risk. Medicines were administered by competent nursing staff.

Staff were committed to preventing abuse. Staff spoke about blowing the whistle if needed.

Incidents and accidents were recorded and people were safeguarded from potential harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff met with their managers to discuss their work performance, but this had not been consistently happening.

Staff had attained the skills they required to carry out their role.

People were cared for by staff who knew their needs well. Staff understood their responsibly to help people maintain their health and wellbeing.

Nursing staff monitored people's health and referred people to health services when needed.

Staff had completed training in respect of the Mental Capacity Act 2005 and understood their responsibilities under the Act.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them with kindness, compassion and respect.

People's privacy and dignity was respected by staff.

Staff showed concern for people's well-being in a caring and meaningful way and responded appropriately to their needs.

Is the service responsive?

Good

The service was responsive.

People were provided with care based on assessments and the development of a care plan about them.

Information about people was updated so that staff only provided care that was up to date.

People were consistently asked what they thought of the care provided and had been encouraged to raise any issues they were unhappy about.

People were encouraged to participate in activities.

People and their relatives knew how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Leadership in the service had been unstable and ineffective. People told us they had not experienced a well-led service and the provider had not acted quickly to improve their experiences.

The quality of the service was monitored through regular audits that were effective in highlighting areas requiring further improvement.

People were asked their views about the quality of the service. The acting manager promoted person centred values within the service. They planned to continually improve people's experiences.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered.

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 26 and 29 September 2017. The first day of the inspection was unannounced and the second was announced. On day one of the inspection the inspection team consisted of one inspector, a nurse specialist and two experts by experience. The experts-by-experience had backgrounds in caring for elderly people. Day two of the inspection was carried out by one inspector.

Before the inspection, we checked the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. We checked that the provider had followed their action plan and to confirm that they now met legal requirements.

We observed the care provided for people. We spoke with 22 people and seven relatives about their experience of the service. We spoke with eleven staff including the acting manager, the area manager, the operational support manager, the quality development manager, one registered mental health nurse, two registered general agency nurses, the dementia lead, one senior care worker and two care workers. After the inspection, three relatives contacted us to give their views about the service. We received feedback about the service from three health and social care professionals.

We looked at records held by the provider and care records held in the service. This included seven care plan daily notes; safeguarding, medicines and complaints policies; the recruitment records of the six newly recruited staff employed at the service; the staff training programme; medicines management; complaints and compliments; meetings minutes; and health, safety and quality audits. The provider sent us other information about the maintenance of equipment, DoLS applications and fire safety after the inspection. This was received in a timely manner.

Requires Improvement

Is the service safe?

Our findings

There were mixed views from people and their relatives about how safe the service was. People said, "I feel very safe, ask anything of them (staff) and they will do their best to help you." Another said, "I look forward to a visit from the girls they are so friendly always and I can trust them."

A relative said, "There have been three incidents of Mum being attacked by fellow residents coming into her room; it was very frightening for her. The management in the service told us they were taking steps to keep Mum safe, particularly from a male who used the service. We were told he had been moved to another part of the service and he was having one to one staff support. We then came in to visit Mum one day and he was sitting next to her in the lounge, she was terrified."

Another relative said, "Due to the high numbers of staff leaving, care for his wife has not been consistent." They told us that this had some impact on his wife's negative behaviours.

Another relative said, "They (staff) really go above and beyond with their help here and always put us and mum first, especially as far as her safety is concerned."

Many of the people who could verbally tell us about their experiences of the service and the relatives we spoke with had concerns about the staffing levels at Kingsfield Care Centre. One person said, "When someone is pressing the nurse call bells they go on and on and on," Another said, "During the night the call bells take a long time to be answered."

A health and social care professional said, "The home is often short staffed, when I am in the home I am always looking for staff, my telephone calls to the home are not always answered." And, "When I last visited there was not a nurse available on the middle floor and the member of care staff was on their own." Another health and social care professional told us, "My concern centres principally around the availability of staff. If I manage to get into the building, I often have to walk up and down until I find someone who may be able to help. The lack of reception area also effects telephone contact with the home as messages left appear not to get passed on. Due to high turnover of agency staff, there can at times be a lack of carers with a good knowledge of the needs and presentation of specific service users and this can impact on the efficiency of reviews and assessments."

At our last comprehensive inspection on 25, 26 and 27 July 2016, we found that the provider had failed to ensure enough staff were deployed to meet people's emergency and routine needs which was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to meet the regulations. The provider sent us an action plan which showed they had met the regulations by 31 March 2017.

At this inspection, the provider had taken steps to safeguard people. The provider had worked cooperatively with the local authority safeguarding team to investigate and respond to safeguarding issues in the service. They had also reduced the number of people in living in the service whilst they recruited more staff. At our

inspection in July 2016 there were 76 people and at this inspection there were 56 people. This had reduced the impact of fluctuating staffing levels during a period of recruitment and had increased the amount of staff hours available to deliver care. The provider had put additional management resources into the service and they had recruited five qualified nurses, four team leaders and three senior care workers. Most of the newly recruited staff had started their two week induction at the service on 26 September 2017, which was the first day of our inspection. We were unable to assess the impact of the new staff recruited on people's experiences of the staffing levels in the service at this inspection.

The acting manager used a dependency tool to identify the staffing levels required at the service. The dependency tool used identified the amount of staffing hours required based on the levels of need of those living at the service. The dependency tool was completed monthly. The dependency tool indicated that the number of staff hours available were higher than the base line dependency levels calculated, based on the current needs of people living at Kingsfield Care Centre. This meant that during the inspection we could not corroborate statements people made about staffing levels.

Once on shift, staff were deployed based on a shift planner completed by the acting manager. On the day of the inspection, in addition to the acting manager, who was a registered general nurse (RGN), there were ten care staff available to deliver care between 8 am and 8 pm. In addition to this, another three qualified registered general nurses (RGN) were available, each deployed to different floors in the service. At night there were six care staff managed by an additional two qualified nurses. The September and October rota showed that these staffing levels were consistent with the planned levels of staff required. We checked the daily shift reports for actual staffing levels between 02 September 2017 and 25 September 2017. These were consistent with the planned staffing levels, for example they showed ten care staff and three RGN's were on shifts. One member of staff said, "Sometimes we are short staffed if staff go sick, but we mainly have enough staff." Another member of staff said, "Staffing is getting much better now, they have just recruited three team leaders, one for each floor, they have just started their inductions." Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were available to people.

The quality development manager told us that there had been some issues with the telephone system in the service, which had resulted in some people not being able to get through. They told us that the provider was working to resolve the issue. After the inspection we called the service three times on different days and our calls were answered by staff.

The service had a safeguarding policy which set out the definition of different types of abuse, staff's responsibilities and the contact details of the local authority safeguarding team, to whom any concerns should be reported. CQC had received 12 safeguarding notifications since our inspection in July 2016. One person had been seriously injured by another person living at the service. However, all of the safeguarding issues raised had been investigated within the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document contained guidance for staff and managers on how to protect and act on any allegations of abuse). The safeguarding team commented, 'The recent registered manager and deputy manager have consistently engaged proactively with safeguarding, and we have no concerns about self-reporting'. Safeguarding issues in the service have been under investigation. In response to this the provider had reduced the number of people living in the service and had changed their admissions policy by not admitting people with more complex behavioural care needs. The numbers of safeguarding incidents in the service had fallen since the provider had changed their admissions policy.

Staff received training in safeguarding, knew what signs to look out for and felt confident the management

team would listen to and act on any concerns they raised. One member of staff said, "I have been on safeguarding training, I look out for things like bruises, skin tears and rashes on people and report any concerns." Staff knew how to "blow the whistle" which is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith. The management team understood when and to whom they should report safeguarding concerns. The service had undertaken investigations in a timely manner when requested by the local authority and used these to identify areas for improvements.

The provider's recruitment policy was followed by the management. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants for jobs had been checked against the disclosure and barring service (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. Before employment, all applicants for posts at this service were asked to explain in full any gaps in their employment history. This was fully recorded and double checked by the acting manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. The agency Nurses were registered to practice with the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded. Our discussions with the agency Nurses in the service confirmed that they had the skills and experience to carry out their duties and responsibilities acting as shift leaders. Newly recruited staff talked us through the recruitment process they had experienced which was in line with the provider's policy.

The service had a medicines policy that gave guidance to staff on how to order, receive, store, administer and dispose of medicines safely. Agency nurses that administered medicines demonstrated they knew how to put this guidance into practice. An agency nurse described the process of safe medicines administration to us in detail. We observed them putting this into practice. They explained to each person that they had their medicines, gave them a drink and checked that people had taken their medicines before signing the medicines administration record. Guidance was in place for people who took medicines prescribed as 'when required' (PRN) so they were administered according to people's individual needs. During the inspection people were asked if they were in pain and their response used to determine whether to give pain relieving medication. People said, "I get my medicines on time." Another person said, "Medicines are brought on time, if I'm going out for a walk I ask for a couple of paracetamol." However, one person told us they had requested some PRN medicines, but had waited for more than an hour and a half. Body charts were in place to clearly identify to which part of a person's body a prescribed cream needed be applied. Medicines checks were carried out in line with the provider's policy and there was an audit of all medicines entering and leaving the service. Nursing staff understood how to keep people safe when administering medicines.

People were protected by nursing staff who understood their responsibility to record the administration of medicines. The medicine administration record (MAR) sheets showed that people received their medicines at the right times and as prescribed. The system of MAR records allowed for the checking and recording of medicines, which showed that the medicine had been administered and signed for by the staff.

The provider had policies and guidance in place about protecting people from the risk of service failure due to foreseeable emergencies, like flood or fire. Contingency plans were detailed and professionally written to make sure people's care would continue in emergency situations. Each person had an emergency evacuation plan (PEEP). Staff told us they received training in how to respond to emergencies and fire practice drills were operating to keep people safe. The acting manager operated an out of hours on call system so that they could support staff if there were any emergencies.

The acting manager had assessed the risks and safe working practices were followed by staff. People had risk assessments in their care plans that were individually designed to minimise risk. People had risk assessments that were specific to their needs. People's risk assessments addressed communication, mobility, falls, and bed rails when appropriate. Sleeping risk assessments instructed staff about the frequency of night observations and repositioning, to check that people were safe. Care plans had actions to be taken to minimise risk. Staff were observed assisting people to transfer and move around the units, and this was done in a safe way. Staff were following these instructions in practice.

Equipment was serviced and staff were trained how to use it. The premises environment was maintained to protect people's safety. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping.

The provider had checked that the environment was safe for people. Other environmental risks were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, to minimise the risks from water borne illnesses.

There were up to date safety certificates for legionella, gas appliances, electrical installations, portable appliances, lift and hoist maintenance. The maintenance staff were quick to respond to repairs. Staff logged any repairs in a maintenance logbook and the maintenance staff monitored these until completion. The maintenance staff carried out routine health and safety checks of the service including regular checks of water temperatures, fire safety equipment and fire drills. Comprehensive records confirmed both portable and fixed equipment was serviced and maintained.

Requires Improvement

Is the service effective?

Our findings

People told us that staff were trained well. One person said, "They are only young girls but they are well trained," and another person said, "All the day staff have had professional training."

People told us that they liked the food that was on offer to them. One person said, "If I am feeling a little fussy about eating they (staff) will go out of their way to find me something I like, and even if I am hungry at odd times something will always be found for me." Another person said, "My appetite is not what it used to be, but I get so many lovely things offered to me, it is hard to refuse when they go out of their way to be so very accommodating."

A relative said, "Mum went off her food completely but they tried everything to help and she would have fortified shakes and drinks if she didn't like what else was on offer, they really went out of their way to help her. The staff are wonderful and try their hardest at all times." Another said, "The staff are brilliant, I simply cannot fault them I would definitely say they are excellent at their jobs, well trained and exceedingly well informed." Another relative said, "What I find encouraging is that whenever we are concerned about Mum or something that may have happened we can always find a record of it on her care plan right down to what she had to drink that morning and that is very satisfying and reassuring for us to know."

At our last comprehensive inspection on 25, 26 and 27 July 2016 we found that staff in the service were not receiving appropriate supervision and appraisal which was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to meet the regulations. The provider sent us an action plan which showed they had met the regulations by 31 March 2017.

At this inspection the provider had implemented a supervision planner which showed that most staff had received at least one supervision since April 2017. All of the nursing staff working as shift leads on the day of our inspection were agency nurses so they were not available as formal supervisors to Care UK staff.

We were told by the quality development manager that about twenty new staff had been recruited in the last two months. About half of these new staff had started their induction to the service on the first day of our inspection. This meant that we could not fully assess the effectiveness of the supervisions planned for all of the staff. All of the newly employed staff had been receiving supervisions as part of their induction. For example, nine new staff had started work in July and August 2017. They had all received a supervision. Staff we spoke with told us that they were receiving supervisions. However, there were still some gaps. One member of staff said, "I get supervisions, but not that often as we do not get time." Some staff had received supervision on a monthly basis and other staff had not had a recorded supervision for five months. Although there had been improvements, we continued to have concerns about how the management team, in its current form could deliver the planned supervision schedule and how supervisions would consistently take place for each staff member.

We have recommended that the provider resources an effective and sustainable supervision programme for

staff in line with Skills for Care Guidance. (Skills for Care provides practical tools and support to help adult social care organisations in England recruit, develop and lead their workforce.)

The provider checked that people's nutritional and hydration needs were being met. Care plans had nutritional risk assessments. For example, one person's nutritional assessment told staff that the person needed a pureed diet and thickened fluids to minimise an identified choking risk. Nutrition and fluid chart records confirmed people at risk were provided with the correct diet and thickened fluids. Staff used a Malnutrition Universal Screening Tool (MUST). MUST is a five step screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. The MUST in care plans identified if people were at low, medium or high risk. Care plans identified when people were on specific diets, such as soft or diabetic diets. Risk assessments were in place for those who were diabetic. People's risks levels were recorded so that staff understood who was at the lowest or highest risk. People at medium or high risks required staff to observe and record what the people were eating and drinking each day. All of the charts we checked had been totalled so that people's recommended daily food and fluid intakes could be effectively calculated. People at risks were being weighed on a monthly basis or weekly when there were any urgent concerns. People's records showed when referrals were made to a GP, dietician or speech and language therapist when appropriate. Care plans detailed people's food preferences. We observed people's eating or drinking preferences were met by staff who gave individual attention to people who needed it.

The chef had introduced a menu that was responsive to people's likes and needs. Menus were displayed in pictorial formats in the dining room. Staff and the chef had diet sheets that identified what diet people required and what options they had selected. Medical information was recorded where this impacted on the persons eating and drinking. For example, if the person was a diabetic or had an allergy to any foods.

People at the service were being supported by staff to attend routine health visits and were getting support with routine optician, dental and GP checks. Staff were managing pressure ulcers effectively. There were eight people identified as at risks from pressure ulcers developing. These skin/pressure areas were being managed by staff using prescribed creams, body repositioning and air flow mattresses to minimise the risks of serious ulcers developing. People's care plans had a Waterlow Score. A Waterlow score gives an estimated risk for a person to develop a pressure sore and these were reviewed monthly. Records showed that staff were identifying any pressure sores at early stages and were recording their healing appropriately with pictures and body maps. Updates were being recorded along with any health care guidance from people's GP or Tissue Viability Nurse (TVN). However, we noted that one of the photographs showing a developing ulcer had not been identified with the person's name, the date or with a measurement. This meant that it was not possible for staff to identify the person if the picture was separated from the care plan or to monitor any deterioration or improvement effectively.

Referrals to other health professionals were done in a timely manner by nursing staff following assessment and observations by staff. For example, staff had referred one person to their GP with a possible urine infection. Antibiotics were prescribed and administered on the same day staff had raised their concerns.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The agency nurses on shift told us they had received training to carry out their roles. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Nurses had training in life support, first aid and the management of diabetes. The first aid training had provided them with information on how to manage/support people who may be bleeding or choking. Training records confirmed that Care UK staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. The staff records we saw contained information about recent training staff had attended and information confirming staff had received an

induction. Training gave staff the opportunity to develop their skills and keep up to date with people's needs.

Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training in wound care and gained knowledge of other conditions people may have such as diabetes and dementia. At our last comprehensive inspection on 25, 26 and 27 July 2016 we made a recommendation about staff training in end of life care. At this inspection staff were not delivering end of life care to any people. However, we found that the provider had started to deliver end of life care training to their staff should this be required.

New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. Staff then started to work through the training to Care Certificate standards. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised. Staff were encouraged to complete a Diploma/Qualification and Credit Framework (QCF). To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services 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. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. The management understood when an application should be made and how to submit them. A log of DoLS applications and renewal dates was held and monitored in the service. 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.

People's right to consent to their care was respected by staff. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. People or their representative had signed to agree their consent to the care being provided whenever possible. Staff talked us through in detail about how they sought people's consent before they provided care for people. This meant that staff understood how to maintain people's individuality and respect choice.

Good

Is the service caring?

Our findings

We observed friendly and compassionate care in the service. One person said, "We are treated with great care and dignity at all times I will give them that." Another person said, "The staff are 100% in all respects I simply cannot fault them and can say with hand on heart that I look forward to them popping their head around the door or just coming with a cup of tea for me."

Most people and their relatives spoke positively about the staff that provided care. One relative said, "I did stay while dad was being given a shower the other day and I was most impressed by how gentle and caring the girls were. They managed with great care and Dads dignity remained intact at all times. It wasn't as traumatic as I had imagined it could be they did an outstanding job they really did."

Staff built good relationships with the people they cared for. Staff promoted a non-discriminatory atmosphere and a belief that all people were valued. Staff were seen to be kind and compassionate towards people. One member of staff told us, "Care is my priority, I treat people as if they were my own Mum or Dad." Throughout our inspection, observed care was kind and respectful. When staff spoke with people who were sitting down, staff were lowering their position so people who were seated could see them at eye level and talk in a clear way to make themselves understood.

Staff spoke kindly to people, did not rush them and addressed them in the way they preferred. Staff knew people well and understood what care they needed. People said, "I am sure I don't make life easy for the wonderful staff but I would say they do respect my wishes and let me do as much as I can myself which is my preference." Another said, "The girls always know when I am having a bad day and just take that extra care to cheer me up I think even if it is just an extra biscuit with my tea that sort of thing or a walk around the garden if we can."

People and relatives told us that they were involved with the planning and reviews of their care plans. One person told us, I do have a care plan and I would say they jolly well stick to it as I am a fussy old thing and like things to be done properly and I like order so we make sure that my care is given just so." A relative told us, "Dad has a detailed care plan and we are kept fully involved with that and if any changes need to be made we informed and it is discussed with us as well as with dad."

People's dignity and independence were respected at all times. All people reported that staff knocked before entering their rooms and close the door for personal care. One person said, "They (staff) always draw the curtains and ask my permission to wash me during personal care." Another said, "Staff always knock." Staff were observed knocking on people's doors, introducing themselves, asking for permission to enter, and closing doors when giving personal care.

Staff had an understanding of what people were able to do for themselves and staff encouraged people to remain as independent as possible. One person said, "I shower myself, make my own bed and do my own dusting." Another person said, "I like to look after myself it keeps my independence." Staff gave examples of how they assisted and encouraged people to be independent. People's dignity was respected during meal

times. Staff described to us in detail how they maintained people's dignity when delivering person care, from entering their room to making sure people were comfortable before they left them. Staff said, "I always look out to make sure people have a drink at hand, I ask if I can do anything else before leaving the room and I always make sure the call bell is at hand for people."

Staff operated a key worker and named nurse system. This enabled people to build relationships and trust with familiar staff. People and their relatives knew the names of staff, nurses and management team. A relative said, "The staff are excellent and keep us fully informed about everything that goes on with Dad."

Care plans described people's communication needs on a day to day basis. The care plans included a good level of information so that it would be clear to staff reading them how best to communicate with the people they were caring for. Reference was made to hearing / visual aids people had and the support they needed to use these.

Information about people was kept securely on a computerised system that required staff to log into it before they could access information. Paper records were returned to the nursing stations to be locked away when not in use with access restricted to staff. When staff completed paperwork this was either stored in people's bedrooms or kept at the nursing stations to maintain confidentiality.

Good

Is the service responsive?

Our findings

People and their relatives said the service was responsive to people's needs, but not everyone was happy with how the provider had responded. One person said, "My opinion is often sort which is flattering and my input is often acted upon and even brought up at meetings I am told so they obviously do listen to us and take it on board."

Another person said, "If we have any worries at all the staff will always be there to listen and help you can rest assured of that. Even if I am alone in my room someone will always pop their head around the door for a quick chat."

A relative said, "My sister was in a vegetative state when she was discharged from hospital. They have looked after her and brought her to a stage where she is now enjoying life again. The care staff are excellent and the management act quickly if we have a problem."

Other people said, "We are often asked our views and we are often told what is going to change but whether this happens or not I can't tell you."

A relative said, "There are relatives meetings, but we have to say they are a shambles to be honest. There is just no organisation to them and no preparation whatsoever."

We discussed the mixed feedback we received with the acting manager. They told us they were aware of people's concerns and were taking action to improve people's experiences. The provider had a complaints procedure in place which was followed by the management. There had been complaints made about the quality of the care at Kingsfield Care Centre. However, the provider had used the complaints system to try and resolve any issues people had. The acting manager had a complaints log in place to record all complaints received, relevant investigations, their outcomes and how this was communicated to the people involved. All of the complaints were reviewed by the provider's regional manager and included having face to face meetings with people who had complained to try and resolve complaints.

People and their relatives were encouraged to communicate their views on the service they received. This increased their involvement in the running of the service. The acting manager had recently introduced a weekly 'Managers surgery' to try and encourage people to talk about the quality of the service they received.

People and their relatives took part in by annual satisfaction surveys. The satisfaction performance of this service was benchmarked against the other services in the provider group. There had been a small improvement in people's satisfaction between March 2017 and September 2017. A relative said, "We were asked for our views on Mums care and the service and we have now filled out a questionnaire that we were given." Some people told us that recent meeting they had attended were not well planned or well run.

The acting manager had produced action plans to improve people's satisfaction with the service at Kingsfield Care Centre. This included holding effective monthly 'Resident and relative meetings.' These had

been taking place to capture people's views and minutes of the meetings were circulated and displayed for people to read. Future meeting dates were advertised within the service. One person said, "At the recent meeting the new acting manager listened to our comments, before other managers were always defensive. We used to have a board with a 'you asked' and 'we did' section and this is to be reinstated."

People received care from staff who knew their needs, their individual likes and dislikes and their life stories, interests and preferences. People's needs had been fully assessed and care plans had been developed. Before people moved into the service an assessment of their needs had been completed to confirm that the nursing or residential service was suited to the person's needs. Each person had their health and care needs assessed in depth.

Daily clinical governance meetings and heads of department meetings were held by the acting manager for nurses and senior staff. People's care needs were discussed and recorded with follow-up actions delegated to staff. For example, on the clinical meeting notes taken on 24 August 2017 we noted that staff needed to chase some stool test results with the local GP surgery. The records showed contacts with the surgery and the results had been received by 29 August 2017. The daily meetings minimised the risk of changes in people's care needs not being responded to.

People made choices about their daily routines whenever possible. One person said, "I can get up when I like within reason, I have my breakfast and all my meals in the dining room and go to bed when I like."

Changes in people's needs had been responded to appropriately and actioned to keep people safer. For example, a person had been moved to a room closer to the nursing station to minimise the risk of falls. The person's relative said, "Mum has had several falls, after a series of meetings with the acting manager she has been moved to a room nearer the nurses' station so they can keep a better eye on her. The room move has been very successful and made Mum much more animated, we are very supportive of the staff everything is here for a cracking good home."

Care plans and risks assessments evidenced monthly reviews. Referrals had been made when people had been assessed for specific equipment, which was in place. For example, people had beds that provided protection from pressure areas developing and enabled staff to move the height of the bed up or down to assist the delivery of care. These gave guidance to staff and maintained continuity of care.

People had opportunities to take part in activities. There were activities coordinators in place who had established an activities program. During the inspection a group of people took part in a cooking session in the dining room making flapjacks. Whilst the flapjacks were cooking, there was a discussion about what food people could make for Halloween. The morning activity was craft in the form of a mosaic. There is an activity plan for each day. The Daily Sparkle was on the activity plan, which was a reminiscence newspaper, published 365 days a year, which offers a range of nostalgia topics and activities, targeted at the elderly and those with dementia. The provider had recently appointed a registered mental health nurse to lead on the development of adaptations in the service for people living with dementia. We observed tactile activities fixed to the corridor walls which people could use, such as plug sockets and switches, padlocks, locks and keys, taps and memory boxes. These provided activities for dexterity and function.

Requires Improvement

Is the service well-led?

Our findings

People were concerned about the number of managers and changes in the management team at Kingsfield Care Centre, although people were happy that the acting manager was now in charge. One person said, "We need someone in charge who understands people and has empathy with us the residents. Things need to be organised around here." Another said, "Home is managed brilliantly, deputy manager is excellent always says hello when she passes by."

A relative said, "There was a change of manager two weeks ago which is for the better. There have been three or four managers since we have been here." Another relative said, "I would not say the service was well led, simply because there does not seem to be a leader." Another relative said, "What this place needs is a good leader, it has gone through some difficult times and we nearly took Mum out but we have seen a marked improvement just in the last couple of weeks to be honest. The atmosphere has been better just this week."

This service has had an overall rating of requires improvement since 19 November 2015 and has been rated as requires improvement in the well-led domain since 19 November 2015. The service was also being monitored by the local authority safeguarding team in relation to the risks people faced from the service delivery. Whilst the service has now started meeting the Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not been able to demonstrate that the actions they have been taking has improved peoples experiences of the care received. For example, some relatives have repeatedly made complaints to the provider about poor care that is resolved, but then not sustained. Staff turnover has been high and staff morale has been consistently low. For example, the providers 2017 staff survey was still showing that staff experienced poor levels of management engagement.

This service consistently performs at the bottom of the providers own service league table. For example, recently collated feedback from relatives about their experience of the service put Kingsfield Care Centre at 106 out of 110 services. This meant that the actions taken by the provider so far were not consistently improving people's experiences of the care in the service.

The registered manager had left the service on 15 September 2017. The provider had appointed the deputy manager to be in day-to-day charge at Kingsfield Care Centre whilst a new manager was appointed. At the time of this inspection the provider had recruited a new manager who would register with the commission, but they were not yet in post. This meant that we were unable to fully assess the sustainability and the leadership in the service.

The provider had also put additional management resources into the service to support the acting manager. One member of staff said, "Things are starting to roll out and smooth things, it's getting a lot better." Another staff member said, "The additional support from the regional manager and other senior managers has been very helpful, I have definitely seen a change for the better." An agency nurse said, "The current management are very supportive, it's a much happier environment now."

We have recommended that the provider seeks advice and support from organisations that could provide focused and timely improvements to the management of the service.

At our last comprehensive inspection on 25, 26 and 27 July 2016 we found that staff in the service were not keeping accurate and complete records in relation to the care and treatment provided. Actions were not being taken to assess, monitor and mitigate risk in relation to fire systems within the service. This was a breach of Regulation 17 (1) (2) (b) (c) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made. The records kept on the computerised care recording system were up to date and information was fully recorded. These enabled people's health and wellbeing to be monitored and reviewed. Staff told us they had received additional guidance from management about keeping accurate care records. Staff said, "We have really got on top of consistent record keeping."

An agency nurse said, "It is part of my role to check that records are completed, the staff have supported me with this." We checked to see if daily care notes had been completed and this was the case. However, there were still some areas on the paper based system that were not clear. For example, a care plan stated that a person was unable to use the nurse call bell to summons assistance. Therefore an hourly staff check was in place to maintain contact with the person and to make sure their needs were met. However, the hourly check form had not been fully completed. We also found a record of challenging behaviour for a person that referred to a behavioural care plan. However, there was no behavioural care plan in place. We discussed this with the acting manager who went to look into it. They told us that the person did not have challenging behaviours and did not require a behavioural care plan. A member of staff had incorrectly put the challenging behaviour record into use. The acting manager said this had now been removed.

The provider's policies and procedures relating to safety were implemented effectively. The acting manager's approach to risk management and their response to issues was effective. For example, an area of the garden had been cordoned off whilst contractors were sought to repair a loose tile on the roof. General risk assessments affecting everybody in the service were recorded and monitored by the acting manager. Service quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. A health and safety maintenance checklist was in use and other periodic risk management systems were in place to check for hazards that may cause harm, for example checks on bed rails, furniture and wheelchairs. If faults were recorded these had been responded to and the hazard repaired or removed. Risk auditing and periodic maintenance checks minimised the risk of accidents and harm.

The acting manager produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises. For example, some areas of flooring had been identified for replacement and some of the vacant rooms were going to be refurbished.

The acting manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This made issues about people's safety transparent to external organisations who could check the right actions had been taken.

The provider's regional manager was often on site. They had assisted the acting manager to develop the service systems and they 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.

There was a five star food hygiene rating displayed from the last food hygiene inspection.

There were a range of policies and procedures governing how the service 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 service.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the reception area and on their website.