

Meridian Healthcare Limited

Kingsfield Care Centre

Inspection report

Union Road
Ashton Under Lyne
Lancashire
OL6 9JF

Tel: 01613301853

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28 July 2016

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Inadequate ●

Is the service caring?

Inadequate ●

Is the service responsive?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

We inspected Kingsfield Care Centre on 26, 27 and 28 July 2016 and our visit was unannounced on day one.

The service was previously inspected on 14 June 2013 when no breaches of legal requirements were found.

Kingsfield is one of 31 care homes owned by Meridian Healthcare and is situated in the Ashton-under-Lyne area of Tameside. The home provides care, support and accommodation for up to 54 people who require personal care without nursing.

The home is a single storey, purpose built care home and all rooms provide single accommodation, many of which are en-suite. Communal bathrooms and toilet facilities are available throughout the home. Bedrooms are located around four corridors and people have access to a large combined lounge and dining room with an attached conservatory. The large kitchen is attached to the dining room. The home has a separate laundry area and a room named the sun room; this area is equipped with sun lamps, deck chairs and is decorated to resemble a beach. There is a quadrangle garden and patio area in the middle of the building that is accessible to people who use the service. Kingsfield had an attached unit, known as the Windsor Suite, where people living with dementia and higher support needs were cared for. However, this unit had been closed for redecoration and the people who were usually cared for in the unit were spending their days in the conservatory of the main lounge during our inspection.

At the time of our inspection there were 39 people living at Kingsfield.

The service did not have a registered manager in place. 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. The previous manager had left in June 2016 and the provider had deployed a number of relief managers in the period up to our inspection.

We carried out this inspection in response to information we received from the Health and Safety Executive (HSE) regarding a person who had fallen at the home and had sustained a serious injury.

We identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We have made one recommendation about the preparation and service of food for people who require a specific diet.

During this inspection we found that there were not always enough staff available to meet people's needs.

Unsafe staffing levels were reported to us by staff and inaccurate rotas meant that we were unable to make a judgement about whether calculated staffing levels were adhered to. Throughout our inspection we saw many examples where people were left unattended or did not receive support in a timely way.

People were supported by staff who were mostly kind and caring, however, the majority of interactions between people and the staff who cared for them, were task-based and observations we made showed us consent was not always sought before care was provided. We saw a number of instances where people were not treated safely or with dignity and respect and we reported staff members' actions to senior management during the inspection visit.

Staff told us they did not receive communication, direction or support from management.

Care plans and risk assessments were in place; however, they did not always accurately reflect people's current care needs. Inaccurate records placed people at risk of receiving inappropriate or unsafe care and support.

We did not see evidence of people or their representative's involvement in their plan of care or descriptions of how people would like their care needs met.

We found that records of the administration of medicines were in order. Documentation at the home showed us that people mostly received appropriate input from health care professionals, such as district nursing and their general practitioner (GP), to ensure they received the care and support they needed. However, we found one person was visibly suffering from infections and required medical attention that had not been sought, one person who had an untreated wound and one person who, because they were not being repositioned as stated in their care plan, placed them at a higher risk of developing pressure ulcers.

We found people were not always appropriately supported to ensure they had their nutritional needs met in a specifically prescribed way and documentation was not always accurately completed. We made observations that the dining experience for some people was not enjoyable due to insufficient numbers of staff being available to support people.

Staff we spoke with understood how to safeguard people and were able to demonstrate their knowledge around safeguarding procedures and how to inform the relevant authorities if they suspected anyone was at risk from harm. However, not all staff demonstrated an understanding of the legal safeguards around mental capacity. We found that people had not always been protected and staff had not reported improper treatment as we found during the inspection.

During our observations we found that people were not always moved and handled in a safe way or in accordance with individual assessments.

During our initial tour of Kingsfield on the first morning of our inspection, we noted that some areas of the home had a malodour and we identified issues with infection control in a number of areas of the building.

We found that people could not easily call for assistance; call bells in communal areas did not have attached cords and we found one person's bedroom call bell broken. People who had a sensor mat in their bedroom did not have access to a call bell, because there was only one socket which was either used for the sensor mat or the call bell. Therefore people in these rooms were not able to call for assistance.

Audits and checks for building and equipment safety were in place and up to date.

During our inspection we raised a safeguarding alert with the local authority about our concerns relating to care and support practices; specifically lack of medical attention, people's dignity and unsafe moving and handling of people. We also reported our initial findings to the local authority commissioning team.

We found concerns regarding the high level needs of people at the home and asked for clinical assessments of people to be carried out during the inspection visits.

Due to our findings on the first day of our inspection the provider invoked a 4-week minimum, voluntary suspension on new admissions to the home until the issues we had identified had been resolved.

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 were not moved and handled in a safe way.

Insufficient numbers of staff meant that people did not always receive care and support in a safe and timely way.

Risk assessments were in place; however, these did not always reflect the current care and support needs or give accurate information, for staff to follow, about how to safely provide care and treatment.

We found records of the administration of medicines to be in order.

People who had sensor mats in their bedrooms were not able to have access to a hand held call bell and summon assistance if required.

Safe recruitment practices had been followed to ensure that suitable staff had been employed to care for vulnerable people.

Is the service effective?

Inadequate ●

The service was not effective.

People did not always receive the required nutritional support in the way that had been prescribed for them by health care professionals.

People were not always involved in decisions made about their care and support.

Required training was incomplete or not up to date for all staff members.

Consent was not always sought before support and care delivery. Staff did not have knowledge or understanding of the Deprivation of Liberty Safeguards.

Is the service caring?

Inadequate ●

The service was not always caring.

We saw that people were sometimes treated in a caring and respectful way; however, we also saw that people were not always treated with privacy and dignity.

We saw instances where people were spoken to, or spoken about, in an undignified and unkind way.

Low numbers of staff meant that people were not always treated by attentive staff who had time to spend with them.

Staff told us they did not have time to read people's life story documents, but would like more time to get to know people. They also needed more time to be able to sit and talk to people on a one to one basis.

Is the service responsive?

Inadequate ●

The service was not always responsive.

There was an activities programme and activities co-ordinator in post. People did not receive one to one support to enable them to participate in their own interests.

We saw that people were not engaged in positive activity throughout the day during our inspection.

People did not always have access to call bells and people's requests for assistance were not always attended to in a timely way.

Is the service well-led?

Inadequate ●

The service was not well-led.

There was no registered manager in place at Kingsfield and there had been a series of relief managers for several weeks.

The provider had failed to communicate incidents of concern to the CQC as is their legal responsibility.

Staff told us they did not receive support and direction from management.

Care records and personal information was not kept secure and confidential.

Corporate quality systems were in place to monitor the quality

and safety of the service; however these had not identified the issues we found during the inspection and were therefore ineffective.

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, 27 and 28 July 2016 and day one was unannounced. The inspection was carried out by two adult social care inspectors on days one and two, and one inspector on day three.

Before we visited the home, we checked information we held about the service including contract monitoring reports from the local authority and notifications sent to us by the provider. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service.

On this occasion, we had not asked the service to complete a Provider Information Return (PIR) because we carried out the inspection in response to concerns received. A PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We walked around the home and looked in all communal areas, bathrooms, the main kitchen area, store rooms, medication room, Windsor Suite and the laundry. We also looked in several people's bedrooms and outside the building; in the garden and patio area.

During the three days of inspection, we reviewed a variety of documents. This included policies and procedures relating to the delivery of care and the administration and management of the home and staff. We looked at five people's individual care records, the administration of medication and five staff personnel files to check for information to demonstrate safe recruitment practices. We also checked to see if training and regular supervision had taken place.

As part of the inspection process we observed how staff interacted and supported people at mealtimes, in the lounge area and throughout the home at differing times of the day. We also observed the way people

were spoken to and several instances of care delivery where staff used manual handling techniques to move people.

We spoke with two people who use the service, seven relatives and two visiting professionals. We also spoke with the two assistant operations directors from the organisation's head office, the handyperson, two senior carers and six staff members who provided care and support to people living at Kingsfield.

Is the service safe?

Our findings

We found that people were not being cared for by a sufficient number of staff at Kingsfield Care Centre.

People's visitors told us they thought there were not enough staff to provide care and support to all the people and that staff were rushing around. One visitor told us, "Sometimes staff seem stretched and it's difficult to fit it all in".

The assistant operations director told us that they use a dependency tool to assess people's needs and to calculate how many care staff are needed to ensure that people receive the required levels of care and support. Usual care staff levels were six carers and one senior carer during the day and three night care staff on duty in the evenings. We were unable to ascertain exact staffing levels from the rotas supplied to us during the inspection, as they did not reflect the actual numbers of people who were on shift each day. The dates were missing and included the names of people who were not currently in work. However, staff we spoke with and visiting relatives confirmed that these specific staffing levels had not been maintained and told us that only three staff instead of seven had been on duty during the previous weekend day shifts.

On the first morning of our inspection, we found there were four carers and one senior on duty when expected levels were six carers and one senior. The senior carer was the most senior person on duty as the deputy home manager was on long-term sick leave and the relief home manager did not arrive until later in the day. This meant that one senior person was providing care, giving out medication, supervising care staff and dealing with any incidents and enquiries that would require the most senior person on duty to address.

During the afternoon on the first day of our inspection, we became aware of one member of staff from a sister care home who had arrived to provide further care staff cover at the home. Another staff member we spoke with on the first day of our inspection told us they usually worked until 11am each day. However when asked why they were still at work after 11am, they told us, "I was asked to stay until 4pm to help out." It was clear that this person didn't normally work after their shift had ended. On the second day of our inspection we became aware of one carer who had come into to work on their scheduled day off, they told us they had done this to support their team of carers. This meant there was more staff on duty during our visit, than would have been, had we not been carrying out an inspection.

We spoke to several members of staff who all told us they were concerned about the safety of people due to low staffing levels. One staff member told us, "There's a definite issue with staffing levels...someone might have a fall; people have falls that wouldn't normally happen if we're fully staffed" and, "I don't think people are safe with the staffing levels". "Three staff at night just isn't enough". Another staff member we spoke with told us they felt that people were in danger when they are short staffed. They told us, "People get left alone and can fall and argue...we've had quite a lot of falls recently". And, "Three staff at night is not safe, especially if someone needs to go to hospital, last month there was only two (staff) on at night". Staff we spoke with all expressed the same concerns about the people's safety. Another staff member told us, "It's impossible to be in two places at once, people are vulnerable...risk of falls when we're short staffed. Lots of people need two staff."

One person we spoke with who lives at the home told us they were shouting out for assistance for half an hour because they wanted to use the toilet and said, "There's not enough staff...I have to wait so long." One visiting relative told us they felt there were not enough staff at times and the staff are rushing around, they told us whilst gesturing to people in the lounge, "Some people here are unsteady on their feet; look around, people have bruises on their faces."

During the inspection, the visiting assistant operations director spoke with the inspectors and acknowledged that staffing had fallen well below calculated levels. They told us this was because Kingsfield Care Centre had not had a consistent home manager for several weeks and they had not been keeping on top of staffing levels. They went on to say that any absence had not been addressed or backfilled leading to inadequate care staffing levels. The provider told us they would be providing safe staffing levels immediately and an extra staff member would be employed to work on the night shift, thus increasing night staffing levels to four carers.

During the initial stages of our inspection, it became apparent that the needs of some of the people living at Kingsfield Care Centre were of a very high level; including frailty and exhibiting complex needs. We also raised concerns with senior managers from the organisation that peoples need were not being met by the current staffing levels and the skills mix and competencies of the staff employed. Our concern about these people was such that we instructed senior management on the first day of our inspection to conduct clinical reassessments of all the people who had high levels of need. This was needed to make sure people received the correct levels of care and support. We also wanted the provider to assure themselves and us that the people present during our inspection were correctly placed and where necessary seek medical assistance. We also noted that some people had bruising and skin tears, for example one man had bruising and skin tears to one side of his face and one lady had large bruise on the back of her head. Additional staffing arrangements were put in place by the end of day one of the inspection and the proceeding days, which included the deployment of the provider's Quality Manager, who is also a registered nurse, who was supporting the staff to identify which high dependency residents needed referral for reassessment and instructing staff about safe care delivery. It was also anticipated that some people would require reassessment from their funding authority to make sure they were correctly placed, and if not moved to a more suitable placement i.e. a care home with nursing.

Staffing levels at Kingsfield Care Centre did not provide adequate care and support to reflect the actual dependency levels and care needs of the people who lived at the home and ensure that people received the care and support they required in a safe and timely way.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We found that people had a Personal Emergency Evacuation Plan (PEEP) in place. A PEEP provides additional information on accessibility and means of escape for people with limited mobility or understanding and includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire.

We looked at a sample of five people's individual care records and found that people had risk assessments in place however; we found that not all plans reflected people's current care needs. For example, one person who required assistance to eat, and was at risk of malnourishment, had not had their nutritional risk assessment reviewed since March 2016. The same person had a nursing assessment in place, but no outcome had been recorded on the form. In addition, the person was unable to reposition themselves, which meant they were at risk of developing pressure ulcers. In these circumstances good practice would

mean they were assisted to move position or change position after one or two hours. We observed this person had been sat in the same position for six hours. We could not find a risk assessment in place for pressure care for this person and therefore they were not being adequately monitored to prevent pressure ulcers developing. We also concluded that appropriate checks were not in place. We asked staff to ensure the person was repositioned regularly. This meant that people did not always have the necessary risk assessments in place to minimise the risk of harm during care and support.

During the second morning of our inspection visit one person was found to have fallen on the floor of their bedroom. They had been unable to summon assistance because they had a sensor mat in place at the side of their bed and no access to a call bell. The person was found when a carer had entered their bedroom to assist them in getting up. It was found that the person had pushed their sensor mat to the side and therefore the sensor mat alarm had not been activated. The person told us they had moved the mat because they thought it was a wet area and they would slip on it. We asked staff if they knew how to risk-assess the situation before safely moving the person. None of the three staff present were able to tell us this procedure. One staff member went for the person's risk assessment from the office. This document did not clearly indicate to staff how to safely move the person and we found this person's care plan did not contain suitable and sufficient risk assessments to effectively manage this risk. All the time the person was still on the floor, having not been checked over or assisted appropriately.

We left the room and found the provider's visiting clinical lead manager and requested that they assess the person and decide the safest way to move them from the floor. This meant that although a risk assessment had been completed, it did not reflect the person's moving and handling needs and staff were not aware of the procedure to be followed to ensure they could safely move the person. The person continued to be on the floor for a further 20 minutes whilst decisions were made around the safest way to move them. Staff told us they had previously picked the person up from the floor themselves, however, the clinical lead manager, on completing a full body check of the person, assessed that the person required to be lifted from the floor using the hoist.

The clinical lead manager was visiting in response to our concerns around the dependency needs of people and would not usually be present at the home. This meant that staff would have moved the person from the floor without the correct knowledge of how to assess someone for injury or how to safely move someone who has fallen and may be injured.

The above examples demonstrate a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We reviewed care records and found that people had moving and handling assessments in place. Throughout our observations during the three day inspection, we found that staff mostly employed safe manual handling techniques when moving people. However, we found people were not always moved by staff who were suitably competent and skilled to enable them to move people in an appropriate, safe and dignified way.

We saw that one person was transferred from a lounge chair to a wheelchair with two staff using an inappropriate underarm lifting technique. Another person was transported from the dining room to the lounge area in their wheelchair by one staff member tipping the person backwards so that only the back wheels were in contact with the floor and 'wheelied' across the room. We also noted that the person was not wearing a lap belt.

We observed another incident of concern where one member of staff was assisting a person to walk from

the lounge area to the dining room. The person stopped walking and stood still; one staff member came up behind the person and started to rock the person from side to side saying, "Left, right...Left right." The person continued to stand still and the second staff member moved a dining chair and put it behind the person, causing them to sit back into the chair. The two staff members then proceeded to slide the person, sitting in the chair, across the laminated floor and placed them at the dining table. This resulted in the person's foot becoming trapped under the chair whilst being slid across the floor. We asked that the person be checked for any harm sustained in the incident, we also reported the incident immediately to the management team.

The above examples demonstrate a breach of Regulation 12 (1) (2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

On the first morning of our inspection we could see that people were being transported in wheelchairs that were not safe to use, fit for purpose or being used in a safe way. We saw that staff moved people without using the attached footplates or that wheelchairs did not have both footplates attached. The use of a wheelchair without the correct use of footplates poses a risk of injury to people's feet and ankles. We reported these findings to the management immediately and informed them they must remedy the situation. A number of staff told us they had reported the poor condition of the wheelchairs to management on several occasions, but no improvements had been made in response to their concerns. One staff member told us in relation to the wheelchairs, "We've told management time again, but they have said it's their own responsibility." Another staff member told us, "I have told management they are broken and we need new ones, but nothing is done about it." And another staff member told us, "We've been asking for wheelchairs for months."

Due to our concerns on the first day of the inspection around the people being transported in wheelchairs in an unsafe way, we reported this back to the provider, who then had ten usable wheelchairs delivered the same day.

This was a breach of Regulation 12 (1) (2) (a) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

As part of our inspection we looked at how accidents and incidents were recorded, analysed and acted upon. The provider was initially unable to locate the documentation for our inspection, however, copies were provided on the second day of our visit. Accidents and incidents were recorded on specific forms and then transferred to the corporate database for analysis. We saw that documentation and analysis had been completed on a monthly basis. We looked at a sample month of recordings for January 2016 and found that accident records indicated a high level of falls; records showed us a total of 12 reported unwitnessed falls. We did not see evidence that the analysis report information, that clearly indicated a high level of falls, was being actioned to minimise the risks to people and reduce the number of accidents and incidents. We were not given any information and did not see any evidence of further investigation into the trend or steps taken to mitigate the risk.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During the inspection we looked at four staff personnel files to check that safe recruitment practices had been undertaken. We found that the files contained information including, work history, references from previous employers and checks from the Disclosure and Barring Service (DBS). The DBS carries out checks and identifies to the home manager if any information is found that could mean a person may be unsuitable

to work with vulnerable adults. This meant that the provider had received satisfactory assurances and that robust and safe recruitment practices were followed to ensure that suitable staff had been employed to care for people who because of their circumstances may be vulnerable.

Arrangements were in place to safeguard people from potential abuse; a safeguarding policy was in place and training was provided for staff. However, training documentation showed us that not all staff had received training or were up to date with refresher training. One staff member we spoke with told us they had not had training around safeguarding but was able to tell us about two safeguarding incidents they were aware of. Other staff members we spoke with were able to tell us about the different types of potential abuse and what steps they would take to report any concerns they might have. One staff member told us they would report any concerns to a senior carer. The same person told us they would report any serious concerns to the Care Quality Commission (CQC). This meant that although training was not always complete, the staff members we spoke with were aware of potential safeguarding issues and knew what steps to take if they had any concerns around people at the home. A whistleblowing policy was in place and staff we spoke with were aware of how to access this. Despite demonstrating knowledge around safeguarding people from abuse, there was a failure on care staff to report instances of improper treatment as we found during our inspection.

This was a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We looked at the way in which medicines were managed at Kingsfield Care Centre. We found that there was a relevant policy in place and systems used for stock control and medication administration. The home used a local community pharmacy to manage the stocks and deliver the medicines. The home had the required safe cabinet and record system for storing controlled drugs (CDs); a controlled drug is a drug whose use and distribution is tightly controlled because of its risk or abuse potential for example morphine. Temperature checks for the medication fridge and store room were monitored and within safe limits. The room currently used for storage of medicines was small and a new, larger store room was being prepared during our inspection visit.

Medicines were administered by senior care staff from a lockable medicines trolley and were recorded on the medication administration record (MAR) sheets in individual files. Only trained senior staff and management had key access to the medication trolley. The MAR sheets contained a photograph of the person which helped to ensure that the right person was receiving the correct medication. There was a protocol in place for PRN medications; these are to be given as and when required, and these were clearly identified on the person's MAR sheets. We checked a sample of nine of these records and found them to be in order. We saw that medication record audits were conducted daily to check a sample for accuracy and to provide extra checks on the safe administration of medication. Creams and liquid medication was kept in individual baskets labelled for each person and we found topical cream charts were completed when applied, for example, when care staff have applied cream to a person in their bedroom.

We observed one medication round on the first morning of our inspection and found that the senior carer on duty that day was in charge of administering the medicines to people in the large lounge/dining area. During this medication round we saw the medication trolley was unlocked and the doors open for short periods of time on several occasions. We also witnessed two occasions where the medication trolley was not in the member of staff's eye line and the senior carer had their back to the trolley; there were 23 people in this area during this time and only one senior carer, who was conducting the medication round. This meant there was a risk that people, some of whom are living with dementia, had access to medicines in the medication trolley.

We found that district nurses visited the home and carried out blood tests for glucose levels for people with diabetes and they also administered insulin injections. District nurses had their own files kept at the home where they made their own recordings of any care interventions; these files were accessible to care staff if required.

During the inspection, we toured the building and found communal areas within the home to be mostly clean and tidy; however, we also found areas of concern regarding infection control. The home had a malodour in many parts of the building. We found there were no working facilities for people to wash their hands in one toilet and no hot water for people to have a wash in one wing of the building. We also reported to the management that one toilet, that we checked each day and found that the bins had not been emptied for three days. These bins were for paper towels and continence products and gave out an unpleasant odour.

We saw that staff wore appropriate personal protective equipment (PPE) where necessary and this was accessible throughout the home. Staff wore different colour aprons and gloves dependent upon the task. This meant that staff followed safe infection control practices to minimise the risk of cross contamination between people who used the service. We found the sluice room did not have a secure entry system and was secured only with a simple bolt on the outside of the door and contained cleaning fluids. We looked in the laundry and found there was a security keypad entry system, however, the number code was written above the lock, which meant that chemicals and soiled laundry items could be accessible to people who live within the home, some of whom live with dementia. The laundry did not have a safe system in place to prevent cross-contamination; the dryers and washing machines were next to each other creating a risk that clean clothes could easily come into contact with soiled items. There were hand-washing facilities in the room but these were inaccessible to staff as they were obscured by a washing machine.

When we spoke to staff about the availability of slings, they told us that they did not use different slings for each person and they just used the one available. This practice meant that there was a risk of cross infection by using the same sling for more than one person. Each person needs to have a sling for their personal use. In addition to issue with infection control, slings need to be the correct size for the person to ensure safe moving and handling.

The above examples demonstrate a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During the inspection, we reviewed the health and safety documents. We saw that safety checks, such as water and fire checks were carried out and general building maintenance contracts were up to date. Equipment, such as, hoisting, laundry and electrical equipment were regularly serviced. We spoke with the handyperson, who told us of the checks they made on a regular basis, such as clear fire escapes, water safety, window locks and safety checks of the outside area.

Is the service effective?

Our findings

During this inspection we reviewed people's personal care files to check if people were supported to maintain their health and well-being. We saw people were supported to access other health care professionals, such as district nurses and dieticians. These visits and appointments for people were also documented in separate files in the main reception office. We observed morning shift handovers on two days and saw that people's current conditions were discussed and who required input from healthcare professionals that day. Although we could see evidence in people's care records that they had received input from professionals, we found that the medical needs of people were being neglected during our inspection. We found one instance where professional input was not being followed by the home with a continuation of a prescribed care; we observed one person to have bare legs displaying an open sore to their ankle. We spoke to care staff and they told us the person had been prescribed a special stocking to be worn with cream and this had helped with the wound, however, the wound was not currently being treated because the home had run out of supplies. This placed the person at risk of deterioration of the wound and potential infection.

We found one person who was nursed in bed and their feet were pressed up against the unprotected wooden footboard of the bed as there was no protector; leading to a potential risk of developing pressure ulcers. The person was immobile, frail and had thin skin that was susceptible to the risk of break down if not protected from hard surfaces. We asked staff to reposition the person so they were more comfortable and in a safer position.

On the first day of our inspection, we spoke to one person in the conservatory. It was clear that the person had spilled food down their clothes and on the table; they also told us they were cold. We could also see that the person had symptoms of infections in both eyes. Through talking to the person we also identified that they were suffering from severe oral thrush. We reported this immediately to the senior carer in charge; they told us they would contact the GP to request a visit. The GP subsequently prescribed anti-biotic eye drops and anti-fungal mouth drops. Treatment commenced immediately and we could see over the next two days the person's conditions improved.

These examples mean that people were not sufficiently protected from suffering as a result of neglect or potential neglect. We reported our findings to the provider during our inspection.

The above examples demonstrate a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

As part of our inspection, we looked at the menus and food choices available to people living at Kingsfield Care Centre. The provider gave us a copy of the set menu for the next two weeks, showing options for each meal and snacks throughout the day. Supper consisted of biscuits and milk drinks every night with no alternative listed for people who did not like biscuits or milk, or for people who could not eat biscuits due to dietary requirements. During the inspection we found that although the menu indicated choice, people were not always offered choice during mealtimes. During our observations of the breakfast meal, we did not

see people being offered a choice. People were served cereal and toast without being asked what they would like. We spoke with a staff member about choices for people and they told us, "We know what people like and that is what they get." We asked about a cooked breakfast option being offered to people, as per the menu, and the staff member told us it was for those who always get it. We did not see that people were always supported, or efforts made, to enable them to make a choice for their food at mealtimes. During the lunchtime meals, we saw that people were given a drink of cordial in a plastic beaker, some people were given a choice of orange or blackcurrant, however, we observed not everyone was given the option. The menu states that the main meals are served with a chilled drink, but people may have tea or coffee with their dessert.

On the first day of our inspection we became aware that people had not been offered a drink mid-morning, as staff told us they had not had time to do the drinks trolley. This meant that people had not had a drink between breakfast and lunchtime. One visiting relative stopped us in the lounge and told us, "On Saturday I had to ask for a drink for my relative as it was warm and they had not had a drink." Throughout our inspection we saw many instances where people did not have access to a drink. We spoke with management and asked them to ensure that everyone was offered a drink and we saw the drinks trolley was taken around to people regularly during the rest of our inspection.

We found that the cook was on long term sick leave and the kitchen was being covered by three kitchen assistants. We spoke with the kitchen staff about the nutritional needs and preferences of people and found they were not aware of the specific dietary requirements of people living at Kingsfield Care Centre. There was no information held in the kitchen to inform staff of people who required to have their food prepared in a specifically prescribed way and staff did not know if anyone in the home was diabetic. We asked kitchen staff how they would prepare food for someone who was diabetic and they told us they would serve the same food everyone was having, but would give a smaller portion. Kitchen staff were unaware of the needs of diabetic people and how their food needs to be prepared. This meant there was a risk that people could be served food that may make them unwell.

People with certain health conditions require their food to be prepared in a specific way to ensure they can eat and swallow their food comfortably and safely. For example, if someone is at risk of choking. In these instances a stage two diet means that food needs to be pureed and a stage three requires food to be of a minced consistency. Care staff and kitchen staff told us that certain people needed to have their food blended but had no information or knowledge around the different food stages and how food needs to be served to ensure people are able to eat safely. General blending of food does not mean the food is prepared to the safe consistency as per their specific needs. Kitchen staff we spoke with did not know what fortifying food meant and did not add anything to anyone's food in order to add calories. A fortified diet requires high calorie food items, such as cream, to be added to food for people who are underweight or at risk of losing weight. When asked about cream being added to people's food, one kitchen assistant told us they used to use cream in porridge, but they now use milk.

We saw that people who required their food to be served in a prescribed way, such as pureed, had it served where all the ingredients had been pureed together. For example, we saw that lunch on the first day of our inspection was a Chinese meal that was being served on plates to people, however, some people had this served to them in a bowl as a brown puree. This meant that some people would not be able to experience the individual tastes of each food item, which can cause lack of appetite.

We recommend that meals for people with specific dietary requirements are served their meals in individual items in the same way as everyone else that lives at the home.

We were aware that a number of people living at the home were receiving specialist input from the community dietician team and they had a specifically prescribed diet and the lack of staff knowledge and information held in the kitchen meant that food was not being prepared in the prescribed way and served in a safe way.

We looked in the care plan of one person living at the home who required specific nutritional support. The person had input from a dietician in April 2016 and had a full nutrition care plan from them which prescribed a stage 2 diet, with their meals to be fortified with high calories food items. A diet sheet was included in the nutrition care plan along with suggestions of high calorie food to be offered. This person was very underweight with a body mass index (BMI) of 12 and required monitoring by the home to prevent further weight loss. We checked care records for this person and found that an eating and drinking care and support plan had been completed on the second day of our inspection and food and fluid input/output charts were only available for the previous three days. We asked the provider for previous records so we could evidence the nutritional plan had been followed since it had been prescribed and monitoring had been taking place, but we were told they could not be located. We looked at the records for the first day of our inspection and found the 24 hour fluid intake and output records indicated that this person had taken just 450mls of fluid since breakfast and had not passed urine all day. We also looked at their 24 hour food intake record, breakfast record and daily record of care to see what had been recorded around what they had eaten that day. We found records stating that this person had eaten a certain meal for lunch. However, we observed this person regularly throughout the day and were aware they had been served a different meal and had not eaten it. We observed staff place food in front of them and walk away. The food was left uneaten for long periods in front of the person. This person found it difficult to eat their food and required assistance and prompting. We did not observe any input from staff during mealtimes. In addition, we saw that this person was regularly without access to a drink for long periods. We found this person's prescribed nutritional care plan was not being followed and meant they were at risk of the complications caused by further weight loss and dehydration. We informed the senior managers of this and made sure food and drink was available to this person during the inspection.

We reviewed a sample of peoples completed breakfast charts which recorded the food served to the person, but not how much they had eaten or drank and no record was kept of intake. This meant that accurate records were not being kept in order to effectively monitor the person's condition in line with the nutritionist's care plan.

During our observations, we saw that insufficient staffing numbers had a negative impact on the dining experience of people. For example, staff served meals by placing food in front of people and then left to serve someone else; leaving people who required assistance without the support they needed. We saw a number of instances involving several people where food was left on the plate and taken away uneaten. People were not encouraged or supported to eat/ drink what had been provided.

One person had an altercation with another person at one dining table, leading them to spill juice down their clothes; the person was taken away by a staff member to change their clothes, when they returned they were not taken back to the dining table but taken to the lounge area away from the other diners. Their meal was retrieved and placed on a small, occasional table at the side of them. They did not receive a drink. The person was unable to eat in this position and in trying to do so; they spilled food down themselves and over the floor. They got up and left the lounge area without eating their meal. We reported this incident to the management and asked them to ensure this person was offered an alternative meal and to ensure that all people had received enough to drink.

We asked staff if they thought people were supported to eat well at Kingsfield Care Centre, one staff member

told us, "A lot of people need prompting, but we haven't got the staff to be doing it."

One person required full assistance to eat and we observed the kitchen assistant giving the person porridge from a spoon whilst in a backwards reclined position instead of them being positioned in an upright position. This meant that the person was at potential risk of choking.

The above examples demonstrate a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

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 made 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 homes are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We looked at whether Kingsfield Care Centre was working within the requirements of the MCA and DoLS and we saw that the relevant applications had been made to the local authority.

We found when we spoke to staff that they did not all have an understanding of the MCA or DoLS and were not able to confidently describe to us what this meant for people who lived at the home or give us examples. One staff member told us they did not know what DoLS was and had not received training. Another staff member was able to tell us what they knew about people's mental capacity and their choice to leave the home, however, they also told us that they thought most people who lived at the home were subject to a DoLS authorisation. Staff told us that people living at the home did not know the keypad number and they did not tell them.

We reviewed the training matrix and could see that 39% of staff had not received training in this subject. This meant that not all staff had the knowledge to be able to ensure that people were not deprived of their liberty without the legal safeguards in place and to ensure that care and support was always provided in line with the MCA.

We spoke to staff about people's choices and gaining consent to provide care and support to people at Kingsfield Care Centre. One staff member told us how they would give people choices and ask consent to perform a task; they gave us an example of asking someone what time they preferred to go to bed.

During our inspection we saw that staff sometimes sought consent from people before providing care and support. However, we saw that people were often told they were moving from the lounge to the dining area and vice versa. We saw many instances where staff did not always seek consent before care was given, for example, people were taken to the toilet without first being asked if they would like to go.

We found there was no evidence to support that people or their representatives had been involved in writing their own plan of care. We did not see any evidence that people's preferences had been taken into account

when care plans had been written. People had a "life story" as part of their care records, but staff we spoke with, told us they had not had time to read them or their care plans. This meant that staff did not know the background to people and how they preferred their support and care need to be given.

We saw in one care plan that the person did not have capacity to make decisions and we found evidence of a best interests meeting to decide where the person should live. A best interests meeting, is usually held when a decision needs to be made about someone's care and where a person's lack of capacity has been established through assessment. We saw that a single assessor had completed and signed documents in the person's care plan. There were no other people involved in the best interest meeting, no second opinion, no alternatives explored and no evidence given as to the mental capacity of the person for whom the decision was being made for.

Care records of one person, who lacked capacity, showed us they did not have anyone to represent their wishes, nor did we see evidence to show this person had been enabled or supported to make decisions about their care and they did not have an advocate to help them make decisions about their care. We found in these care records a letter from a general practitioner giving permission for the home to give the person covert medication. Covert medicines are medicines that are given without the person's knowledge. Covert medicines should only be given when the person is deemed to lack capacity, and when providing covert medicines has been assessed as being the least restrictive option in that person's best interests. We did not find any evidence of a best interest meeting around the decision to provide covert medication, nor any evidence to show this decision had been reviewed.

The above examples demonstrate a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

As part of our inspection we looked at whether staff receive training and the necessary support from the provider, such as, supervision and personal development, to enable them to carry out their duties. We spoke to staff who told us they used to get supervision from the previous home manager; however, it had not been happening recently. Staff told us they do not feel supported under the current management arrangements and felt communication between staff and management is poor.

On our request, the management produced for us an up-to-date training matrix of their own required courses, this showed us what training staff had undergone and when refresher training was due. We saw that a number of staff had received the required level of training; however, there were gaps in training and refresher training for some staff. For example, 20% of staff had not received infection control training, 41% of staff had not received training in nutrition and hydration, 44% of staff had not received dignity training and 39% had not received training in emergency procedures. This meant that people were receiving care and support from some staff members who did not have the knowledge and skills needed to provide care and support that reflected best practice. We looked at whether staff had specific training to meet the needs of the people at the home, for example, we found that many people living at Kingsfield Care Centre were living with dementia. However, the training completion rates for the Introduction to Dementia were 54%. In addition, we identified that there was a high level of incidents of people experiencing a fall; however, we found that 44% of staff had not received training in falls awareness. This meant that there was a risk that some staff did not have the knowledge and skills needed to provide care and support to meet the needs of people at Kingsfield Care Centre.

The above examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Is the service caring?

Our findings

Throughout our inspection we saw that some staff were kind and compassionate in the way they provided care and we observed instances where staff engaged with people and reassured them when providing assistance. For example, we observed two care staff talking kindly and reassuringly whilst assisting a lady to be hoisted into a wheelchair. We also saw where one senior carer was laughing and joking along with people whilst dispensing their medications.

We could see some staff were kind and caring. However, most interactions and care delivery were quick and task-led; people got one chance to do something, such as, move to a different chair, if people said no they were not asked again. Staff did not have the time to spend encouraging, nurturing or try different approaches, for example, to try and encourage someone to eat their meal.

During our inspection, staff we spoke with told us they do not get time to sit and talk to people and their families, one staff member told us, "If we had more staff, we would have time to do things with people and relatives." And, "We never get chance to sit and chat; I would like to get to know people but I can't as I do not have time." Another staff member told us, "I would like more time to talk to people and play games; get to know them."

We spoke with people and their relatives about the care they received at Kingsfield Care Centre. One person told us, "It's alright actually. Staff; they're alright."

One visiting relative we spoke with told us they visit every day and have no concerns, they told us, "Staff are very helpful. Staff attend to her quick enough. Care is good, if I have a complaint I tell them." Another relative told us, "Very good carers; very nice." Also, "Staff work hard in difficult circumstances. I've never seen anything I am concerned about."

Not all visitors were complimentary about the care their relative received at the home. One relative told us, "The care has been up and down...lots of chopping and changing...It's not to the standard we would have accepted." Another visiting relative told us, "They haven't got the staff to deal with my [relative] and as a result, the care is falling way below." Another relative we spoke with, told us they did not think staff had an understanding of dementia and told us when asked about the care and support received by their relative, "We have found [relative] soaking wet...mum has told us she is treated very cruelly...some (staff) are very nice and some are not."

One visiting professional told us when we asked about staff, "They go over and beyond their duty; they even do charity things to raise money for the people." Another visiting professional had come to see one of their clients and they told us, "There's been lots of changes in staff, it's very unsettling...I haven't seen anything to concern me."

We asked staff how they ensured people were treated with dignity and respect during care delivery. One staff member told us they would ensure privacy; speak to people how they feel they would like to be spoken

to themselves, also they like to ensure people have good hygiene and "look decent." Another staff member told us they would respect people's own privacy, treat everyone as an individual and give them freedom of choice. A third staff member told us they would provide person-centred care and attend to needs that are personal to the person; by talking to them; getting to know them and how they prefer to be cared for; respecting people's choice and that some people prefer different carers.

During the inspection site visits, the inspectors saw that people were not always clean, well-groomed and their dignity was not always respected. Staff had not always ensured people were supported with personal care and dressed appropriately. We saw people who had not had their hair brushed, had long and dirty finger nails, people who had spilled food down their clothes and many ladies with facial hair. We saw people asleep in chairs in undignified positions, for example, one lady was sitting exposing her underwear; most of the ladies had bare legs and some people had bare feet. One person had removed their skirt exposing their underwear and continence products and was crawling around the floor in the conservatory. We saw one senior staff member go into the conservatory and leave again and in doing so walked past the half-clothed person on the floor without offering any assistance. We reported this to management and asked that the person's dignity and needs were attended to by staff.

During one lunchtime observation we saw one person had fallen asleep whilst sat at the dining table. They had slumped forward leading to their hair and face coming into contact with their meal. One staff member spoke to the person to try to rouse them but could not; staff continued to serve people their lunches around them until another staff member noticed the person had had a continence accident whilst asleep and the floor underneath their chair and around them was wet. Staff then roused the person and took them away to attend to their personal care needs.

We found one person sitting near an open door; they told us they were cold. The person was frail and very underweight and we asked staff to bring them a blanket and a cardigan to make them comfortable.

We observed instances where people were spoken to or about in an undignified manner and staff did not always treat people with care and compassion.

Whilst inspectors were talking with one person who lived with dementia, one staff member walked by and remarked to the inspector, "Good Luck." Indicating they would be lucky if the person responded to them. The inspector later spoke with the staff member and asked them to explain what they meant; the staff member said they made the remark because the person has dementia, repeats themselves and it would be difficult to have a conversation. This demonstrated the staff member did not have an understanding or the skills and knowledge around dementia care to meet the care and support needs of this person.

During another incident with the same person and same staff member, the person was tapping the table with their hand. The person had their breakfast in front of them on the table, but no drink at 9am. The staff member told the person, "Stop banging (name)." and then remarked to the inspector, "She only does that to get attention." The staff member then snapped, "(Name) eat your breakfast!" We explained to the staff member the person may require assistance and reported the action of the staff member to management. We monitored this person and saw they had still not been offered a drink at 10am and we asked a staff member to offer the person a drink.

We witnessed a further incident with the same person and another member of staff. During lunchtime on the second day of our inspection we observed the person was sat in the conservatory and was tapping a spoon against a cup. We witnessed a staff member walk from the dining area into the conservatory and take the spoon from the person without comment or explanation and took the spoon back to the kitchen and

placed it back with the clean cutlery. The inspector went to check on the person and the person lifted an empty tea cup to the inspector and said, "More tea?" This indicated that the person may have been trying to attract attention as they were thirsty and required a drink. However, the staff member did not speak to the person or try to engage with the person to find out what they wanted. The inspector asked another staff member to bring the person a drink.

On the first day of our inspection we observed one staff member who was escorting someone to move from the lounge area to the dining area for their lunch. The dining area was busy with people sat at tables waiting to be served their meals. The staff member who was assisting the person approached the table and whilst doing so was making gagging facial expressions to the other staff members behind the back of the person and announced, "She needs changing." This was not done discreetly in order to maintain the person's dignity. Two staff members approached the person and because the person was now asleep with their head on the table they remarked, "Do her later." The two staff members left the person in a soiled condition for 20 minutes before returning to assist them with their personal care.

The above examples demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect

We found during our observations that people living at Kingsfield Care Home were not treated in a kind, compassionate way nor treated with privacy, dignity and respect. Due to our concerns around our findings we reported these instances immediately to management of the home and to local commissioners in order to safeguard people from further improper treatment.

Is the service responsive?

Our findings

We reviewed five people's care documentation and found that they included information on how to care for the person by the way of care plans and risk assessments. However, of the care plans we reviewed we did not see evidence of people and their relatives being involved in or contributing to decisions around their care. We did not see evidence where people had been supported to follow their interests and we did not see recordings of people's aspirations and what they liked to do that was personal to them.

We spoke with the relatives of one person and they told us they want to be involved in caring for their relative and in formulating the person's care plan. They told us staff at the home had not made them feel welcome and despite the family being close and the person happy for their family to be involved, they would not discuss their relative's care plan with them and they had not been able to speak to anyone about their relative's care. They told us the senior in charge had told them that they do not have the time to discuss their relative's care. The relatives were distressed during our conversation and said, "We have no idea what is happening." The relatives told us they had asked on two occasions for a lamp for their relative's room, as their relative did not like to be in the dark at night. However, no lamp had been provided. We asked one of the provider's senior management team to speak to the relatives regarding their concerns during our inspection. We spoke with the relatives the same day and they told us they were satisfied with the resolutions offered by management.

We did not see evidence in the care files that people had been involved in writing or reviewing their care plan and we did not see where people's preferences, choices had been incorporated into the plans. We did not see any documentation to show us that the person or their representative had been involved in their plan of care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

Each person had a document named 'Life Story' that was kept in the office; we looked at some of these documents and found them to be blank or incomplete. The management told us this was because they were changing over the paperwork. People who live at Kingsfield Care Centre have clear boxes on the walls that contain items relating to what is important to the person, such as, family photographs. Staff told us they did not have time to sit and read people's personal information. We asked staff how they get to know people and how they knew how the people preferred their care and support to be provided. One staff member told us, "They have boxes on the walls outside their rooms, we can refer to the care plan and families tell us stuff."

We asked a staff member if they knew the background of one particular person, who lived with dementia and displayed anxiety in the home. The staff member told us the person used to teach aerobics and dancing and then added before walking away, "But of course they can't do that now". There was no evidence that any attempt had been made by the management to provide any personalised activities or engage this person in activities and/or conversations about their interests.

We saw throughout our three days of inspection that people were left in the lounge with nothing to do, the result of this was that most people slept. People were slumped in large armchairs. Many of the arm chairs were made from hard material and there were no cushions so people looked uncomfortably slumped over. We saw one instance where a staff member brought a pillow to support a person's head who was asleep on one of the big chairs. On another occasion, one visiting relative went and got pillows from their relative's room to support them, whilst sitting in one of these chairs. They told us, "They are big chairs with no support."

There was an activities programme on the wall in reception of Kingsfield Care Centre displaying what was going on each week. The provider also told us they had an activities co-ordinator in post; however, they were not in work during our inspection visits. We did not see any activities taking place at the home during our inspection. One person we spoke with told us, "There's things going on, but they don't interest me." We looked at the notice board and saw evidence of activities that had gone on in the past by the way of photographs taken of people participating in activities.

We spoke to staff about activities available at the home, one staff member told us, "They're good; they do puzzles and painting." Another staff member told us, "Not a lot of residents participate...they love armchair aerobics...only a small number of people play dominoes or bingo."

We did not see any evidence that one to one care or activities were provided; this was verified by talking to staff who confirmed people did not receive any personalised activities.

We saw people were left for long periods in communal areas with little or no staff present and that people sometimes had to wait a long time for assistance. People called out repeatedly for assistance from care staff and we could see that call bells in the communal lounge and conservatory were not within people's reach and did not have pull cords attached. We saw that when people required assistance and did not receive it because staff were not available; they got up from where they were sitting to attract attention. We saw one lady had got up very unsteadily and was supporting herself by holding on to a supporting pillar in the lounge and shouting for assistance.

We monitored one bedroom call bell response time and found that the same room number had been waiting for assistance for ten minutes before the alarm stopped. We also found that staff were able to cancel the call bell from the communal lounge area and not at source; this meant there was a risk that the call for assistance may not be answered if the staff member cancelled the call and then became distracted before responding to the call.

One person's visiting relative told us that on one occasion their relative had telephoned them because they had been waiting half an hour for assistance after activating the call bell. The relative then rang the home with the intention of telling staff their relative needed assistance; however, no-one answered the phone. This led to a formal complaint against the home.

We found two bedrooms (one vacant) with broken call bells. Where sensor mats were in situ and in use in people's bedrooms; the call bell was inoperable because the wall socket could only accommodate one cable. This meant that people who had mats to indicate to staff if people had got out of bed had no means of calling for assistance. We found the sensor mats to be light in weight and made of shiny black plastic. The mats were placed at the side of peoples' beds and could easily be pushed to one side. These type of mats are not always suitable for everyone because people who live with dementia or sight loss, can sometimes mistake the black mat for something else, for example, a hole in the floor. During the inspection we found that one person had moved the mat because, it looked "wet" and thought they would slip if they

stood on it.

We brought this to the attention of the management who told us they would be ordering new sensor equipment that would be placed under peoples' mattresses so they were out of sight. They also told us they had arranged for cable splitters to be fitted that would facilitate both the sensor mat and call bell cables so that people were no longer left without the means of calling for assistance. The management told us the splitters had been delivered during our inspection.

The home benefits from a hairdressing salon that is used by a visiting hairdresser once per week. We saw several ladies enjoying the hairdresser experience; we could see lots of smiles and positive, pleasurable interactions between the hairdresser, staff and ladies. We could see that the ladies enjoyed this activity and the atmosphere around the hairdressing salon was fun. During our inspection, we were approached by the visiting hairdresser who told us they had spoken to the home management several times to inform them that the salon area was not big enough to accommodate the amount of people who would like to attend the hairdressing session once per week, this meant that some ladies had to sit outside the salon wearing their rollers. The hairdresser was concerned that these ladies could fall and also felt excluded from the fun and laughter in the salon. In addition to these concerns, the hairdresser told us about two ladies who enjoyed having their hair done each week, but due to an error in the home's administration, the hairdresser had not been paid for several weeks. This meant these two ladies were no longer able to benefit from a weekly visit to the hairdresser. We passed these concerns over to the visiting assistant operations director, who then spoke to the hairdresser to resolve the issues.

We looked at how people's current care needs were communicated to and between staff. We looked at people's daily recording sheets that showed what their care and support needs had been that day and night. We attended two evening to morning shift handover sessions with staff to see how vital information about people's immediate care needs were communicated. We found that each person was discussed and information, such as, a carer being concerned that someone had a water infection and required a sample sent to the GP was shared with other staff. People's moods and behaviour were also discussed. We found that the handover was a verbal exchange only and the senior carer on duty led each meeting, however, notes of the information to be passed over shifts was written down on a scrap of paper. This meant there was a risk of the information being lost and staff had no formal handover record to refer to during the shift or for future reference.

Staff we spoke with about communication and handovers told us, "They're not great...I find out things from other staff members just during the day."

Despite comments from staff around issues with the management of the home, staff told us they formed part of a strong, cohesive team. One staff member told us, "It's a great team; you won't get a better team."

As part of our inspection, we looked at how the home actively sought and acted on feedback from people who use the service and their relatives. The home had a policy in place to conduct annual surveys with residents and relatives. The provider gave us documentation around what they had done to ascertain how satisfied people were at the home. We reviewed feedback documentation around comments collated from a resident's survey taken 2016; the results indicated that most people were happy with living at the home. We also looked at the results and feedback of a relatives' survey from the same period, we found that the questions were sorted into and related to the five domains inspected by the CQC. The results of the relatives' survey and feedback gave mixed results around how satisfied people were with the care received; there were positive and negative comments. We did not see evidence of what the provider had done to address the issues raised by the relatives in the survey and feedback they received, particularly in relation to

some of the negative comments in the relatives' feedback comments. Comments recorded in the relatives' feedback document gave a clear indication that relatives felt that some carers were not compassionate or respectful with people at the home. Other concerns from relatives included; dignity, staffing levels and missing personal items. One respondent commented around their relative's care, "Not always treated with dignity and respect or compassion."

This was a breach of Regulation 17 (1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider also gave us copies of documents pertaining to a staff survey conducted in 2016 gathering opinions of staff satisfaction in their role and management, the results of which were positive.

Is the service well-led?

Our findings

At the time of the inspection Kingsfield Care Centre did not have a manager in post who was registered with the Care Quality Commission (CQC). There had been no consistent managerial support at the home to ensure oversight of the home's performance and the quality of care provision.

Due to the absence of a home manager for several weeks, the management of the home had been covered by a number of relief managers and had also been overseen by the registered manager from one of the provider's sister care homes. Staff told us there had been many days over the previous few weeks where no manager had been on site; one manager was in post for 3 days but then subsequently left. The senior staff members at Kingsfield Care Centre told us they have been standing in and covering many shifts to ensure there is at least some leadership for the home. They told us this had led to them working long hours and said, "The responsibility is horrendous...we've got no support." Staff told us there had been no manager at the home the day before our visit. Another staff member told us, "Everyone is stressed; more hours, more days...we need more seniors."

On the first day of our inspection we found there was no visible leadership in the home. However, once the inspection was underway we were joined by a relief manager and several senior managers to support the inspection. During our inspection we gave daily feedback to senior management throughout the three days and when issues of concern were found and/or observed. This was necessary due to the seriousness of some of our findings and required immediate action to be taken.

We spoke with a number of staff members who all strongly expressed to us the problems they have been experiencing due to the lack of management of the home. The main issues communicated to us were around staffing levels and communication. Staff told us they did not know what was going on and rotas were not correct; staff were put on shift without discussion or consultation. They told us they did not know who to ring when short staffed and this had led to understaffing of care shifts. One staff member told us, "I feel that I can't talk to anyone... people just leave...we don't get spoken to right by management...they don't tell us anything." Another staff member told us the current relief manager is unapproachable and there is no communication or support from management. Staff told us they did not feel motivated or supported in their role, one staff member told us, "Staff morale and the atmosphere has gone right down and relatives have commented."

We looked at staff team meetings and found they had happened in the past when the registered manager had been post. However, staff told us they have not been happening recently, one staff member told us, "The last one got cancelled." Staff told us although they did not feel supported by management; they felt supported by their team members.

The assistant operations director acknowledged there had been problems with home manager cover since the previous registered manager had left their position. On the third day of our inspection they placed an experienced relief home manager in position and gave assurances that they would be in place consistently until a new home manager was recruited. This meant that people and staff would have a new home

manager in place for the foreseeable future to provide stability and consistency in the management of the home. The assistant operations director was also providing support to the home during the third day of the inspection and they told us they would be monitoring the home closely and conducting weekly visits.

We did not see evidence during our inspection to demonstrate where management had been responsive to information in order to improve the service. We did not see where feedback from relatives' and people's surveys had led to changes in the service. Information identified in the accident and incident recordings indicated that further investigations were needed to look at the high level of falls. However, we did not see evidence that this had been addressed or steps taken to reduce the incidence of falls. We saw that a number of wheelchairs were not fit for purpose and we were made aware that this had been reported on a number of occasions and this issue had not been addressed or resolved until our inspection.

During the inspection, we found that systems and procedures were in place as Kingsfield Care Centre was a care home owned by Meridian Healthcare Limited and had existing quality assurance systems. We found that these policies and procedures were not always being implemented or followed by staff to ensure the effective and safe delivery of care. For example, staff training and supervision was not up to date, a high number of falls had not been investigated and acted upon and we found issues with health and safety.

We also saw that procedures put in place to ensure safe and effective delivery of care were not being followed or completed accurately, such as, nutrition and hydration charts and prevention of pressure sore plans. The management was not aware of these failings in the recordings and did not have an overview of this situation to enable suitable timely action to be taken.

Audits and checks were in place for a number of areas within the care home. Checks we reviewed included; monthly medicines audits, equipment tests, fire safety and maintenance checks. Despite these checks, we found that the environment was not always clean and safe. We found cleanliness and safety concerns throughout the building as found during the service walk around, for example, malodours, a lack of hot water and hand washing facilities, inaccessible call bells, unsafe wheelchairs and infection control risks in the laundry. A regular, robust environmental check would have identified these areas and help minimise the risk of the potential for future incidents. This meant that although the provider had policies and processes in place, they did not operate effective systems to monitor the safety, quality and risk of services to people within the home.

The above examples demonstrate a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The personal information of people who lived at the home was not kept confidential and systems did not adhere to the Data Protection Act 1998. Personal information, such as, care plan, life stories and risk assessments, were stored on shelves in the open office, which meant that this private information was accessible and not kept secure. There was a whiteboard on the wall in the office with the full names of each person living at the home. This information included the person's name and room number. This whiteboard was visible to people who lived in and visited the home and included person identifiable information that needed to be kept confidential. When we looked at the information displayed on this board we found information to be incorrect and required updating. This out of date information could result in unsafe care and support being delivered. Other personal files, such as daily records, were accessible to anyone in the home as they were kept in unlocked cabinets in the communal lounge area.

This was a breach of Regulation 17 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Under the terms of their registration with the Care Quality Commission (CQC), providers and registered managers have a legal obligation to notify us of certain incidents, events or changes to the service. During our inspection we became aware of several safeguarding incidents at Kingsfield Care Centre that had not been reported to the CQC since 2014. By not notifying us of incidents such as these, we are unable to assess if the appropriate action has been taken, the relevant people alerted and that people who use services are safe.

This was a breach of Regulation 18 (1) (2) (e) of the Care Quality Commission (Registration) 2009.