Care UK Community Partnerships Ltd

Kingsfield Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**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 over three days, on the 25, 26 and 27 July 2016. The first day of the inspection was unannounced and the second and third day were 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 76 people living in the service when we inspected. Nineteen people were accommodated in part of the service which was designed for people who needed nursing care. Nursing staff and care staff assisted people to manage chronic and longer-term health issues associated with aging or after an accident or illness. This included compassionate end of life care. The other parts of the service provided residential accommodation and nursing care to 55 people living with non-complex dementia.

This inspection was brought forward due to concerns we had received about the quality of care in the service. At a previous inspection on 10 and 14 September 2015, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to people's care needs not being kept up to date. At this inspection improvements had been made and people's care plans reflected the most recent information about them. We also made a recommendation about improving the way the computerised and paper based records system operated.

There was not a registered manager employed at the service. 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 had appointed a person into the registered manager role.

During the process of transition between registered managers the service had been managed by an experienced manager from another home in the same organisation.

Staff received training that related to the needs of the people they were caring for and nurses were supported to develop their professional skills maintaining their registration with the Nursing and Midwifery Council (NMC). However, staff delivering end of life care had not received any end of life care training. We have made a recommendation about staff training.

The provider had a system in place to assess people's needs and to work out the required staffing levels. However, our observations indicted that the provider had not ensured that they employed enough nursing and care staff to meet people's assessed needs at all times. Not all staff absences were covered so that people could experience consistent care delivery. For example, activities or timely staff responses to their request for care.

Staff were not consistently meeting with their line managers to discuss their work performance and the system in place for staff supervisions and appraisals was not up to date.

Records about the care people had received were not always up to date or fully completed.

Nursing staff had the skills and experience to lead care staff and to meet people's needs and the deputy manager provided nurses with clinical training and development. There was an appointed nurse with responsibility for infection control. However, nursing staff morale was low due to on-going changes to the way nurses were deployed within the service. Nurses could be deployed on different floors on different days. This had led to situations where communications between nurses had not been followed up. For example, messages left for the next nurse on that floor to follow-up had not been acted on.

The provider and manager ensured that they had planned for foreseeable emergencies, so that should emergencies happen, people's care needs would continue to be met. Equipment in the service had been tested and maintained. However, there was a lack of clarity around who was responsible for ensuring that risk within the environment were properly managed. For example, not all of the recommendations from the most recent review of the fire risk assessment in September 2015 had been implemented or assessed.

There were policies in place for the safe administration of medicines. Nursing staff were aware of these policies and had been trained to administer medicines safely.

Nursing staff assessed people's needs and planned people's care. They worked closely with other staff to ensure the assessed care was delivered. General and individual risks were assessed, recorded and reviewed. Infection risks were assessed and control protocols were in place and understood by staff to ensure that infections were contained if they occurred.

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

People were supported to eat and drink enough to maintain their health and wellbeing. They had access to good quality foods and staff ensured people had access to food, snacks and drinks during the day and at night.

Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. Nursing staff understood their professional responsibility to safeguard people. The manager responded quickly to safeguarding concerns and learnt from these to prevent them happening again.

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

People had access to qualified nursing staff who monitored their general health, for example by testing people's blood pressure. Also, people had regular access to their GP to ensure their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. This included checking nurse's professional registration.

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

If people complained they were listened to and the manager made changes or suggested solutions that people were happy with. Actions taken were fed back to people at residents and relatives meetings. The provider collated formal feedback from people, their relatives and staff to drive improvements within the service.

The manager of the service and other senior managers were experienced and understood the issues and challenges the service was facing and had been working to correct these. They were assessing and reviewing the action plans they had implemented to improve the quality of the service. The progress of the action plans had been communicated up to the provider organisation through its internal quality monitoring systems. This was reflected in the changes they had already made within the service.

We found 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 version of this report.

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.

There were not sufficient staff to meet people's needs. The provider used safe recruitment procedures and risks were assessed.

Staff knew what they should do to identify and raise safeguarding concerns. Medicines were managed and administered safely. Incidents and accidents were recorded and monitored to reduce risk.

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

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received an induction and training and were supported to carry out their roles but this did not cover all of the specialist training required.

Staff were not consistently meeting with their managers to discuss their work performance.

People's rights were protected by staff who were guided by The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were cared for by staff who knew their needs well. Staff understood their responsibility to help people maintain their health and wellbeing. Nursing staff routinely monitored people's general health. Staff encouraged people to eat and drink enough.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated.

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

People were treated with dignity and respect.

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. Activities were organised to promote involvement and reduce social isolation.

Information about people was updated often and with their involvement so that staff only provided care that was up to date.

Complaints were investigated and resolved for people to their satisfaction.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records were not always fully completed.

There were structures in place to monitor and review risks. However, quality audits were not regularly carried out to ensure effective service delivery or that actions from previous audits had been completed.

People, their relatives and staff were asked their views about the quality of all aspects of the service.

Kingsfield Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 25, 26 and 27 July 2016. The first day of the inspection was unannounced and the second and third day were announced. On day one of the inspection the inspection team consisted of one inspector, a nurse specialist and an expert by experience. The expert-by-experience had a background in caring for elderly people. On day two of the inspection the inspection team consisted of one inspection and day three one inspector.

Before the inspection 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 observed the care provided for people. We spoke with nine people and five relatives about their experience of the service. We spoke with twelve staff including the manager, the area manager, four nurses, four care workers, the activities co-ordinator and the maintenance person to gain their views about the service. We asked two health and social care professional for their views about the service.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at eight people's care files, six staff record files, the staff training programme, the staff rota and medicine records. At the end of the inspection we asked for more information to be sent to us. The manager sent us further information about specialised diets for people at risk of choking and about fire evacuation signage after the inspection.

Requires Improvement

Is the service safe?

Our findings

People who could verbally tell us about their experiences of the service and the relatives we spoke with did not have any concerns about safety at Kingsfield Care Centre. However, concerns were raised about the staffing levels. One relative said, "It is not as bad today as it is on Mondays, there are less staff on other days, at the weekend there are only three."

In addition to the manager, and deputy nurse manager there were 14 staff available to deliver care, plus three qualified nurses. The rota showed that time was given between shifts for staff to hand over. Staffing levels were consistent and any staff or nurse absences were covered by approved agency or internal staff. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

Staffing levels were not planned to meet people's needs. During our inspection we observed a number of instances where people calling out were not responded to by staff. For example, two people in distress in their bedrooms where ignored by nearby staff. A member of staff said, "Today, we have been rushed off our feet." We observed two staff assisting a person in the lounge who had fallen. The person was not hurt, however we then observed the same person trying to walk without her walking aid using the wall to support herself; the person was very unsteady on her feet. We had to alert staff as the person was at risk of falling. When staff arrived they told us that people often forgot to use their walking aids, for example zimmer frame. This meant that people at risk were either ignored or not properly supervised or monitored as staff were busy elsewhere.

It was not easy to find staff when they were needed. There was a period of time on the second floor of the service where it was not possible to find any staff to assist a person who had been asking for help to find a toilet. Also at the same time a relative was looking for staff to assist for their loved one in her bedroom. There were three staff, including the nurse in charge on the floor, but they were all busy. The inspector on that floor looked for a member of staff, looking in all of the communal rooms and corridors. The inspector had to ask for staff to assist by telephoning the reception office and explaining the situation.

People told us they had to wait a while for staff to respond to the nurse call bells. We saw from the minutes of a residents and relative meeting from February 2016 that people had complained about the wait times. One person had waited 40 minutes and relatives complained that their relative was not being assisted to the toilet when they needed help. This resulted in people experiencing poor care and reduced their independence and dignity.

Staff absences were not covered to promote the consistency of care. During the inspection there was only one activities co-ordinator when there should be three activities coordinators, one for each floor of the service. At the time of the inspection, one was on leave and one was on sick leave which left one activity co-ordinator to cover the whole service. This meant that planned one-to-one and group activities could not go ahead as people expected.

The examples above showed that the staffing levels in the service did not match people's needs, and there were not enough staff deployed to cover both the emergency and routine work of the service. This was a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recruitment policy was followed by the manager. 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 manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. Nurses were registered to practice with the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded.

People received their medicines safely from staff who had received specialist training in this area. The provider's policy on the administration of medicines followed published guidance and best practice and had been reviewed annually. Nurse's medicines competences were checked by the manager against the medicines policy to ensure good practices were maintained. Staff trained to administer medicines in the non-nursing part of the service were supported to do this safely by qualified nursing staff. We observed the safe administration of medicines. Medicines were stored safely and securely in temperature controlled rooms within lockable storage containers. Storage temperatures were kept within recommended ranges and these were recorded. Nurses knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

Medicines were correctly booked in to the service by nurses and this was done in line with the service procedures and policy. Nurses and trained staff administered medicines as prescribed by other health and social care professionals. For example, medicines specific to end of life care were well managed. 'As and when' required medicines (PRN) were administered in line with the PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

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 ensure 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 manager operated an out of hours on call system so that they could support staff if there were any emergencies.

People were protected from potential abuse by staff trained in how to safeguard adults. The provider had an up to date policy about protecting people from abuse. Staff told us how they followed the providers safeguarding policy and their training. They understood how abuse could occur and what they needed to do if they suspected or saw abuse was taking place. Staff explained to us their understanding of keeping people safe.

The manager had ensured that risks had been assessed and safe working practices were followed by staff. Risk assessments considered the levels of risk and severity, which was in line with recognised best practice. People had been assessed to see if they were at any risk from falls or not eating and drinking enough.

Equipment was serviced and staff were trained how to use it. The premises environment was maintained to protect people's safety and to meet their needs. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping. When staff needed to use equipment like a hoist to safely move people from bed to chair, this had been individually risk assessed. We saw comprehensive records that confirmed both portable and fixed equipment was serviced and maintained.

Requires Improvement

Is the service effective?

Our findings

People said, "I like the food it is very good", and "I like the staff, but they are always very busy." One person said, "The food in here is beautiful, well cooked, good quality and there's plenty of it." Relatives told us their loved ones health care needs were being fully met.

Nursing staff and health care workers had not been receiving regular supervision as set out in the provider's supervision and year-end review process. Staff told us that they were not receiving regular supervision and that this was affecting their work. For example, some staff told us they were unofficially being given responsibilities they could not manage. We spoke to the manager about this. They acknowledged that since they had been in post they had prioritised dealing with other issues, such as areas of staff performance which had reduced the time resources she had to meet the providers supervision timescales. This meant that staff were not being given opportunities to discuss their work and improve their practice.

The manager told us that they had been implementing a new system of 'Talk not tick' supervisions as previously the supervision processes had been a tick box exercise. There was a lack of clarity regarding how the management team could deliver the planned supervision schedule and how these would take place for each staff member.

The supervision plan provided showed that no one-to-one staff supervisions had taken place between January and March 2016. We found that only 40 staff mid-year reviews had taken place between April and July 2016 out of 106 staff listed. No information was made available to us that every member of staff had received a year-end review between October 2015 and December 2015 which is when, according to the providers processes these should have taken place. We found that more than half of the staff who had met a manager for a mid-year review had performed inconsistently against the provider's performance standards. This had the potential to escalate the risk of people experiencing care from staff who were not working to the required standards.

The examples above showed that the staff in the service were not receiving appropriate supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18 (2) (a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People had their nutritional needs assessed and were provided with a diet which met their needs and preferences. The staff met with people individually to discuss their food preferences. People were complimentary about the food and told us that after were always choices of meals. Nutrition assessment tools were completed every month for each person and actions were taken to support people to stay healthy if they were considered to be at risk. For example, in cases were the person's body mass index (BMI) had dropped, the catering team was informed and they provided fortified food for the person. However, staff had not always fully understood how to deliver care based on people's care plans. We observed a person being served a meal at lunch time by one member of staff, another member of staff removed the meal as

they thought the person was on a soft diet. We informed the manager about this. The manager sent us some follow-up information about this. They told us that neither member of staff had read the persons care plan which had been addressed, but that at the same time the care plan was not clearly written to guide staff about the person's dietary requirements. The manager confirmed the person had been assessed by a speech and language therapist since the inspection and was now prescribed a soft diet. This ensured that staff now had the information they needed to deliver effective care.

People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night and foods like sandwiches were left for people to access. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place. Care plans detailed people's food preferences. People's preferences were met by staff who gave individual attention to people who needed it.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. Nurses 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. Information provided about current levels of training showed 86% of staff were up-to date with their training and staff who needed training had been identified. Training records confirmed staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular meetings with managers.

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. Staff were delivering end of life care by keeping people comfortable and meeting their needs. However, we noted that staff were providing end of life care to people without any formal training. New staff inductions followed nationally recognised standards in social care. For example, the care certificate. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately.

We have recommended that the provider researches and follows published guidance about the levels of training staff need in relation to the delivery of end of life care.

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 manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line

with agreed processes. This ensured that people were not unlawfully restricted.

People's health was protected by health assessments and the involvement of health and social care professionals. A GP visited the service and people had access to occupational therapist and other specialist services. We observed staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. We asked staff about their awareness of people's recorded needs and they were able to describe the individual health care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Care plans covered risk in relation to older people and the condition of their skin referred to as tissue viability. The care plans could be cross referenced with risk assessments on file that covered the same area. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing settings to estimate and prevent risk to people, including from the development of pressure ulcers.) Records showed that the management of pressure area care was effective.

Good

Is the service caring?

Our findings

We observed friendly and compassionate care in the service. People said, "The staff are very kind and caring." Others commented that 'Nurses were very helpful' and 'We know each other, there is a very pleasant atmosphere." Another person said, "I have a pleasant room and like to stay as independent as possible."

Relatives told us that they valued the support their loved ones get. One commented, 'The staff are kind and caring, my wife wouldn't want to be anywhere else now that she has dementia.' People were complimentary about how good staff were at communicating with them when needed.

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.

Staff built good relationships with the people they cared for. Staff promoted a non-discriminatory atmosphere and a belief that all people were valued. This resulted in people feeling comfortable, relaxed and 'at home'. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. We saw staff listening to people, answering questions and taking an interest in what people were saying. We observed staff talking people through the care they were providing and confirming with people if it was okay. When speaking to people staff got down to eye level with the person and used proximity and non-verbal gestures (good eye contact, smiles and nods). People responded well to the quality of their engagement with staff. People could choose to stay in their rooms, chat to others in the main lounge and dining room or use the separate lounge to sit quietly and read or meet friends and relatives. This promoted a relaxed atmosphere for people.

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.

People's rights were protected. Staff respected people's privacy. Records showed that independent advocacy support was available for people who lacked the capacity to make certain decisions. People we spoke with described staff care that preserved people's privacy and dignity in the service.

People were able to state whether they preferred to be cared for by male or female staff and this was recorded in their care plans and respected by staff. People were able to personalise their rooms as they wished. Some people had memory boxes containing items or pictures of their choice to help remind them where their room was.

People's rights 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 sought people's consent before they provided care for people. This meant that staff understood how to maintain people's individuality and respect choice.

People and their relatives had been asked about their views and experiences of using the service. The provider's quality policy included gaining written feedback from people about the service. The feedback people gave was analysed and collated for the manager and the actions being taken were fed back to people. This enabled people to stay involved with developments and events within the service and give them the opportunity to influence decisions the provider had made about changes in the service.

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

Good

Is the service responsive?

Our findings

At our inspection on 10 and 14 September 2015, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Arrangements were not always in place to ensure that when people's needs had changed their care plans were up dated.

At this inspection we found that people's care was kept under review and changes were made to improve their experiences of the service. People said, "We like getting involved in the quizzes and sing along sessions." Others told us about going into town with the activities co-ordinator or eating out with their relatives. People told us they could go to a manager in the event of any problems.

We saw records of referrals to GPs and other external professionals seeking advice from them when required. Staff kept records of when they liaised with healthcare professions to make sure people received prompt care and treatment to meet their physical and mental health needs. For example, a nurse in charge had re-checked the doses of prescribed medicines with a consultant psychiatrist to make sure the records were correct.

People received care from staff who knew their needs, their individual likes and dislikes and their life stories, interests and preferences. The manager had started to introduce a new system to ensure they knew as much about people's likes/dislikes and life histories. People's needs had been 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. Risk identified in each area had an associated care plan which listed interventions to be implemented to address the risks.

There were some people who received additional support from the community mental health teams. Clear support and advice about this was available to staff on record. People's health and wellbeing was protected by in depth care planning. Care plans focused on areas of care people needed, for example if their skin integrity needed monitoring to prevent pressure areas from developing. We reviewed how wound care was managed in the care home. Registered nurses had received training in managing risk for people with poor skin integrity. They also had support from District nurses via GPs when requested. Information about people's life histories was in place, telling others who people were and about their lives and loves. Knowing about people's histories, hobbies and former life before they needed care could assist staff to help people to live fulfilled lives, especially if they were living with memory loss, dementia or chronic illness.

The manager and staff responded quickly to maintain people's health and wellbeing. Dependency assessments had an emphasis on weight and body mass indicators. Nurses had implemented weight management plans based on advice from a dietician and emergency health care plans in response to people's illnesses. We cross checked this against the care plans and found they were kept under review. This had resulted in the people maintaining their health through good hydration and nutrition and minimised the risk of infection. After people had been unwell, the progress to recovery was monitored by nursing staff and if necessary further advice had been sought from their GP. This ensured that people's health was protected.

Changes in people's needs had been responded to appropriately and actioned to keep people safer. For example, we saw in a care plan that to minimise the risk of falls a person needed a walking frame and two staff to deliver care. 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 ensured continuity of care.

People had opportunities to take part in activities and mental stimulation but these were not consistently provided due to staffing levels. We spoke with the activities co-ordinator about their role which they clearly enjoyed. There was a range of activities available for people from arts and crafts, social events and external entertainers. The times and types of activities were advertised to make people aware of what was happening and when. We saw planned bookings for external entertainers to visit the service. This normally happened three or four times a month. The activities coordinators worked in the service five days per week and were flexible in their approach trying to include as many people as she could to join in the activities she organised. We observed the coordinator was well known by people and had a good understanding of people and of what activities people liked to do. The people we spoke with spoke highly of the activities coordinator and how well she planned the different activities that were provided. Some activities also took place outside the home and on an individual basis, if this was what was needed by individuals and one-to-one activities were offered to people who preferred to stay in their rooms. This reduced the risk of people feeling isolated.

People experienced a service that enabled them to openly raise concerns or make suggestions about changes they would like. There had been seven complaints between January 2016 and July 2016. The manager had taken robust action to investigate complaints and had responded to people in writing with the outcome of their investigations. When things had gone wrong the manager had apologised to people. The manager promoted a learning culture from complaints and made improvements when needed. For example, standards of the catering and food people experienced had been improved after people had complained about the quality. This increased people's involvement in the running of the service. There was a policy about dealing with complaints that the staff and the manager followed. Information about how to make complaints was displayed in the service for people to see.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had left the service early in 2016 and the provider had appointed an experienced manager from another service 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 was due to start on 9 August 2016. People's comments included, "Yes, it is well run here and the manager is very nice".

People told us that they valued the opportunity to attend meetings with managers and that they were able to make comments about the changes the management had been making to the service. One person said, "I have my say at residents meetings." Minutes of residents and relatives meetings recorded people's views, their relatives views and management responses.

At our inspection on 10 and 14 September 2015 we made a recommendation about improving the efficiency between the paper based and computerised records systems.

At this inspection we found that information recorded between the two systems was auditable and it was possible to follow through on information that had been recorded on the paper based system because this had also been added to the computerised records.

People's care and treatment has not been fully recorded to ensure their health and wellbeing could be monitored and reviewed. A person's care plan gave details of how staff should monitor and record the person's food and fluid intake so that the information could be used by their GP to monitor their diabetes. Between 13 July and 26 July 2016 the records for this person had not been fully completed. For example, between 13 July and 16 July 2016 only one undated entry had been made about how much they had eaten. On 23, 24, 25 and 26 July 2016 the records had only been partially completed. We saw that the nurse in charge had put a note on the front of the persons file asking staff to complete the missing records. We spoke to the nurse about this and they told us that staff noted down what the person had eaten and drank, but they had not recorded the information in the person's file. Not having a full record available meant that the person was at risk of receiving inappropriate care and treatment as their GP or paramedics would not have access to all of the information they needed to make an informed assessment.

General risk assessments affecting everybody in the service were recorded and monitored by the manager. Service quality audits had taken place and were recorded. The audits covered every aspect of service delivery. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. However, the audits of the service were infrequent and were not taking place in line with the provider's quality audit policy. For example, medicines audits should be undertaken monthly. The last recorded internal medicines audit had taken place in April 2016. This meant that people were at risk of receiving medicines without the effectiveness and safety of the medicines administration being regularly checked.

The manager checked that risk assessments, care plans and other systems in the service were reviewed. All of the areas of risk in the service were covered. However, we found that the actions from a fire risk

assessment carried out in September 2015 had not been completed. For example, fire warning signage was required but was not in place when we checked.

The examples above showed that the 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.

Comments from staff presented a mixed picture. Some staff told us that changes within the service had caused staff morale to fall. This had resulted in poor communication and some staff had not taken responsibility for tasks left by staff handing over. Other staff told us that the current manager had been making some positive improvements within the service. The manager has set up various meetings for nursing and care staff to ensure staff were engaged and to re build team cohesion. These included daily shift hand over meetings, management team meetings and nursing staff meeting. Staff meetings were recorded and shared. We discussed some of the challenges being faced within the staff team with the manager and area manager. They were confident that they had a strategy in place to ensure people's care would be maintained whilst they implemented changes to current staff working practices, recruited to staff vacancies and changed the way nursing staff and care staff were deployed. They felt that the changes would result in people experiencing more person centred and effective care.

Staff said, "The manager has done what she said she would, for example we now have a summer uniform." And, "The manager is approachable." Information about how staff could blow the whistle was understood by staff. Staff told about their responsibilities to share concerns with outside agencies when necessary. Staff also confirmed that they attended team meetings and handover meetings.

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

The manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team and carried out investigations into any issues raised when required. The manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.

The provider's area manager was often on site. They had assisted the 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.

The current manager and area manager were working to a service improvement plan that underpinned consistent improvement. The improvements included introducing more person centred care plans based on published research and guidance, improvements to the information they gathered about people's life histories and the introduction of better end of life care plans. The manager told us that the provider listened to, considered and acted on requests made for additional resources. A consultation had started in relation

to the activities people wanted and the area manager told us that the provider would fully resource activities. 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.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and complete records were not being kept 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. Regulation 17 (1) (2) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels in the service did not match people's needs, and there were not enough staff deployed to cover both the emergency and routine work of the service. Staff in the service were not receiving appropriate supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)