

Meridian Healthcare Limited

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?

Inadequate 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We inspected Kingsfield Care Centre on 1, 2 and 5 of December 2016. Our visit was unannounced on day one.

Kingsfield Care Centre is one of 14 care homes in Tameside owned by Meridian Healthcare, part of the organisation HcOne, and is situated in Ashton-under-Lyne. 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 along 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. Staff told us this room was not in operation and had not been used for some time. There is a quadrangle garden and patio area in the middle of the building that is accessible to people who use the service. Kingsfield Care Centre has an attached unit, known as the Windsor Suite, where people living with dementia and higher support needs are cared for.

At the time of our inspection there were 37 people living at Kingsfield.

At the last inspection 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 registered manager had left in June 2016 and the provider had deployed a number of relief managers in the period up to our previous inspection in July 2016. Since our last inspection the provider had placed one consistent relief manager in the home and a new home manager had been employed in the three weeks prior to this inspection.

The service was previously inspected on 26, 27 and 28 July 2016 when breaches of eight legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found. We took enforcement action and Kingsfield Care Centre was placed into special measures. We took action and asked the registered provider to make improvements which included ensuring people were involved in their plan of care, people were treated with dignity and compassion, people were given choice and consent was always obtained, infection control issues were addressed, staff were trained to move people safely, people were able to call for assistance when required, accidents were analysed and acted upon, people's medical needs were promptly and appropriately met, people had their nutritional and hydration needs met, sufficient staffing levels were in place and to ensure adequate and consistent leadership of the home.

The Care Quality Commission has met regularly with the provider as a result of the July inspection to seek

assurances that concerns identified have been addressed. We received a series of monthly action plans that stated all actions would be completed by the end of October 2016 and the provider confirmed to us that action had been taken to address the shortfalls in care and support we identified in July 2016.

During this inspection we found a number of improvements had been made around appropriate staffing levels, the moving and handling of people, the environment, access to call bells and levels of dignity and respect shown to people. However, although some improvement had been seen during the inspection, we also found a continuation of breaches of legal requirements. These continued breaches were regarding meeting people's nutritional and hydration needs, involving people in care planning, timely response to people's care and medical needs, consent, staff training and supervision, and management of the service.

We identified breaches of seven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

The overall rating for this service is 'Requires improvement'. However, we are continuing to place the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to continue to place services in special measures.

During the last inspection we found that there were not always enough staff available to meet people's needs. On our return we found an increased presence of and more attentive staff. However, we observed instances where people did not always receive care and support in a timely way.

Staff told us communication, direction and support from management had improved. One staff member told us, "A big improvement overall. The biggest has been morale of the staff and residents."

Care plans and risk assessments were in place; however, we found these were not always being followed to ensure safe and effective care delivery.

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. However, we saw records of a newly introduced scheme 'resident of the day' where people would have an individual full review of all care and support needs.

We found that records of the administration of medicines were mostly 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 to be in need of medical attention that had not been sought and we had to intervene to ensure they received the required assistance.

We found people were not always appropriately supported to ensure they had their individual nutritional and hydration needs met, such as, the texture of the food. Associated documentation was not always accurately completed. We made observations that the dining experience for some people was not always enjoyable and some people were left without support to eat their meal.

During our observations, we found that people were moved and handled in a safe way and in accordance with individual assessments. People were assisted to move by staff who were kind, caring and provided reassurance.

During our initial tour of Kingsfield Care Centre on the first morning of this inspection, we noted that the previous malodour had improved but was still evident in some areas. We found improvements in infection control measures throughout the home; however, we found a number of issues still needed addressing, such as hand washing facilities in people's bedrooms and access to hot water in one area of the building.

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

At our previous inspection we raised several safeguarding alerts 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. The local authority have maintained links with the home since the last inspection and have reported improvements with some aspects of care; however, some concerns still remain which correlate with the findings of this inspection.

Due to our findings on the previous inspection the provider invoked voluntary suspension on new admissions to the home until the issues we had identified had been resolved. This was still in place during this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

People were moved and handled in a safe way.

Improved numbers of staff meant that people mostly received care and support in a safe and timely way. However, we saw instances where people were not attended to when required.

Risk assessments were in place; however, these were not always followed.

We found records of the administration of medicines to be mostly in order; however, we found PRN (when required) protocols were not always in place.

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.

Not all staff had received the required training and staff had not received regular supervision or appraisal.

Consent was not always sought before decisions were made around support and care delivery.

Is the service caring?

Requires Improvement ●

The service was not always caring.

We saw that people were mostly treated in a caring and respectful way; however, we also saw that people did not always receive care and support in a timely way.

Relatives were highly complementary of staff and about the care people received.

Staff told us they did not have time to read people's life story documents.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

There was an activities programme and activities co-ordinator in post. However, there was a lack of personalised activities for people.

People and their relatives had not had meaningful input into care planning.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

There was no registered manager in place at Kingsfield. A new home manager had been in place for three weeks.

Staff told us support and direction from management had been improved.

Corporate quality systems were in place to monitor the quality and safety of the service and had identified shortfalls in care delivery; however our inspection found these shortfalls had not been resolved.

Regular visits had been undertaken by senior management since the service had been placed in 'special measures'.

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 1, 2 and 5 of December 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, local Healthwatch information 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. Prior to our visit we also received information from social work professionals who visited the home.

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 the service being placed in special measures. 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, the medication room, the Windsor Suite annexe 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. These included policies and procedures relating to the delivery of care and the administration and management of the home and staff. We looked at four people's individual care records, individual nutritional and hydration records, the administration of medication and four 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, the Windsor Suite and throughout the home at differing times of the day. We also observed the way people were spoken with and observed several instances of care delivery where staff used manual handling techniques, such as using the hoist, to move people.

We spoke with people who use the service throughout the inspection, five relatives and one visiting professional. We also spoke with the home manager, the deputy manager, the operations director and assistant operations director from the organisation's head office, two senior carers and three staff members who provided care and support to people living at Kingsfield.

Is the service safe?

Our findings

During this inspection we found staffing levels and attentiveness to people's needs had been improved since our last visit. However, we observed a number of instances where people did not receive care and support in a timely way and there were several occasions where a number of people were left unattended in the large lounge area.

People's visitors told us they thought there had been improvements but there were not enough staff to provide care and support to all the people. One visitor told us that staff did not ask people to "Wait a minute" as much as they had previously done, and said, "The girls are brilliant, they seem to have increased staffing. Staff are really good; if there isn't enough of them it's the manager's fault, not theirs." Another visitor told us they had noticed there was more staff and more organisation within the home, they told us, "Staff are great, there's just not enough of them, but [name] is well looked after." A third visitor told us they felt their relative was safe and felt there was enough staff but, "They're kept busy all the time."

The home uses 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. Care staff levels currently in place meant that there were six carers and two senior carers during the day and three night carers and one senior carer on duty in the evenings. Apart from the medication rounds administered by senior staff only, the senior care staff performed mainly an administration/managerial function; ensuring care records and other documentation were kept up to date. There were also several ancillary staff employed throughout the day, for example, a laundry assistant, domestic staff and a breakfast assistant. The breakfast assistant worked five days per week. Staff we spoke with felt these staffing levels were currently manageable with the dependency levels of the people living at the home, but had concerns for safety if occupancy levels of the home increased. The assistant operations director told us there were plans to recruit another four or five care staff to remove the need for the use of agency workers to make up the staffing levels during staff absences. They told us they were also in the process of changing over staff shift patterns and will move away from set rotas to assist with the cover of each shift. This meant there would be less need to cover shifts with agency staff. Although the management told us they tried to use the same agency workers to ensure consistency, it is more beneficial that people who live at the home receive personalised support from permanent staff who know them well.

We checked recent staff rotas and found the calculated staffing levels were mostly adhered to. These staffing levels and deployment of staff throughout the home meant that improvements had been made since our last inspection carried out in July 2016.

During the last inspection we spoke to several members of staff who told us they were concerned about the safety of people due to low staffing levels. We spoke with staff again at this inspection and they told us they felt improvements had been made. One staff member told us, "Staffing levels are okay. We could do with more staff after 2pm and one extra staff at weekends." Another staff member told us, "Staffing levels have improved. There's less agency and more permanent staff. People are getting more consistency." In the

Windsor Suite, we found two staff provided cover for several people who lived with dementia and had higher support needs. Staff told us they thought this was sufficient staffing levels; however, they expressed concerns that when two staff were needed to assist people with their personal care needs, other people would be left unattended in the lounge.

Our concern around the dependency needs of people at the last inspection was such that we instructed senior management on the first day of our inspection to conduct clinical assessments of all the people who had high levels of need. This was needed to ensure that people received the correct levels of care and support. During this inspection we did not see these issues to the same extent and found that people were mostly receiving adequate care and support. However, on the first morning of our inspection we observed one person who appeared to be eating a paper napkin at the dining table. Care staff were not aware of this and we reported this immediately to one carer who removed the remaining part of the napkin and offered the person a drink and toast. We gave feedback to the manager immediately regarding this incident and prompted them to remind all staff to observe that this person did not put anything inappropriate in their mouth. We checked this person's care records and found several documents, including a risk assessment pertaining to identified risks of this person putting items in their mouth and thus a risk of choking or harmful ingestion. An evaluation of the risk assessment completed in October 2016 stated that the person should be "under continual observation". Later the same day, we again observed this person sitting alone at a dining table chewing an artificial flower from the display on the table. Due to the on-going risk of potential harm to the person we asked the home manager to put some more stringent safeguards in place to ensure this person's safety and suggested the person needed constant observation as detailed in their risk assessment. The home manager instigated staff support to ensure the person received one to one care and observation and the person was medically checked. They told us they would be asking for a reassessment of this person's care and support needs to assess if Kingsfield could continue to provide a safe environment for them.

We looked at a sample of four people's individual care records and found that people had risk assessments in place and were regularly reviewed. Risk assessments were in place for many aspects of people's care and support needs, for example, mobility, continence and communication. Since the previous inspection the provider had introduced choking risk assessments for all people and had reviewed all moving and handling risk assessments. The person who was chewing the artificial flower had an assessment in place for this risk, but the actions to mitigate the risk were not being followed as stipulated in the plan. This meant the person was placed at risk from choking or ingestion.

We noted on the first day of inspection there were eight people who were mobile around the home who were not wearing shoes; some people were wearing socks and some people's feet were bare. Much of the flooring at Kingsfield Care Centre is hard and could pose a potential slip hazard for people not wearing shoes. We checked a sample of three of these people's risk assessments and found there was a falls risk assessment in place for one person; however, there were none in the other two care files. This meant the risk of falls had not been identified and management plans were not in place for these people.

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 significant improvements had been made and staff now employed safe manual handling techniques when moving people. In all observations where staff were assisting people to move, we saw people were handled safely, were provided with constant reassurance and explanations by staff. Staff took their time ensuring each person was at ease during every stage of moving. People were treated in a kind and caring way throughout. One visiting relative commented, "A massive improvement when using equipment and a better understanding of dementia care."

We saw that wheelchairs were in good condition and were being used correctly by care staff. However, we noted the wheelchairs were being stored in the smoking room and this caused them to smell strongly of cigarette smoke. We asked staff to remove them from the smoking room and store them elsewhere in the building.

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. The home also had a 'grab and go' bag held in the office that held the PEEPs and other important information around people's care needs in the event of an evacuation of the home.

Due to a high number of recorded falls identified during the previous inspection, the provider, as part of their action plan to keep people safe, told us they would ensure all staff would receive face to face falls training and a 'falls team' would be implemented at Kingsfield Care Centre. We looked at training records and found that almost half of care staff had not received this classroom training and this included three of the four senior carers. We spoke with management regarding the implementation of a falls team and found this had not yet been implemented.

As part of our inspection we looked at how accidents and incidents were recorded, analysed and acted upon. 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, however, information about accidents and incidents for the last two months had not been uploaded to the database. The information held at the home around current accidents and incidents was therefore, not up to date. We asked the home manager to update the records so we could review the most recent accidents and incidents within the home. We reviewed the accidents and incidents for October 2016 and found there had been 10 unwitnessed falls and two resident altercations. The report included details of the individual incidents and what action was taken immediately and what the outcome was. The outcome for each incident was to monitor and/or observe the person. 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 investigations into the trend or steps taken at a strategic level to mitigate the risk and prevent reoccurrence. There was no action plan to reduce the occurrence of falls.

This was a continued breach of Regulation 12 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 vulnerable people.

Arrangements were in place to safeguard people from potential abuse, including a safeguarding policy. At our previous inspection we found that although staff had not always received safeguarding training, they 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. A whistleblowing policy was in place and staff we spoke with were aware of

how to access this. Staff told us how they would report serious concerns to the Care Quality Commission (CQC). However, at the previous inspection we raised several safeguarding alerts with the local authority as there had been a failure by care staff to report instances of improper treatment which we identified during the inspection. Some of these safeguarding cases were still on-going at the time of this inspection and these people were still receiving visits from the local authority. We found during this inspection that staff had now received training in how to safeguard people from abuse and how to report any potential concerns.

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 robust 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 home had installed a new temperature-controlled medication room since our last visit and medicines were kept securely. This meant that medications were being stored safely as too high or low temperatures can compromise the quality or effectiveness of the medicines.

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. Creams and liquid medication were kept in individual baskets labelled for each person and topical cream charts were completed by care staff following each application of cream. The medicines MAR sheets each contained information on known allergies and a photograph of the person, which helped ensure that the right person received the correct medication. The photographs were updated annually. There was a protocol in place for PRN medications; these are to be given as and when required, and were clearly identified on the person's MAR sheets. We checked a sample of six of these records and found them to be mostly in order. However, we found one missed signature in the month on one person's MAR sheet; however the dosette box showed the medication had been given. Any hand-written additions for temporary medicines require two staff signatures to ensure the accuracy of the information transfer to the MAR sheet. We found one person had received additional, temporary antibiotics and no second signature was present. We found two people's medication records to be missing the associated PRN protocol for analgesia to be given when required.

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. However, the findings from our review of a sample of the medication records had not highlighted the omissions we found during our inspection. This meant that previous audits had not been robust enough to identify the discrepancies we found.

We observed one medication round on the first and second mornings 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. On the first medication round we saw the medication trolley doors were closed but unlocked and left unattended for short periods of time on three occasions. During this time the medication trolley was not in view of the senior carer. No other staff member was overseeing the medication trolley as they were occupied attending to other people. This meant there was a risk that people, some of whom were living with dementia, had access to medicines in the medication trolley. We spoke with the senior carer involved and they explained they had had a lot of interruptions during the medication round. There is an increased risk of errors in medication administration when staff are frequently interrupted during the medication administration round.

We recommend that staff are given protected time to administer the medication round to reduce the risk of interruptions and to ensure the medication trolley is not left unattended.

We found that district nurses visited the home and carried out blood tests for glucose levels and administered insulin injections for people with diabetes. District nurses had their own files kept at the home where they recorded their 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 clean and tidy. At the previous inspection, we found the home had a malodour in many parts of the building. However, during this inspection we found this had improved and was only present in a small number of areas, such as reception and one bedroom. The provider told us they had replaced a number of floorings, furnishings and beds throughout the home in order to address the previous malodour. One staff member told us, "The environment has improved; it's much cleaner and carpets have been replaced."

Issues with infection control risks that we had previously identified had mostly been addressed. However, we found there was still no readily available hot water for people to wash or bathe in one wing of the building and it took five minutes for the water to get hot. During this tour we looked in several people's bedrooms and found there was a lack of toilet rolls and also hand towels and bins in people's en-suite facilities to enable people, staff and visitors to safely wash their hands. The home manager arranged for these to be placed in people's rooms the same day. In communal toilets and bathrooms we found the only bins available were used for sanitary hygiene products. This meant that people disposing of paper towels had to access these bins that contain used continence products. We reported these findings to the home manager and the new bins for paper towel use were delivered during our inspection.

We looked in the kitchen and found this area to be very clean and kitchen staff ensured everyone wore a protective coat before entering the area. Kingsfield Care Centre had been awarded a level 5 for food hygiene by the Food Standards Agency in March 2016. This is the highest rating.

We visited the Windsor Suite, which was in a part of the building that had previously been closed. The area had been refurbished and was bright and airy, had a large television centrally positioned and was well heated. However, the lounge area had a slight malodour and we found the chairs were not clean. They were sticky, stained and odorous. We requested the chairs were thoroughly cleaned before people used the area. We looked in the unlocked kitchen area and found a strong damp odour, the radiator cover had come off the wall and there was no thermometer in the fridge to check for safe food storage temperatures. The home manager acknowledged the poor state of the kitchen and told us this kitchen area was due to be refurbished.

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.

At our previous inspection we looked in the laundry and found there was a security keypad entry system, however, the number code was written above the lock. This meant that chemicals and soiled laundry items could be accessible to people who lived within the home, some of whom lived 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. During this inspection we found that no improvements had been made with the laundry regarding the concerns identified at the previous inspection and the risks remained.

During the last inspection we spoke to staff about the availability of hoist slings. They told us that they did

not use different slings for each person they moved and that they just used one that was available. This practice meant that there was a risk of cross infection by using the same sling for more than one person. Each person should have a named sling for their personal use. In addition to issues with infection control, slings should be the correct size for the person to ensure safe moving and handling. At this inspection we spoke with care staff who told us people did not have their own, named sling and told us they used the same sling for more than one person.

The above examples demonstrate a continued breach of Regulation 12 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.

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 evidence that 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 found during the previous inspection that people had their medical needs neglected and we took immediate action to safeguard their health and wellbeing.

We looked at how people's immediate care needs were communicated between management and staff during the day and between the different staff teams during shift handover. The home manager told us they conducted a daily 'flash meeting' where a representative of each staff department would be present for a short meeting. We observed one such meeting during this inspection; items discussed included meal choices, the building grounds and laundry.

At this inspection, 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. During the inspection we found a high number of people were, or had recently been, suffering from chest infections and many people were taking antibiotics; one person had been hospitalised for treatment on the morning of our inspection. We noted down during handover at 7.50am on the first morning of our inspection that one person was reported by the night staff as being unwell. The person had been administered analgesia by the night senior and they informed staff during the handover that this person needed a visit from the GP. We later checked records and found that this information had not been noted down anywhere in handover notes or in the communication diary kept in the office. We looked back at night care records and found the information recorded for this person was "settled night" and their daily record of care for the same evening contained no information indicating they were unwell. The daily record of care for the previous day stated the person had good food and fluid intake; however, their 24 hour food intake record did not correlate and indicated they had reduced food intake that day. This meant there was no written evidence that this person had been identified as being ill and requiring medical attention.

We observed this person during breakfast to be showing visible signs of being unwell. Care staff brought the person a glass of water and a hot drink. We asked the senior carer who was administering medication if anyone had contacted the person's doctor. They told us this had not yet been done, but they would ask the deputy manager to review their condition. Later in the morning we spoke with the home manager who told us the person had been checked and appeared to have improved; we told the home manager we believed the person to be unwell and required a doctor. At 11.50am we again approached the senior on duty and asked if a doctor had been requested to visit the person who was unwell. The senior carer then rang the doctor and requested a visit to the home. At 3pm the doctor visited and diagnosed an infection and prescribed a course of antibiotic medicine for the person.

The above example showed there was a risk the information would not be passed over to the next shift to

ensure the required care and support. Additionally, there was a risk this person may have deteriorated had they not received medical attention in a timely way.

Although we could see evidence in people's care records that they had received input from professionals, we found that the medical needs of some people were not being met during our inspection. On the second day of inspection we noted one person had visible discolouration of a large dressing on their shin. Care records showed us this person had a high risk of complications due to poor skin integrity. We reported our concerns to management who told us the person had an open skin tear underneath the dressing; however, the person had refused to see the district nurse team who had visited the previous day. The person lived with dementia, lacked the mental capacity to make an informed decision to refuse treatment and was unable to understand the consequences of not being seen by the district nurses. The district nurse team were not due to revisit the home until the following week. This meant the dressing would have been in place for two weeks and was displaying visible signs of compromise. This placed the person at risk of deterioration of the wound and potential wound infection. As a result of our concerns, the deputy manager re-dressed the wound immediately and requested a district nurse to visit before the following week.

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

During our previous inspection in July 2016 we found serious concerns around people's nutrition and hydration needs not being adequately met. The provider detailed in their subsequent action plan that several steps had been taken to redress these identified failings. As part of this inspection we looked to see if actions had been implemented and improvements had been made.

In the last inspection report we made a recommendation to ensure people who had their food prepared to a pureed consistency have their meal served in separate portions in order to make the meal look attractive and appetising. During this inspection we saw evidence that the provider had implemented the recommendation around serving food in separate portions.

As part of our inspection, we looked at the menus and food choices available to people living at Kingsfield Care Centre. We viewed the set menu held in the kitchen, which showed options for each meal and snacks throughout the day. The menu included a variety of different meals and offered a balanced diet; however, staff were unaware and we did not see evidence that people who live at the home had contributed to meal choices. The home manager told us one person had expressed they would like to have more Italian food served and discussions had taken place; however, this had not yet been implemented.

We saw that people were offered choice during lunchtimes. We observed some people were shown two meals on plates and they were able to choose which meal they would like to eat. Kitchen staff told us they had trialled this method of giving people choice and found this worked well. We saw food being prepared in the kitchen, which looked fresh and appetising.

Supper consisted of biscuits and milk drinks every night with no alternative listed for people who did not like this choice, or for people who could not eat biscuits due to dietary requirements. We reported on this during the last inspection, however, the supper availability had not changed at this inspection.

At the last inspection we found that people did not have regular access to a drink. During this inspection we found people were regularly offered a drink throughout the day. The provider had implemented a policy of jugs of water or juice to be placed in people's rooms overnight, where it was safe to do so, to ensure people had access to a drink if needed. This meant the provider had acted upon the findings of our previous report. One relative we spoke with told us, "Drinks after dinner can be a bit hit and miss, but that has got better."

During this inspection we again 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. Information was now held in the kitchen to inform staff of people who required having their food prepared in a specifically prescribed way. However, during our inspection kitchen staff could not initially locate the information. When the information had been located we found it was not always accurate or up to date. Important information had not been reviewed from June and July 2016. This meant people were at risk of not receiving the correct diet. We asked staff who required a special diet and which residents required their food to be prepared or served in a specific way. Kitchen staff were unable to tell us who required a special diet, but told us two people had their food served to a pureed consistency. However, information produced for us by the management, showed us five people required their diet to be prepared to a specific consistency. This ranged from a stage 2 pureed diet to a stage 4 mashable diet. We spoke with four members of care staff to check their knowledge of people's specific diets and how food should be served. Staff were not able to accurately describe people's specific dietary needs.

Kitchen staff we spoke with did not understand how to fortify food and told us they did not add anything to anyone's food in order to increase the calorific content. 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 we spoke with kitchen staff around the need for some people to have fortified foods, they told us a milkshake or smoothie was served at 11am every day. However, staff we spoke with gave us contrary information. One staff member told us, they were served at 2pm and another staff member told us they were usually only served around three times per week. This meant although the published menu showed people were offered a high calorie drink every day, this did not happen in practise.

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, such as, a modified texture or fortified. 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. Management told us the menu for all people living at the home was designed to be nutritious and suitable for diabetic people.

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 received a full nutrition care plan from them which prescribed a stage 2 diet, with their meals to be fortified with high calorific food items. A diet sheet was included in the nutrition care plan, along with suggestions of high calorie food. This person was underweight and required monitoring by the care staff to prevent further weight loss. We checked care records for this person and found that a risk assessment for weight loss had been completed. 24 hour food intake records and daily meal records were in place. This person also had a diet notification record in place in the file in the kitchen. Information stated this person had been prescribed a high protein diet, 3 fortified snacks between meals and fortified milk drinks. We reviewed the previous five days records and found there were discrepancies in the records around how much the person had eaten on each day. In addition the food served did not correlate with the person's prescribed diet plan. We did not see any evidence in the records that this person had received the prescribed extra nutritional support or where action had been taken when they had eaten very little. We found this person's prescribed nutritional care plan was not being followed. This meant that the person's specifically prescribed diet plans were not being adhered to and that the

person was at risk of the complications caused by further weight loss.

During this inspection we saw staff encouraging some people to eat. However, we observed a number of occasions where people were served their meal and required assistance or prompting and did not receive it. We observed one person who had been served their meal whilst they were sat in the lounge. The meal was placed to the side of the person on a small table and it was difficult for the person to eat their meal from that position. The person ate a very small amount and was prompted once by staff to eat more; however, staff removed the uneaten meal and gave the person a pudding; which was eaten easily from their lap. We observed another person at breakfast time and saw they were served egg on toast; however, they did not eat this meal. Staff later reheated the meal in the microwave and the person ate a small amount before they were escorted to sit in the lounge. No alternative food was offered. This meant that people had not received enough support to ensure they ate well.

During one observation we saw one person was seated alone at the dining table, where they were served their breakfast and a cup of tea, which was served in a clear, spouted beaker. The person did not receive any prompting or assistance from staff to eat their meal. After 20 minutes of sitting at the table the person started to eat some toast with their hands. We noticed the person's drink was thickened to assist with swallowing and we could see a visible lump stuck to the side of the beaker. We asked staff to check the thickened consistency. Staff did not know what consistency the tea should be thickened to and no information was on the can of thickening powder. Staff checked the records which showed the person's prescription was for a stage 1 syrup consistency. This meant that there was a risk that people were not receiving their liquids as prescribed due to a lack of available information and staff knowledge. We asked management to ensure information about fluid thickening consistencies was available to staff.

As a result of the above observations we checked this person's care records around food and drink. We found the December Residents' Diet Support sheet for the home detailing instructions about how this person's food should be prepared stated "Stage 4 Revert to Stage 3 if in difficulty. Avoid high risk textures. Fluids syrup consistency". In addition, the person's Diet Notification Record dated July 2016 stated the person required a "Thin Puree" modified diet, it did not state the person required a spouted cup and stated they did not require assistance with eating. The two documents were contradictory in instruction and the person received a meal that was not consistent with either a Stage 3 or 4 diet, or with a thin pureed diet. Additionally, the person did not receive their drink thickened to the prescribed consistently. This meant this person was placed at risk of choking and aspiration from the incorrect preparation of food and drink.

We reviewed the records of another person who had received input from the local NHS dietetic service due to being below a healthy weight range. They had an individual nutrition care plan that outlined a diet plan aimed to prevent further weight loss and a Malnutrition Universal Screening Tool (MUST). A MUST is an assessment tool used by care staff and professionals to check if people are at risk of malnutrition. We found their MUST was not accurate and incorrectly scored them as medium risk when the correct assessment indicated they were high risk of malnutrition. We noted this person had recently been recorded as having weight loss and notes made in their monthly review stated "needs monitoring". However, this person had not been weighed weekly in order to check for any further weight loss. We looked at the person's food charts and found they were not always completed nor did they follow the prescribed individual diet plan. There was no evidence this person had been offered milky drinks made with cream or been offered supper each evening, as prescribed by the dietician.

We reviewed the charts of people who lived at Kingsfield who required monitoring of their food and fluid intake. We found they were not always completed. For example, we found one person where their 24 hour fluid intake and output record showed a target input of 1374 mls per 24 hours; however recordings showed

us they had taken just 500 mls of fluid. No actions were recorded as taken. We found another's person's chart showed they had not attained their target fluid intake and had recorded their output for 24 hours as none. No actions were recorded as taken.

The above examples demonstrate a continued 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.

During the previous inspection we found when we spoke to staff that they did not all have an understanding of MCA and DoLS. We reviewed the training matrix at that time and could see that 39% of staff had not received training in this subject. This meant that not all staff had the knowledge 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 revisited the training matrix during this inspection and found that 80% of staff had now received the required training.

During our observations at this inspection we saw that staff sought consent from people before providing care and support. People were given choices and asked what they would like to do. We did not observe any restrictive practice during our inspection.

During our previous inspection 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. As a result of these findings at the last inspection the provider instigated a full review of care plan documentation and implemented a 'resident of the day' scheme. This scheme involved a review of all aspects of the person's care records, housekeeping, manager actions and activities. We reviewed the scheme records and found this had been implemented. However, we did not find evidence in these documents that people or their relatives had meaningful input into people's care plans. .

As part of our inspection we look at how people's wishes are communicated. 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. A best interests meeting will include the person, a representative of the person, a member of care staff and a professional, such as a nurse. This is to ensure a second opinion, explore alternatives and evidence given as to the mental capacity of the person for whom the decision was being made. At our last inspection we found no best interests meetings had been held. We previously identified in the care records of one person who lacked capacity and had no-one to represent their wishes,

there was no 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. We found in these care records a letter from a general practitioner (GP) giving permission for the home to give the person covert medication. Covert medicines are medicines that are given without the person's knowledge, for example, disguised in food. 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. At this inspection we found a best interests assessment record had been put in place regarding this person's covert medication. However, the best interests assessment had been carried out by one person only and therefore did not constitute a decision made in the best interests of the person. The decision made solely by the GP was still being used as a basis to provide the person with covert medication. There was no involvement or consultation with others which is an essential part of a best interests decision.

The above examples demonstrate a continued 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 received training and the necessary support from the provider, such as, supervision and personal development, to enable them to carry out their duties.

At the previous inspection we found significant shortfalls in the level of training completed by staff and the level of supervision given; we found the provider was in breach of the regulations around staffing. At this inspection, the management produced 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 found that most staff had now received the required training levels. This meant that people received care and support from some staff members who had 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. We could see from the training matrix that staff had already completed or were booked to complete training courses around dementia, behaviour that challenges and therapeutic relationships. Staff had also received full training to ensure people were moved and handled in a safe way. Our observations evidenced that staff were now using safe and reassuring techniques when they were assisting people to move around the home. We found significant improvements had been made by the provider regarding levels of training for staff during the five months since our last inspection. One relative we spoke told us they'd noticed improvements, they told us, "There's been a massive improvement when using equipment and a better understanding of dementia care." Despite the improvements in training levels since the last inspection, we found there was still gaps in what was considered to be mandatory training by the provider; some staff had failed to complete the required training. This meant that not all staff who were providing care had received the required level of training to provide effective and safe care. For example, 10% of staff had not completed moving and handling training and 14% of staff had not received training on infection control.

The provider told us through an action plan that they had implemented observations and practical supervision by senior managers to monitor practice. The staff we spoke with told us they had not been subject to this kind of supervision and had not received any feedback from observations. Staff we spoke with told us they had not received a one to one supervision for some time and they had not received an on-going programme of supervision and appraisal from senior staff.

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

Is the service caring?

Our findings

During our previous inspection in July 2016, we found significant shortfalls in the levels of care. Not all people and their relatives were happy with the care and expressed concerns to us around dignity and respect. We also observed some instances during our last inspection where care standards fell well below those expected. People were not always spoken to kindly or with compassion, some people were unkempt and found in an undignified state. 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. Incidents of poor care were documented in the report of our previous inspection.

At this inspection we found improvements in the levels of care at Kingsfield Care Centre. Relatives told us they had seen noticeable improvements in the delivery of care, one relative told us, "Staff are more attentive...they get down to their level and spend time with residents, which they didn't do before. Huge improvements since July 2016. They still have a long way to go but going in the right direction." Another relative told us they had seen improvements since July and said, "Staff are really nice; lovely. We couldn't wish for better staff. Staff are very friendly." A third relative was also complimentary around the caring nature of staff and told us, "[Staff name] is very good. She has a soft spot for [name] and goes above and beyond the call of duty."

Throughout our inspection we saw that 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 one care staff member crouched at the side of a person who was chatting about when they were in the war; it was clear the staff member knew the person well. Another staff member assisted someone to sit down and chatted kindly to the person; they asked if they were comfortable and if they needed a blanket. They asked the person if they would like to watch a film and then brought a selection for them to choose from. It was clear staff knew people well and they talked about people in a compassionate and caring way, one staff member commented, "[Name] is not himself today so I'm keeping an eye on him."

We could see the staff were kind and caring during care delivery. However, we found that many interactions were still quick and task-led; staff still did not have the time to spend encouraging, nurturing or try different approaches with people, for example, spending time to try and encourage someone to eat their meal.

The provider told us they were addressing our previous concerns around people's dignity and respect by introducing dignity champions within the home and ensuring all staff had received dignity training. The training records showed us most staff had undertaken dignity training since our last inspection. We spoke with one staff member who was a newly appointed dignity champion and they told us their role meant that staff had been made more accountable to ensure people were treated with dignity.

Staff told us the home had introduced a key worker system for individual people and we saw evidence of

these key worker forms in people's care plans. The keyworker system meant that certain staff members were linked to individual people and responsible for day to day care. They were also responsible for ensuring care plans were person-centred and reflected people's specific support needs and choices. Additionally, key workers were responsible for practical care needs; for example, ensuring people's bedroom, clothes, shoes and other personal effects were cared for and in good condition. The key worker document also stated the staff member would be responsible for planning activities to meet each person's needs. Staff we spoke with knew the people for whom they were a keyworker. One staff member told us management had explained to them what being a keyworker means and they told us, "I think it is a good thing."

We found improvements during our observations that people living at Kingsfield Care Home were mostly treated in a kind, compassionate way and treated with privacy, dignity and respect. However, we found instances where levels of care still fell short. For example, we noted one person had been sat in the same lounge chair for six hours and staff confirmed this was correct. We checked this person's care records which informed us this person was living with dementia, was not independently mobile and had a full continence assessment. The person needed to be assisted to the toilet every two hours for "continence support and skin integrity." This meant the person was not treated with dignity as they had not been assisted to the toilet for a prolonged period of time and treatment was not in line with their assessed need.

During this inspection, we observed one instance of a member of staff speaking in a derogatory manner about someone. During our observation of the first morning handover on the first day of our inspection, one staff member described the person's night behaviour and told other staff, "[Name] did their usual screaming and shouting." This showed a lack of understanding towards the person and their dementia.

During the July 2016 inspection the inspectors saw that people were not always clean, well-groomed and their dignity was not always respected. During this inspection we found improvements had been made to people's appearance and cleanliness and we did not find the same level of concern. However, one visiting professional we spoke with told us, "People still look a bit unkempt." Mid-morning on the first day of inspection we observed one person had spilled brown liquid down their chin and onto their clothing, we spoke with staff and they told us it was caused by the medicine they had received during the morning medication round. We asked the staff member to ensure the person was asked if they would like to have their face cleaned and clothing changed.

However, we saw other instances where people were promptly asked if they would like to change their clothes if they had spilled a drink or food. This meant people's dignity around their appearance was mostly being respected. People looked smarter than they did on the previous inspection and attention had been paid to people's presentation.

Is the service responsive?

Our findings

During our previous inspection we reviewed care plans and found they included information on how to care for the person through 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. At this inspection we reviewed four people's care plans and found references had been made to involving people in their care planning by the way of care plan monthly evaluations and this was audited using the resident of the day monitoring form. However, in the four care plans we reviewed we did not find evidence that showed us input had been used to provide meaningful personalisation. For example, documentation stated that relatives had not been contactable for their views or the box had been ticked that the person had been spoken to about activities, but nothing had been recorded around what they would like to do.

Documentation had recently been introduced to record views of people and their representatives; however, in the care plans reviewed, we found no evidence of meaningful input. Where documentation was in place to record people's views on their care planning, we saw comments, such as, "Unable to understand" or "Unable to give view at present" and "Unable". Some people's boxes were left blank. We saw no evidence to show the provider had taken steps to help these people understand or where further attempts had been made to support and enable people to actively participate in deciding how they would like their care to be delivered.

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. Although improvements had been made to documentation at Kingsfield Care Centre, we did not see evidence that the person or their representative had been involved in formulating their plan of care.

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

Each person living at the home had a document named 'Life Story' that was kept in the office; we also found the home had introduced a 'Remembering Together' document for people. These documents were designed to inform staff around people's lives before they came to live at the home and what they had previously liked to do, such as, travel and dancing. It stated in one person's file they liked to watch a particular dance television programme; however, we did not see any evidence that this person had been supported to watch this programme.

The home had placed clear boxes "memory boxes" on the walls outside each person's room, which contained items of importance to the person, such as, family photographs. We found that not everyone's memory boxes had been completed or reflected their life and personal preferences. For example, we found in one person's memory box a single sheet torn from a word search book, another person's box contained one DVD sleeve and another person's was empty. We became aware that one person had been a competitive dancer throughout their life up until retirement; however, this person's box did not reflect this.

At our previous inspection staff had told us they did not have time to sit and read people's personal information. We spoke with staff again during this inspection and they told us they still did not have time to read people's information about their lives; however, they told us they were trying to sit and chat with people and get to know their families more. They told us relationships were being developed and they found relatives were approaching them more now and said, "Families seem happier, there's not as many complaints." The visiting relatives we spoke with confirmed they were happier with the care at the home.

There was an activities programme on the wall in reception of Kingsfield Care Centre displaying what activities were happening each week. An activities co-ordinator worked 20 hours per week. Activities in the home included armchair aerobics and hand massage. The activity co-ordinator told us that although there was a programme in place, it was flexible to people's needs and people had a choice if they preferred an alternative activity. The home had access to a minibus and a trip would be planned soon to the local garden centre. We did not see any co-ordinated group activities during our three day visit; however, we saw one instance where two people were engaged in silk flower arranging and one person colouring in a book with help from staff.

We spoke with staff about activities offered at the home. One staff member told us it would be good if care staff could get more involved in activities, but they do not have the time. Another staff member told us, "We need more activities and they could improve." We spoke with staff on the Windsor Suite, who told us they provided some activities, such as a colouring book, watching a film or silk flower arranging on an ad hoc basis, but no co-ordinated activities took place on that unit.

At the last inspection, we did not see evidence that one to one activities were provided; this was verified by talking to staff who confirmed people did not receive any personalised activities. We spoke with the activities co-ordinator at this inspection to check if any improvements had been made. We were told one person, who spent all their time in their room, had an hour session in their room once per week, where a disco ball was used to provide sensory stimulation. Other examples of personalised activities given were listening to music, audio stories and having a chat with people. These were ad hoc and there was no co-ordinated approach to personalised activities to stimulate people. We did not see where people's particular preferences and choices were built into any activities provided. NICE quality standards on the mental wellbeing of older people state that older people in care homes should be encouraged to take an active role in choosing and defining activities that are meaningful to them. This promotes their mental health and wellbeing.

During this inspection, we were unable to monitor call bell response times as a new silent, vibrating pager system had been implemented to replace the audible alarm that signalled someone required assistance. Each of the pagers we checked did not display the correct date or time and we spoke with management who told us this new system did not have a facility to electronically record call bell times. This meant we were unable to ascertain if call bells were responded to in a timely way during this inspection and the management were not able to monitor response times.

The provider told us due to our findings at the previous inspection, they had implemented a weekly call bell audit system. We viewed copies of these audits during the inspection. However, we checked a sample of rooms and found one bedroom did not have a call bell in situ; this was rectified during the inspection.

At the previous inspection, we found people who had a sensor mat in place could not also have a call bell in place. This was rectified during the inspection and the provider had installed a splitter system to accommodate both cables. During the last inspection we also identified that sensor mats were 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 that 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. During our visits to a sample of people's bedrooms, we found the sensor mats had not been replaced and the original black sensor mats were still in place.

The provider's action plans detailed that staff would be allocated clear areas of responsibility each day and daily handover documentation would be introduced to address the shortfalls in communication we identified at the last inspection. We attended two evening to morning shift handover sessions to see how vital information about people's immediate care needs was communicated. The new paperwork specified each person's name, with a view to prompting staff to give a full handover of individual people. We found on the first morning's handover staff mentioned everyone's name and described six people's night experience, such as, one person taken to hospital and one person had been aggressive earlier in the evening. Everyone else had a "settled night" and no further information was discussed. The handover had improved by the second morning and people's night to day support needs were discussed more thoroughly allowing the day staff to have a fuller picture of people and their potential care needs that day. On the second day of our inspection we spoke with one staff member around communication and they told us, "Hand over is usually better than yesterday" and made reference to the first day when we attended handover. Another staff member we spoke with told us, "Communication has massively improved."

At our previous inspection, we looked at how the home actively sought and acted on feedback from people who use the service and their relatives. We found the home had not been responsive to negative comments around people's care that were received during a survey conducted earlier in 2016. Another survey had not been completed since our last inspection. However, the provider had written to all relatives regarding the inadequate rating awarded at the last inspection and had held meetings and 'surgeries' to engage and involve families in the planned improvements for care delivery and the home environment. This meant the provider was actively involving people and their relatives in improving the shortfalls previously identified at Kingsfield Care Centre.

Is the service well-led?

Our findings

At the time of this inspection Kingsfield Care Centre still did not have a manager in post who was registered with the Care Quality Commission (CQC). Previously, we identified there had been no consistent managerial support at the home to ensure oversight of the home's performance and the quality of care provision. Subsequent to the last inspection, the provider had placed a relief manager in post to provide consistent leadership until a suitable home manager could be recruited. The new home manager had been in post for three weeks when we conducted this inspection.

We found during the previous inspection that staff did not feel supported in their role and the home lacked leadership at all levels. All staff we spoke with on this inspection told us there had been improvements in the support and leadership from management since the last inspection. Staff told us they now felt supported in their role and spoke highly of the current and previous home managers. One staff member told us when discussing the new home manager, "I get 100% management support. I think they're fantastic and they have the right mind set. I believe they can turn it around." Staff also spoke highly of the previous relief manager the provider put in place and told us, "Can't fault [name], she was great... The seniors are brilliant too." Staff felt improvements had been made throughout all aspects of the home and they had been listened to by management, one staff member told us, "I don't feel like I'm banging my head against a wall; I feel like I'm being listened to."

Staff told us that although they had not had one to one supervision, they had been part of team meetings to discuss improvements that needed to be implemented at the home. These meetings concentrated on the staff; discussing rotas, checking that everyone was happy in their role and getting along together and asking staff to raise any concerns they might have.

As a result of our findings in the previous inspection, the provider told us they had instigated a home manager daily walk around the home and a series of monthly visits to Kingsfield Care Centre by senior management to oversee the improvements that were needed. In addition, the provider told us they had conducted their own internal quality inspection. We saw evidence that these additional checks on the service had taken place.

During the previous inspection a number of actions required immediate implementation to safeguard people from the risk of harm; however, some of the necessary changes required a longer term implementation plan. The provider sent CQC an action plan outlining the necessary improvements identified during the inspection detailing how and when these requirements would be met. At this inspection we found some actions had been commenced and improvements had been made; however, we found some actions had not been fully implemented and some actions had produced a limited impact. This meant a number of the issues and concerns identified during the inspection held in July 2016 constituted a continuation of those breaches of regulations.

During the previous inspection, we found that systems and procedures were in place at Kingsfield Care

Centre as they were part of a large, corporate provider 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. During this inspection we found levels of staff training had improved and a health and safety audit had taken place; however, supervision and appraisal for all staff had not taken place and our concerns remained regarding the number of incidents where people had fallen and action had not been taken. We also saw that procedures put in place to ensure safe and effective delivery of care were still not being followed or completed accurately, such as, nutrition and hydration charts and prescribed diet plans.

Audits and checks were in place for a number of areas within the care home. Checks we reviewed during this inspection included; daily medicines audits, call bell audits, maintenance checks and care plan audits. Despite these regular checks, we found continued concerns around people's care delivery records, infection control risks, consent and timely medical intervention. This meant that although the provider had policies, processes and checks in place, they did not operate effective systems to ensure their implementation and the resolution of identified actions.

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