Balcombe Care Homes Limited

Kingswood Court Care Home

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Kingswood Court Care Home is registered to provide accommodation with nursing care for up to 59 people. At the time of our visit, there were 50 older people living at the home. The majority of the people who live at the home are living with dementia, some have complex needs and the home also provides end of life care. The accommodation is provided over two floors that were accessible by stairs and lifts. The inspection of Kingswood took place on 16 August 2016 and was unannounced.

At the time of our visit there was a registered manager in post. 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.

People were at risk of harm as safe medicines practices were not always followed. Catering staff were not made aware of people's needs where their diet may affect the efficiency of their prescribed medicines. People told us that they were happy with the support they received to manage their medicines. Any changes to people's medicines were verified and prescribed by the person's GP.

Staff did not have a clear understanding of their responsibilities regarding the Mental Capacity Act or Deprivation of Liberty Safeguards. Where people lacked capacity they were not fully protected and best practices were not being followed.

There were systems and arrangements to monitor and improve the quality of the service. We have recommended that further improvements are made.

People had mixed comments about whether there were enough staff on duty, people told us that on occasions they had to wait before staff attended to them. We identified that staffing levels had an impact on the care and range of activities provided. We recommend that the registered provider reviews the layout of the home when determining the deployment of staff.

People told us they felt safe at Kingswood. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. A relative told us, "I feel that mum is very safe here, staff are very caring." There were systems and processes in place to protect people from abuse and staff had received safeguarding training. Recruitment practices were safe, were followed and relevant checks had been completed before staff commenced work.

Staff were knowledgeable about people's needs, and how to care for people who were distressed or at risk of harm. Information recorded about how to provide support to people who were prone to falls, people being feed through tubes and people using bed rails. Where people were at risk of developing pressure sores there was a plan in place to reduce this risk which were followed by staff. People were supported to take risks safely. People with limited mobility, were not prevented from moving around and were actively

supported by staff who looked after them safely.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe. Each person had a personalised emergency evacuation plan and staff carried out regular fire drills and evacuations so they knew what to do in the event of a fire. There was a contingency plan in place should an emergency have an impact on the delivery of care.

Equipment was checked and serviced regularly to ensure it was in safe working order.

Staff had the appropriate guidance in relation to their role. The registered manager ensured staff had the skills and experience which were necessary to carry out their responsibilities.

People had mixed feelings about the food at the home. People were supported to have their nutrition and hydration needs met. People who were able to eat independently were prompted and encouraged to do so. Where people needed support, they were supported by a member of staff. Throughout the meal we observed staff interacting with people and asking them about the food.

People had access to healthcare professionals such as the GP, district nurse, optician, dentist, physiotherapist, speech and language therapist to support their well-being. The service worked effectively with health care professionals and referred people for treatment when necessary.
We have recommended that the provider continues to plan and take action to provide a suitable environment for people living with dementia to aid their wellbeing and independence.

Staff knew about the people they supported. We saw information in care records that highlighted people's personal preferences, so that staff would know what people needed from them. We observed where a person was distressed the staff member reassured them.

Staff showed kindness to people and interacted with them in a positive way. Staff were caring. Staff were observed knocking on people's bedrooms doors before entering. People's privacy was respected by staff. Relatives and friends were encouraged to visit and maintain relationships with people.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed.

People had access to activities, however there were mixed feelings about the activities provided. The range of activities available was not always appropriate or stimulating for people. We have recommended that the provider reviews individual hobbies and interests and looks for ways of increasing group and individual participation.

Care records did not reflect up to date information regarding people's care or support needs which meant new or agency staff who did not know people might not be working to the most up to date information.

Staff were quick to respond to people's needs. The registered manager told us by having a consistent staff team they were able to build up a rapport with people and that people were cared for by staff they knew and who understood their needs

People and relatives confirmed that they were aware of the complaints system. There was mixed feelings about the way complaints were handled. However the provider had been following their complaints

procedures and taking action to resolve complaints wherever possible.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made two recommendations to the provider. 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 consistently safe.

People had risk assessments based on their individual care and support needs which were reviewed on a regular basis.

Medicines were administered safely. However medicines administration records (MAR) were not always accurate and contained gaps and not all staff including the chef were aware of how foods might affect the efficiency of medicines.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not protected because staff did not act in accordance with the MCA.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

Staff provided care, and support which promoted well-being. People were supported to have access to healthcare services.

We have recommended that the environment is adapted to meet the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

Positive caring relationships had been developed between people and staff.

Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring.

People felt that staff knew them well and they were supported to make choices so they could maintain their independence.

People's relatives and friends were able to visit.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were being provided with a responsive service despite a lack of individual detail in some care plans.

We have recommended that the opportunity for people to be involved in group and individual occupation and activity is Reviewed.

People were encouraged to voice their concerns or complaints about the home.

People's needs were assessed when they entered the home.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Although care plans were not always up to date this did not impact the care people were receiving. We have recommended that improvements continue to be made.

The provider's did have systems to quality monitor the service and care although these had not always identified shortfalls. We have recommended that further improvements are made.

The provider had sought, encouraged and supported people's involvement in the improvement of the home.

People told us the staff were friendly, supportive and management were visible and approachable.

Kingswood Court Care Home

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.

We visited the home on 16 August 2016 and it was an unannounced inspection. The inspection team consisted of three inspectors, a specialist advisor who was a nurse specialising in wound management and an expert by experience. Our expert-by-experience was a person who has personal experience of caring for someone who has dementia.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous CQC inspection reports. The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We gathered information about the home by contacting the local authority safeguarding and quality assurance team. The local authority and safeguarding team did not identify any concerns about the home. We also reviewed records we held which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law.

We spoke to 18 people, six relatives, nine care staff, one nurse, activity co-ordinator, housekeeping staff, chef, catering manager, the deputy manager and the registered manager. We observed care and support in communal areas and looked at four bedrooms with the agreement of the relevant person. We looked at 12 care records, risk assessments, medicines administration records, accident and incident records, minutes of meetings, four staff records, complaints records, policies and procedures and external and internal audits.

We last inspected the service on 4 November 2013 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and secure at the home and with the staff who provided care and support. One person told us, "Safe because I am well cared for. Very satisfied." A relative said, "Very safe been here for six years. Before coming in I looked at 12 other homes and this was the one, no need to look anywhere else had a good feeling and have not been disappointed." Despite people's positive comments about their safety, improvements were need around the deployment of staff which had an impact on the care provided.

People were at risk of harm as safe medicines practices were not always followed. We viewed the medicines administration records (MARs) and found that these were not always accurately completed. There were ten occasions were staff had not initialled to denote that medicines had been administered.

There were no written individual PRN [medicines to be taken as required] protocols for each medicine that people were prescribed. Nursing staff knew what medicines people were taking, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects. Staff also told us that their knowledge of people would enable them to decide whether or not a person required their PRN medicine. Catering staff were not made aware of people's needs where their diet may affect the efficiency of their prescribed medicines. These concerns were brought to the attention of the registered manager and discussed with the catering manager who stated they would ensure that the information for each person was updated.

The failure to have effective medicines management systems in place is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A medicines profile had been completed for each person and any allergies recorded. A photograph of each person was on their MAR to ensure that staff were giving the medicine to the correct person. All medicines coming into and out of the home were recorded and medicines were checked and recorded at each handover. Medicines were stored securely and where medicines required refrigeration temperatures were monitored.

People and their relatives had mixed comments about whether there were enough staff on duty. One person told us, "Very happy, no complaints. Small things that I ask they do straight away."." A relative told us, "Someone always makes sure that [family member] has a call bell in reach and a carer usually comes within four to five minutes." Another relative told us, "Come in at weekend and there are hardly any staff around."

The deployment of staff had an impact on the range of activities and the quality of care provided. As the home is a large home and is divided into three units over two floors, the layout of the home had an impact on how staff were deployed. The registered manager used a dependency tool to calculate the number of staff required in relation to people's care needs. However we found that the minimum levels of staff required were not met on seven occasions in the previous 3 weeks. During our visit we saw how the deployment of staff had an impact on the care people received. We saw positive and negative examples of how quickly staff were able to respond to people's support needs. We observed on occasions staff responded immediately,

other times people had to wait longer up to eight to ten minutes . A number of people on different floors preferred to stay in their rooms all day and staff were unable to regularly check on them or spend meaningful time with them outside carrying out basic personal care tasks. The registered manager informed us that there were a number of vacancies they were trying to fill.

We recommend that the registered provider reviews the deployment of staff taking the layout of the home in to account. The deployment of staff should enable people's needs to be met at all times.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. The staff had access to a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults at risk. This provided staff with up to date guidance including contact details about what to do in the event of suspected or actual abuse. Staff knew that the registered manager would contact the safeguarding team to report any concerns. A member of staff told us, "I would report it to my superior and if necessary the CQC or local authority." Staff told us that they had received safeguarding adults training within the last twelve months and were aware of their role in reporting suspected abuse. We confirmed this when we looked at the staff training programme. People were provided with guidance such as posters about what to do if they suspected abuse was taking place which helped them to feel safe and report concerns.

There was a staff recruitment and selection policy in place to ensure only staff suitable to work at the service were employed. All applicants completed an application form which recorded their employment and training history. The provider ensured that the relevant checks were carried out as stated in the regulations to ensure staff were suitable to work with adults at risk. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. Records seen confirmed that staff members were entitled to work in the UK.

Staff were knowledgeable about people's needs, and how to care for people who were distressed or at risk of harm. Risk assessments and protocols identified the level of concern and how to manage the risks. Information was recorded to guide staff in how to provide support to people who were prone to falls, people being fed through tubes and people using bed rails. People's weight was monitored and recorded on a monthly basis. Where people were at risk of malnutrition, information was reviewed on a weekly basis by their GP. The information provided enabled care and treatment to be planned in accordance to people's needs. Staff knew the risks associated with people's care needs and what action to take to mitigate such risks. People with limited mobility, were not prevented from moving around and were actively supported by staff who looked after them safely. Throughout the day we saw people were able to move freely around the home. Staff supported people to maintain their mobility by encouraging people to get up from their chairs. Staff only intervened if it was necessary.

Where people were at risk of developing pressure sores there was a plan in place to reduce this risk which were followed by staff. For example by using pressure relieving mattresses or pressure cushions. However we noted that two mattress settings were not set correctly. This meant that the optimum level was not always provided to give comfort and relieve pressure on susceptible areas prone to pressure ulcers. We raised these issues with the clinical lead and registered manager who reviewed the settings and adjusted them.

There was a system to manage and report incidents, accidents and safeguarding concerns which kept people safe and minimised the risk of reoccurrence. Accidents and incidents were recorded electronically on people's files and the registered manager kept a central log which was used to monitor any trends. Members of staff told us they would report concerns to the registered manager. We saw incidents and safeguarding

concerns had been raised with the local authority where required and relevant action taken. Accident forms were completed and appropriate action was taken to mitigate risks to people's safety. For example, where a person was found sitting on the floor, they were checked for injuries, none were found and they were made comfortable.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe because each person had a personalised emergency evacuation plan and staff carried out regular fire drills and evacuations so they knew what to do in the event of a fire. There was a contingency plan in place should an emergency have an impact on the delivery of care. Staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts or flooding. The provider had identified alternative locations which would be used if the home was unliveable. This would minimise the impact to people if emergencies occurred.

The communal areas and corridors were free from obstacles which enabled people to move freely around the home. Handrails were placed throughout the home to support and aid people's mobility. Fire, electrical, and safety equipment was inspected on a regular basis. Specialist equipment such as wheelchairs, bath and shower aids were checked on a weekly or monthly basis to ensure they were safe and in working order. There were arrangements in place to repair or replace faulty equipment. Arrangements were in place for the security of the home and people who lived there. All entrances to the home were through a bell system managed by staff. We saw a book that recorded all visitors to the home.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about the effectiveness of the staff. They told us that they thought staff were competent. A relative told us, "Know all the staff, see them all the time. Respect, admiration and affection for them." Another relative told us, "Staff couldn't be better for [family member] and me. I come in every day from 10.15am to 6.30pm. I see dedicated staff."

People's rights were not protected because staff did not act in accordance with the MCA. Where important decisions needed to be made and someone's mental capacity was in question, mental capacity assessments were not completed to see if people could make the decision for themselves. The 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. Best interests were not always considered when specific decisions that affected people were made. We noted that an MCA had been partially completed for personal care, nutrition, end of life, relationships, but there was no information about specific decisions, the only other information recorded was that the person had fluctuating capacity. We noted that a DoLS application had been applied for. No documentation had been completed to record any discussions in regard to the decisions made. This meant people's rights had been affected.

People's rights were not always upheld. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager had completed and submitted DoLS applications to the local authority for two people who could not leave the building without being accompanied and a person using bedrails. However they had not submitted for other people living at the home whom may require their rights to be protected, the registered manager stated that they were reviewing and assessing each person before DoLS applications were submitted.

Failure to meet the requirements of the Mental Capacity Act 2005 was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to make their own decisions and their consent was sought before personal care was provided. Staff checked with people that they were happy with the support being provided on a regular basis and attempted to gain people's consent. Staff waited for a response before acting on people's wishes and sought reassurance that people had understood questions asked of them.
People were cared for by staff who had the appropriate skills and competence and who were adequately supported to carry out their roles. Staff confirmed they had received training and that they had sufficient knowledge to enable them to carry out their role. Staff provided us with information about people's care and support needs and how they met these. During our observations, we saw staff assisted people to stand up from chairs using their walking frames and further observation of transfer techniques confirmed that staff had sufficient knowledge to enable them to carry out this task safely and effectively. The provider's records

confirmed that all staff had received mandatory training such as safeguarding adults; administration of medicines; food hygiene; health and safety and infection control. New staff confirmed they had attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. A member of staff told us, "I worked with a senior who taught me all the basics from scratch. It prepared me for the role as I had a very good teacher, she made it easy."

Staff received appropriate support that promoted staff's professional development. A new member of staff told us, "I have had one supervision." Other staff told us they had received regular supervision "It's ok, we talk about our ability to work alone, organising the work, documents and training." Documentation confirmed that regular supervision took place with staff. Management observed staff in practice to review the quality of care delivered and any observations were discussed with staff.

People had mixed feelings about the food at the home. One person told us, "The food is debatable. Tough meat and not enough seasoning." Another person told us, "Very difficult to cater for all these different people here who all like different things but there is a good choice. I like the food." A third person said, "Excellent food, lovely food." A relative told us, "Food not the best. Not much flavour for aged pallets. Little things like no apple sauce with pork and quite tough meat that people can't chew." People were able to choice what they wanted to eat as staff offered them a choice of two dishes. The chef prepared and cooked all of the meals in the home. There was a choice of nutritious food, snacks and drinks and alternative options were available if people did not like what was on offer.

People were supported to have their nutrition and hydration needs met. We saw staff assisting people to get ready for lunch, at a slow and steady pace, they were not rushed. People who were able to eat independently were prompted and encouraged to do so. Where people needed support, they were supported by a member of staff. Throughout the meal we observed staff interacting with people and asking them about the food. Throughout the day people were encouraged to take regular drinks, to ensure that people were kept hydrated. People confirmed that they had sufficient quantities of food and drink. Staff confirmed that a dietician or speech and language therapy team were involved with people who had special dietary requirements. Some people required products to be added to their food and drink to enable them to swallow without harm and staff followed these instructions and reported any concerns.

People had access to healthcare professionals such as the GP, district nurse, optician, dentist, physiotherapist, speech and language therapist to support their well-being. People told us they could see a doctor when they needed to. One person told us, "I see the doctor if I need to. He comes in and gives me a check-up from time to time." Another person told us, "Doctor does rounds weekly, calls in when he thinks he ought to. Always speaks when he come in and asks if there are any problems." We saw from care records that if people's needs had changed, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by staff or relatives to attend their health appointments and outcomes were recorded in their care records. Staff were given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

People's bedrooms were personalised with pictures, photographs and items of religious sentiment and personal interest. It was not easy for people living with dementia to find their rooms or their way around the service as all areas looked the same. Areas of the service were not easily identifiable; walls and doors were painted the same colour and the carpets were patterned. A large or busy pattern can confuse people and cause hesitation if it looks like an obstacle. Although there were signs on the doors describing rooms there were no visual aids to help people, such as photographs outside of their bedrooms. An environment decorated in contrasting colours may help people's orientation and support people's independence. The registered manager informed us that they were working with the Dementia team to make the home more

dementia friendly. Large windows provided natural daylight and provided people living at the home with views of the garden which they said they enjoyed.

We recommend that the provider continues to plan and provide an environment suitable for people living with dementia.

Good

Is the service caring?

Our findings

People and their relatives were generally positive about their care where one person only made a negative comment we informed the registered manager but we did not find evidence that staff were being less caring at any time as everyone else gave positive feedback. One person told us, "People are all very nice and kind." Another person told us, "Fairly independent but help is available when I need it. Carers are pretty good. ." A third person told us, "I like it very much. It has to be the staff they are so caring." Another relative told us, "Care is just as good for everyone, even those who do not have relatives."

People are able to make choices about their care and support, such as when to get up in the morning, what to eat, what to wear and activities they would like to participate in and they were helped to maintain some independence. A person told us, "Get up when I want. Ask to be taken to my room and they help me." People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them.

Staff knew about the people they supported. A relative told us, "[Family members] came in here together. When [family member] passed away they let Mum keep her big room because they said that she needs familiar things around her." Another relative told us, "[Family member] came in she needed two carers to help her. Now she is far more mobile and can do things for herself." A third relative said, "All the care assistants seem to be very good." We saw information in care records that highlighted people's personal preferences, so that staff would know what people needed from them. We observed a staff member reacting to someone's distress in a kindly and appropriate way. This person said they needed to find what they were looking for now. The staff member replied, "Ok, shall we go and look for it together then?" The person seemed reassured and went with the staff member. Information was recorded in people's care plans about the way they would like to be spoken to and how they would react to questions or situations.

Staff showed kindness to people and interacted with them in a positive and proactive way. Staff were caring. Staff were observed knocking on people's bedrooms doors before entering. When they assisted people to move from one part of the home to another staff were heard offering encouragement and words of reassurance to people. Comments included, "That's good" and "You're doing fine." People were seen to smile in response.

People's dignity was respected by staff. People told us that staff treated them with respect and dignity when providing personal care. A relative told us, "Staff have a laugh with Mum, Always say good morning to her, and are respectful towards Mum." When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. People told me how much they appreciated having clean freshly laundered clothes to wear. Staff told us, "I show respect in the care I give them, the way I treat them and speak to them. Occasionally I'll get that smile from them which is precious." We observed staff transferring people from a wheelchair to a chair; staff ensured that clothes were placed in a dignified way throughout the transfer.

People were involved in making decisions about their care. People and their relatives were very positive

about their involvement with the care planning process. They told us they attended the formal six monthly care planning meeting and were constantly updated if changes were made to the care plan. A relative told us, "There is daily information, formal review every six months. There is plenty of opportunity to get involved with the care planning." A relative said, 'Care plans reviewed every six months, detailed. Open to suggestions." We observed that when staff asked people questions, they were given time to respond. Staff did not rush people for a response, nor did they make the choice for the person. Health and social care professionals were involved with an individual's care planning. Staff were knowledgeable about how to support each person in ways that were right for them and how to involve them in their own care.

People were able to maintain relationships with family and friends and visitors were welcome. People confirmed that they were able to practice their religious beliefs, because the provider had religious services held in the home and these were open to those who wished to attend.

People could be confident that their personal details were protected by staff. There was a confidentiality policy in place. Care records and other confidential information about people were kept in a secured office. This ensured that people such as visitors and other people who were involved in people's care could not gain access to their private information.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. Information about how to support and provide comfortable and, dignified care whilst receiving end of life care was documented in their care plan. However information about how to support people's wishes after their death was not fully recorded. We noted that people's relatives were able to visit anytime and that people were not left alone to die.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us that people have a choice of who provides their personal care. A relative told us, "We can select our carer but I don't mind who it is, man or woman.'

Relatives told us that the registered manager had carried out pre-assessments to ensure that Kingswood could meet the needs of their relatives. These were thorough and involved all parties. We saw that pre assessments were carried out before people moved into the home and then were reviewed once the person had settled in. The information recorded included people's personal details, care needs, and details of health and social care professionals involved in supporting the person such as doctor and care manager. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs.

People were receiving a responsive service which met their needs. Staff relied on their detailed knowledge of people as not all of the care plans reflected the most up to date information about people.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. A member of staff told us, "The handover was very good and very thorough. A colleague or the nurse would make sure you were told of any changes in someone's care." Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw information related to a change in medication, healthcare appointments and messages to staff.

People told us about the activities they took part in. People's comments about the activities were "Not really enough to do. Would like more to do." "Staff give X a lot of encouragement to join in with the activities." Activities included bingo, quizzes, musical activities are provided by outside entertainers and in-house staff. A dog with their owner also regularly visited the home. We saw photographs of outings or events people had attended. We observed a timetable of activities on a board. During the morning the activities co-ordinator was running a quiz with people, prior to this activity they were chatting to people and reading the newspaper with one lady. However, there were only three people participating in the quiz as there were very few people in the lounge area. In the afternoon there were several people sitting in the lounge with limited interaction from staff.

Although an activity took place during the inspection this did not include the majority of the people. We did not see any one to one time spent with people who choose to stay in their rooms or needed to because of their health. These are important as they provide social interaction and reduce isolation to people who remain in their rooms or who do not wish to participate in group activities.

There was some physical stimulation such as interactive tactile activities or percussion items around the home for people that provided them with something to do during the day when organised activities were not happening.

We recommend that the provider reviews individual hobbies and interests and finds ways to increase participation for both groups and individuals to provide adequate interest and stimulation during the day.

People and relatives confirmed that they were aware of the complaints system. There were mixed feelings about the way complaints were handled. We noted from the information stated in the PIR that there were a number of complaints made over the last twelve months, which needed to be review. Where persistent complaints were being made as they were unhappy with the responses to the complaints, the registered manager told us they were working on resolving the situation. Others felt their comments and complaints were listened to and acted upon appropriately. People were able to identify a complaint by completing a form, discuss the issue with staff, the registered manager or at the relatives meetings. We looked at the provider's complaints policy and procedure which was displayed at key points around the home. When people first moved in there was a copy provided in the resident's guide which people kept in their rooms. We noted that responses to the complaints contained action to be taken and offers of apology where appropriate. We saw information about the complaint procedure displayed in the home, which provided people with the information about the process, contact details for the registered provider, CQC, and Local Government Ombudsman.

Requires Improvement

Is the service well-led?

Our findings

People told us the service was "A good atmosphere, everyone warm and friendly." "Think it is a lovely atmosphere." Residents felt secure and were more than willing to share thoughts about life at Kingswood. However we found that the systems and arrangements that were in place to monitor and improve the quality of the service and ensure safe practices were not always robust or effective.

Records recording people's care and support needs in their care plans did not always reflect up to date information which meant new or agency staff who did not know people might not be working to the most up to date information. This could have an impact on the care and support provided. One person did not have the information recoded that their needs had changed in regard to their mobility.

There were a number of systems in place to make sure staff assessed and monitored the quality of care provided to people living at the home. We reviewed various audits carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping. We noted that fire, electrical and safety equipment was inspected on a regular basis. However an audit in April 2016 that reviewed medicines records was not effective enough to identify the shortfalls in best practices. It had identified that MAR charts were not adequately being used to record all information needed. Although staff had recorded that action had been taken, we found errors were still occurring. Audits did not identify the missing information on people's care plans or the actions that needed to be taken to improve care planning. The registered manager assured us that improvement to the quality assurance system would continue to be made. We will assess the impact this has on peoples care at our next inspection.

We recommend that improvements continue to the quality monitoring systems and that action is taken where needed to improve the service and care and the accurate recording of information about people's needs.

People were involved in how the home was run in a number of ways. People were supported to express their views about their care, or the service in different ways such as: day to day conversations with staff, 'relatives' meetings and at social events. We saw minutes of the 'relatives' meetings which recorded people's feedback about unmarked clothing, summer barbeque, hot water temperature and going out in the garden. We noted that action had been taken to improve these aspects of people's care, during the inspection we saw people out in the garden. No one complained to us about their clothing and we saw clothes had been marked to identify who they belonged to.

Staff were involved in the running of the home. All the staff we spoke with enjoyed working at the home. Staff told us regular staff meetings were held and they felt they could make suggestions and that these were listened to. Staff had the opportunity to help the home improve and to ensure they were meeting people's needs. Staff were able to contribute through a variety of methods such as staff meetings and supervisions. Staff told us that they were able to discuss the home, quality of care provided, people's diet, meals times and infection control. They felt their suggestions were listened to, for example, staff had suggested two sittings at lunchtime which meant that staff could stagger breaks and there enough staff available to cover.

This had been implemented and was working well in supporting people with their meals.

People, relatives and staff said that the registered manager and staff were approachable and open to suggestions. Staff spoke very positively about the matron [manager] describing her as someone who they know and can approach if there is a problem. A staff member told us, "It's a nice place to work, we work as a team. The manager and nurses support us and the residents are treated well." She went onto say the manager was, "Fine, approachable and listens to what you have to tell her and they are very helpful and supportive." One person told us, "Matron very good because she has time for you." Residents and relatives spoke highly of the registered manager. People were supported by a consistent staff team. Staff told us, "The manager communicates with staff very well and senior managers visit all the time. We're kept up to date with what's going on." Another member of staff told us, "It's a good place to work, that's why I stay here. There's good teamwork and good management, people get a good service."

The registered manager had notified the Care Quality Commission (CQC) about a number of important events which the service is required to send us by law. This enabled us to effectively monitor the service or identify concerns.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1)(2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to have effective medicines management systems in place Regulation 12 (2) (g)