Factual accuracy comments form

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Typographical/numerical errors	Section A
Accuracy of the evidence in the report	Section B
Completeness of the evidence	Section C
Representations against a Warning Notice	Representations via email to HSCA_Representations@cqc.org.uk

Account Number:	1-122586775
Our reference:	INS2-4334963867
Location name:	Allonsfield House
Location address:	Church Farm, Campsea Ashe, Woodbridge, Suffolk, IP13 0PX

Completed by (name(s))	Lisa Brown
Position(s)	Service Quality Manager
Date	14.11.2018

Section A: Typographical / numerical errors in the draft report

Page No	Key Question *e.g. Safe*	**Please set out any typographical or numerical errors** *e.g. Operations Director not Operations Manager* *If the same error occurs more than once, it is sufficient to identify the first occasion, adding "(throughout the report)".*
12		Allonsfield is the older part of the building, whilst Ashefield is the newer bespoke unit constructed to cater to residents with dementia and memory impairment.

Section B: Other challenges to the accuracy of the evidence in the draft report

Page No	Key Question *e.g. Safe*	**Please set out any other challenges to the accuracy of the evidence in the draft report (providing evidence demonstrating the inaccuracy) and describe any impact on the rating(s).** *Challenges to the interpretation of evidence/importance attributed to the evidence should be included here.*
2	Summary	*People told us they felt safe living in the service and when receiving care and support. Our previous inspection had found that improvements were needed in staffing levels. At this inspection we found that this had improved but, in some instances, there were still not sufficient staff to support people in a personalised way and at peak times of need. –* This conflicts with information in the Report, which states that the Home has met proper staffing requirements. On the day of the inspection, the dependency scoring shared with the inspectors clearly showed that the Home was staffed in excess of the minimum staffing requirement. Further, in the Report (page 13) it has also been recorded that the staff were witnessed responding to residents' needs quickly and that positive interaction between staff and residents was duly noted. It is expressly recorded on page 13 of the Report that residents had communicated to the inspectors that staff "go the extra mile" for the residents, which directly conflicts with the statement concerning the staff not providing personalised care and support.

2	Summary	*Care files included a range of risk assessments such as moving and handling, nutrition and continence. These were regularly reviewed and updated according to people's needs. However, we found that reporting of incidents was inconsistent which meant that risks to people were not being effectively monitored.* This "inconsistent" reference is made in relation to an isolated incident, concerning one resident, that took place on 15 May 2018. It is acknowledged that this single fall was not recorded on the electronic system. The fall was, however, properly documented on paper due to there being a slight issue with the electronic system on that particular evening. The fall was, therefore, reported as appropriate and the recording of incidents was not "inconsistent". In fact, other falls on the date in question were indeed documented on the electronic care planning and monitoring systems shown to the inspectors on the day of the inspection. The resident in question, whose fall was reported on paper, is at a high risk of falls. His complete falls history has been documented on the electronic system, showing that the Home's staff had reacted properly in the face of his deteriorating health and decline in mobility. The resident was seen by both the OT and physio, which shows that his needs were indeed properly responded to by the home and the relevant health care professionals were contacted. This resident also saw the GP the day after his fall. The statement in the Report is, therefore, grossly incorrect and all risks to people resident at the Home were, in fact, effectively monitored. It should also be noted that there are three different categories into which falls, etc. can be entered onto the PCS care planning system. They can be recorded either as an accident, an incident or a fall. All of these categories are monitored daily and they are also logged on the C360 electronic system, which captures the data for audit purposes and complements the effective monitoring of residents at the Home.
2	Summary	*The service was not always working within the Mental Capacity Act 2005 (MCA). Where people had Deprivation of Liberty Safeguard applications authorised by the relevant authority these were not kept under the review. We found one which had expired. There was a lack of understanding of the decision-making process using relevant legislation and guidance. We have made a recommendation referring the service to the guidance available on the MCA and the decision-making process. –* There is not a lack of understanding regarding the decision-making process whatsoever. This comment has again been made in relation to a single recently-expired Deprivation of Liberty Safeguard application ("DoL"), which had been scheduled for re-application but had simply not yet been processed. The Home's procedures in relation to DoLs had been, and continues to be, rigorously enforced. It should be noted that all other DoLs were, and they remain, both relevant and up-to-date. It also states in the Report, on its page 11, that staff were witnessed securing consent form residents prior to undertaking any care activity.
2	Summary	*Some of the building interior decoration had become shabby and tired. Decoration in the unit which specialised in supporting those living with dementia was not always appropriate. This had been recognised and there were plans in place to improve these areas. However, there were no firm timescales in place to achieve these improvements –* This is a very subjective matter and the physically demanding nature of a residential nursing home dictates that

		interior decorating works are, in effect, continually ongoing. Full quotes concerning the latest round of planned works can be provided and this was explained during the inspection. Kingsley maintains a keen awareness of areas that require updating and prioritises the related activities accordingly. The Report itself states that the Home was both clean and hygienic, which contradicts the subjective opinion that the Home was "shabby" at the time of the inspection. The erroneous comment should, therefore, be removed from the Report. The area mentioned above in relation to Ashefield (the Home's dementia unit), meanwhile, which states that decoration was not always appropriate, is not correct. The area in question is indeed appropriate for those using the service and it is well designed for those living with dementia, allowing them to explore the relevant areas in a safe manner. There is safe access all the way around this part of the building so that those who wander can do so freely and enjoy time in the secure outside space. The Home's manager further explained that she would like to enhance some of the areas in the Ashefield unit by giving them themes. No timescale was given in this regard as the Home's manager had only been in post five weeks as at the date of the inspection.
3	Summary	*There were two new activities co-ordinators in post with plans in place to improve the experience of people with more person-centred activities. However, these plans were still being developed with some people still feeling disengaged with activities.* On the day of inspection, verbal feedback was given to the Home regarding the performance of the activities coordinator. The inspector stated that she was impressed with the coordinator and the positive interactions she enjoyed with the residents of the Home. The inspector also commented that it was good to see an engaged activities coordinator who was working so effectively within the Home. The Home has a full list of activities completed and the management team takes into consideration every individual's needs and wishes before working to accommodate them within the programme. This exercise is one of continuing development as the needs of the residents in the home change from time to time.
3	Summary	*The service used an integrated electronic care planning system. This had been introduced prior to our last inspection and we found staff understanding of the system required improvement. At this inspection we found this had improved and staff recorded day to day activities on the system. However, there was still inconsistencies with how some information was put into the system.* Staff do know how to use the system, which was shown to be in highly effective use throughout the day of the inspection. We are, therefore, unclear as to what inconsistencies are being referenced here. If this is a repetition of the incorrect concern relating to the reporting of incidents, this has been addressed in the response detailed above. As mentioned, the recording of falls, accidents and incidents are checked daily and they are also logged on the additional C360 electronic system so that all relevant data is properly captured.
7	Safe	*Whilst staffing levels met a safe minimum there was insufficient staff to provide individualised and personalised support to meet peoples presenting needs at peak times. At our previous inspection we observed that there were not enough staff to give people the support they required at meal time. At this inspection we observed the lunch*

		time meal in both of the dining rooms. In one of the dining rooms we saw a calm and relaxed meal with people receiving the support they required. However, in the other dining room where people required more support there were not enough staff to provide personalised support for people to eat their meal. - This conflicts with information presented in the Report, which states that we have met the staffing requirements that are assessed. On the day of the inspection, the dependency scoring was shown to the inspectors and it clearly showed that the Home was staffed above the minimum staffing level requirement. Further, on page 13 of the Report, it has been noted that the staff were witnessed responding to residents' needs promptly. If staffing levels were at or above a safe minimum, then this comment is not factually correct (i.e. to state that staffing levels were inadequate).
7	Safe	*From observation during the inspection we saw that the majority of staff interactions with people were task focussed and took place while staff were providing care and support.-* It is noted in the Caring section of the Report that, on the day of the inspection, there was positive interaction between the staff team and the Home's residents, with staff responding to the needs of individuals in a calm and reassuring manner. It is also noted that feedback from residents was entirely positive when it came to their feelings about the staff and how they went "the extra mile". It is, therefore, contradictory to state that the staff were task focused, with interaction only taking place during the delivery of care and support. On the morning of the inspection staff were seen enjoying karaoke with residents in one of the lounges, interacting in a manner designed to bring happiness and stimulation to the residents. This is not mentioned in the Report and, therefore, by omission it undermines the efforts made by the Home's staff to engage positively with residents at times outside those where care and support is being provided.
7	Safe	No member of staff had the time to sit down with the person and engage with them as they eat their meal. Another person requested an alternative meal and the cook left to prepare this. However, no member of staff had engaged with the person and they got up and left the dining room before their meal arrived. They did not return to the dining room. We observed staff sharing the lunchtime meal with people in the dining rooms and engaging people in conversation. However, they did not sit at the table for the whole meal but came and went with little or no explanation to people sitting at the dining table with them. - This statement contradicts itself, by stating in the first part that the staff do not engage before declaring, at the second part, that staff were seen "sharing the lunchtime meal with people in the dining rooms". The particular resident mentioned in this statement (who left the dining area) is someone that does frequently wander around the Home. The associated care plan documentation clearly records that this behaviour is expected around meal times and, accordingly, the Home's staff are prepared for this to happen. The resident did not request an alternative meal but, instead, when talking to the chef the resident said they needed the toilet and left the dining area. It is, in fact, noted in the resident's care notes that this resident did enjoy a meal that was not "alternative" to the menu but ate their meal slightly later than the other residents when ready to sit

		down. Attached is a copy of the entry made by the staff on the day of inspection and it should be noted that this took place later than the mealtime that was witnessed by the inspectors.
8	Safe	*At this inspection we found that the system was still not being operated to manage risks effectively. Staff were not clear of the different criteria for recording falls and accidents and incidents. This had led to inconsistent recording and ineffective monitoring. -* This statement is incorrect. Despite the category under which events are recorded, they are all efficiently logged and monitored, which provides for an effective risk management environment. This has been explained earlier in this response to the Report, where we have clearly identified that one fall incident was recorded on paper instead of on the PCS system. As stated, this departure from normal operating procedures represented an isolated exception due to a minor system issue. All falls, accidents and incidents are properly recorded and monitored on a daily basis. Where necessary, any falls, accidents or incidents are referred to the relevant healthcare professionals.
8	Safe	*For example, one person had had a number of falls in May and June 2018, some of these had been recorded on the computer care records, some had not. -* This is again a reference concerning the resident who, on 15 May 2018, had experienced three falls during the night and these falls had been recorded on paper record due to an issue with the electronic system. It was evidenced to the inspector that all other falls noted on this date were recorded directly onto the electronic system, indicating that the use of a paper record had been an isolated incident. The Home is, therefore, confident that the falls had been duly recorded and that the inspector saw the paper record. There was no negative impact on the resident concerned, as the resident saw the GP the following day. The Report should not be prepared on the basis that a disproportionate extent of its content concerns one isolated exception that was properly handled, but involved a different recording medium.
8	Safe	*When we were checking the systems used to record this person's falls we found that not all staff were able to effectively access -* The deputy manager at the Home on the day of the inspection had been in post for only four days and was still in the induction period. Although this person had been shown the system, they were still very much learning all of the processes concerned with it. There was no relevant impact on the level of care being provided, as the deputy manager was not providing direct care to residents at this juncture. The deputy manager would not properly have been expected to know at this time how to effectively access and interrogate the information recorded on the electronic system. The Home's manager was monitoring the system and had trained access to the relevant information, as did the Home's senior care staff.
8	Safe	People's care files included a range of risk assessments in areas including falls, moving and handling, medicines, weight loss, nutritional needs, continence care, skin integrity and evacuation in case of emergency. People had individualised risk assessments on behaviours that may challenge and their medical conditions. These provided guidance to staff on how they should support people so that the risk to them could be minimised. – This element of

		the Report indicates that risks to residents are properly minimised through the inclusion in individual care notes of a broad range of risk assessments. It is, therefore, in direct contradiction to the previous paragraph, where it is alleged that risk was not being effectively managed and the system was not being used to manage risk effectively.
8	Safe	*People's rooms and communal areas were clean and tidy. Good standards of hygiene had been maintained throughout the service and there were no unpleasant odours. –* These positive findings are not mentioned in the summary page of the Report, where it states instead that the home was "shabby". We we believe this represents a fundamental failing on the part of the Report's author to present a balanced and comprehensive summary based on all relevant findings. We also believe it is critical that the summary explains that although the Home does, in certain areas, require "updating", it is indeed clean and hygienic without concerns relating to infection control.
9	Safe	*However, we did note that in the car park adjacent to the building site there were black bin liners with kitchen waste on the floor and open to the elements. This could encourage rodents. -* This was not discussed on day of the inspection. The issue concerned one incidence of failure on the part of the waste collection contractor, which was dealt with by the Home as a matter of priority. Had the matter been raised with the Home's management team during the inspection, correspondence between the Home and Kingsley's head office would have been shared with the inspectors. This correspondence shows that the issue had been addressed and was being resolved. Most fortunately, such an issue is not at all common and, in addition, there is effective pest control in place as a precautionary measure around the Home at all times.
10	Effective	*For example, the provider had set out 25 mandatory training subjects. -* The spreadsheet sent to the inspector is extracted from the C360 system used across the Kingsley Healthcare group's homes. It flags these subjects as "mandatory" training courses but this is not, in fact, the case and the courses are actually designed to be undertaken on a needs-driven basis. This incorrect status is being amended on the system by Kingsley and it has been highlighted to the C360 system providers.
10	Effective	*For example, of 39 eligible staff only 20 were up to date with dementia training.* This statement is not correct. In fact, the position was that 39 out of 44 staff had undertaken the training in question. 8 staff were required to attend training updates, which meant their names were shown in red on the pertinent spreadsheet. The operations manager's reports clearly stated that there was a training plan in place until end of the calendar year, which would capture refresher training and any shortfalls. A copy of the operations manager's report was sent to the inspector as requested.
10	Effective	*We found that one application that had been granted had expired. The manager was not aware of this. DoLS authorisations were not being effectively monitored. –* The Home had submitted all relevant DoLs applications and these remain appropriate in the case of each resident concerned. One application had indeed expired at the time of inspection and a reapplication had not been submitted immediately. This was, however, rectified without delay.

		The above statement in the Report is, therefore, unfair as the need for one reapplication to be made does not indicate that the Home's DoLs applications were not being "effectively monitored".
10	Effective	*There was a lack of understanding of consent to care and treatment being sought in line with legislation and guidance. For example, one person had been assessed as having capacity. However, a relative had been given documentation to consider regarding resuscitation. There was no evidence that the person had been involved in the decision-making process*. - This gentleman was clearly assessed as not having capacity and this is stated in his capacity assessment and care plan. A best interests consultation was undertaken with the involvement of his daughter, his GP and the Home staff. The decision agreed by all parties, which was properly signed off by the GP, was for the implementation of a DNAR and advance care planning. The Home was not asking for legal authority. The input of the resident's family was sought as he did not have capacity and had been diagnosed as being terminally ill and was receiving end of life care. The comment made in the Report is, therefore, factually incorrect and should be removed.
10	Effective	There was no evidence that the person had been involved in the decision-making process. – As mentioned above, this resident was assessed as not having capacity. He had been diagnosed as being terminally ill and was receiving end of life care. It was appropriate for the Home to undertake a best interest consultation with his GP and a family member so that suitable care planning could be implemented as his condition continued to deteriorate. Again, this comment is erroneous and should not be included in the Report.
11	Effective	*Food was also not served in a way that supported people to remain as independent as possible. For example, we observed two people trying to eat their meal with their fingers. For one person this was fishcakes and for the other it was a chocolate brownie desert served with chocolate sauce. People living with dementia often benefit from bite sized food which can be eaten with their fingers as they may lose the ability to use cutlery.* We fail to see how this is an appropriate observation. Residents were observed eating in a manner they preferred and which benefitted them personally. There was a selection of foods available to them, which they were clearly enjoying. We do not agree that just because a resident has dementia they should be offered alternative foods unless they express a preference for them. The Home's approach was indeed promoting the independence of those residents who chose to eat their meals with their fingers. Staff were not intervening to assist these residents, which would have deprived them of their independence in this specific context. It is clearly stated in the relevant care plans that the residents should be encouraged to maintain independence around meal times. The comment made by the inspector is, therefore, once again inaccurate and should be removed from the Report,
12	Effective	*Some of the decorations in this unit were shabby and in need of upgrading*. – This comment is wholly subjective and has been contradicted by subsequent observations in the Report as detailed above. It should, therefore, be removed.

12	Effective	*Some areas were very plain and lacked stimulation for people living with dementia. –* The areas in question are not at all lacking in stimulation for those residents of the Home living with dementia. The area is specifically designed so that those living with dementia can move around it freely, accessing the Home's open spaces safely and without difficulty. The comment has no basis in fact and it should be removed from the Report.
14	Responsive	*For another person there was one line about their life history. This person displayed quite challenging behaviour on occasions. Some background information about this person would have helped staff better understand any reasons for this and develop positive strategies for supporting them. The care plan did not contain a positive behaviour plan to guide staff in techniques to distract, defuse and pre-empt challenging situations*. - This resident has no readily identifiable triggers, which is clearly stated in the pertinent care plan. The matter was also discussed on the day of the inspection as this resident has been referred to the mental health team. The Home is still awaiting the team's visit feedback so that efforts can be made to construct a plan that will prove to be effective in the absence of any specific triggers. There are currently strategies in place, as detailed in the care plan, that provide for staff to work in pairs when providing care to this resident. One staff member enters the resident's room to reassure and talk with the resident, whilst the second staff member competes any cleaning and maintenance associated with the resident's environment. This resident's activity care plan clearly states her likes and dislikes, which supports the care team in their efforts to better understand the resident's behaviour. This resident also has no close family or next-of-kin with whom the Home might consult in order to secure more detailed information regarding her life history. This comment also conflicts with the Report's previous statement to the effect that there are care plans in place that properly reflect the needs of the residents. Attached is a copy of the behaviour care plan that was present during the inspection.
15	Responsive	*However, they went on to give an example of something they had put in place to support their relative but which was not being carried out by staff*. - This was not included in the feedback given at the time of the inspection. It is not at all clear from the comment to whom "they" refers, so we are not aware of what might have been "put in place". Was this something that had been introduced by the resident's family? Was it something suitable given the resident's specific circumstances? The Home will require more information if it is to be able to look into this effectively. Further comments from the inspectors are, therefore, awaited.
16	Well-Led	*"We as staff cannot contact the head office. We have to speak to the manager." –* This statement is not correct. All staff at the Home have the telephone numbers for the Group's head office and they are able to call at any time. The necessary telephone numbers are available to staff both in the Home and online. The Group's policies and procedures provide that staff should, in the first instance, speak with their manager unless circumstances dictate that this would be inappropriate. In addition, various members of the head office team visit the Home frequently and communicate with staff at all levels. The service quality manager can also confirm that staff email her and/or call her directly without hesitation.

16	Well-led	*Another member of staff told us about a particular concern around holidays and holiday pay. They told us that changes had been made and staff felt they had lost out because of this. –* This staff rota issue was rectified and no staff member lost any of their holiday entitlement nor any of their holiday pay. This misconception is, therefore, rebutted and as it does not have any relevance to the CQC inspection the comment should be removed from the Report.
16	Well-led	*Staff also expressed concerns that when they were working there was nowhere secure to store personal items. -* There is a lockable staff room on the first floor of Allonsfield, to which all staff have access. This facility has been in place for a long time. If staff choose to leave their personal belongings in a part of the Home that might not be secure, then this election on their part cannot be attributed to the Home. The Home has provided staff with a secure area to store personal items, which renders the inspector's comment factually incorrect and it should be deleted from the Report accordingly.
16	Well-led	*A relative told us, "We don't get much notice for relative meetings. I would like to have been told that there was a new manager and two new activity co-ordinators –* The Home has supplied to the inspectors, at their request, a copy of a letter sent to relatives advising them that a new manager was commencing employment at the Home. The particular relative to whom the inspector spoke did not receive the letter because the person concerned was not listed in the Home's records as the family's primary point of contact. To compound the issue, the letter was sent to the properly-nominated family member but there is no communication between the recipient of the letter and the family member to whom the inspector spoke. The position was clarified, and the matter was duly rectified, in August during a meeting between the service quality manger and the relative spoken to by the inspectors. As soon as the Home had been made aware that the relative had not received the notification letter, the mailing list was amended to include both of the resident's relatives. In addition, the resident's care plan was updated so that both relatives are to be kept informed. There has been no further issue in this connection and, therefore, the point made by the inspector here is moot, having no practical relevance to the inspection of the Home.
16	Well-led	*The senior business manager explained that the provider now sought electronic feedback by way of a tablet which was available in the service. However, this had not been being used in the period leading up to our inspection. Therefore, we concluded that people, relatives and staff were not consistently involved and informed about the running of the service –* There was a staff survey completed in May 2018 following which a "You said, We did" notice was made available together with copies of the surveys. This information was stored in the front of the Complaints & Compliments file, which was made available to the inspectors at the time of the inspection. The activities coordinator was also completing surveys with residents (assisting them, where necessary, if the residents were unable to use the tablet) and this remains an ongoing exercise. Again, the completed surveys were made available on the day of the inspection. The relatives' survey is now scheduled to be sent out prior to the year end of the year

		now that the new manager is in post. All relatives are also encouraged to provide the feedback on the tablet when they enter the Home. The manager maintains an 'open door' policy and frequently discusses issues, concerns or ideas with relatives, staff and residents. The surveys are completed on an annual basis.
17	Well-led	*Our previous inspection had found that staff were not competent in operating the electronic care planning system. At this inspection we found that staff knowledge and competency with the system had improved. However, there were still inconsistencies in recording of incidents and a lack of detail in the care plan. Senior members of care staff were not always able to effectively navigate the system. The provider had not taken adequate action to address our previous concerns. -* As explained in the previous comments above, this statement is not factually correct. The deputy manager the inspectors consulted in relation to the system had been in post for only four days and was actually still participating in the induction process during the inspection. Senior care staff at the Home are able to navigate the system without issue and demonstrate this on a daily basis. The perceived inconsistency, which is incorrect, relates to the recording of falls, accidents and incidents. The single matter has already been adequately explained earlier in this document (i.e. the isolated incident where a paper record was made in the face of a system issue). The Home believes that it is not critical to concern itself with the headings under which entries are filed and records kept in this specific respect. Its proper focus remains on ensuring that the falls, incidents and accidents are indeed recorded promptly and monitored on a daily basis. There has not been any case where a resident has been placed at risk because, for example, a fall had been input into the system as an accident or an incident. This was demonstrated to the inspector on the day to the inspection and it is surprising, therefore, to see this inaccurate comment included in the Report.
17	Well-led	*Neither had the quality assurance system identified the discrepancies in the reporting of accidents and incidents. The quality manager told us that two care plans were audited each month to check the quality and content. These audits had not identified or taken action with the concerns we had identified with care plans. For example, lack of detail regarding people's end of life care and people's life story. They also told us that two care plans were audited each month. With 31 people living in the service this meant that it was at least a year between each audit of the care plan*. - This comment also relates to the manner in which the Home's staff record falls, incidents and accidents on the Home's electronic systems. This has been explained above and the comment is not relevant in this respect. Meanwhile, the operations team audits 10% of the care plans pertaining to the Home's current residents on a monthly basis. In this case, therefore, there are three care plans audited each month and not two. This approach is in line with current requirements and industry best practice. In addition, all care plans are reviewed on a monthly basis by senior staff and the Home's management team. It has also not been noted in the Report that the audits conducted by the Home have themselves been inspected by the service quality manager. The handwritten notes

		made by the service quality manager are present on the relevant care plans, which are held in the file that was available to the inspectors on the day of the inspection.

Section C: Additional relevant evidence that should be taken into account ("completeness")

Page No	**Key Question** *e.g. Safe*	**Please describe (and provide copies of) any additional evidence which you consider should be taken into account in the report.**	**CQC decision** ✓or X or Partial	**CQC response** *If you agree to make amendments you must confirm any impact on breaches or the rating. If you choose not to make any amendments you must provide reasons.*
7	Safe	Entry on daily notes concerning the resident who left dining area during lunch time to show that this resident did, in fact, have their meal at a later time and the meal taken was not an 'alternative' to the meals on the menu.		
14	Responsive	Care plans for resident with challenging behaviours.		
16	Well-led	Staff survey results		
16	Well-led	Example of resident survey completion		