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Kingsbury Court

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

Kingsbury Court opened in April 2015 and provides accommodation, care and support for up to 60 people, some of whom may be living with dementia. The service is registered to provide nursing care although this area of the service had not commenced at the time of our inspection due to a staggered approach to opening the service.

The inspection took place on 11 August 2016 and was unannounced.

There was no 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 and associated Regulations about how the service is run. A manager had recently started work at the service and supported us throughout the inspection. They told us they had begun the process of registration with the Care Quality Commission (CQC) and our records confirmed this

Sufficiently skilled staff were not provided throughout the service. There was a high level of agency staff used which impacted on the care people received. The manager told us that a number of staff had recently been recruited and were currently under-going recruitment checks prior to starting work. There was a lack of leadership throughout the service which led to staff not being deployed in an organised manner to ensure people were supported safely. Staff did not receive the induction and support they required to enable them to provide effective support to meet people's needs. Risks to people's safety and well-being had been identified although control measures to reduce risks were not always followed.

Care plans were completed and regularly reviewed although these were found to be repetitive and did not always provide guidance to staff in how to provide people's care. Agency staff did not have access to people's care plans and did not have access to personalised information about the people they were caring for. Where this information was provided we found that people received care in line with their preferences. People received health care support when required although relatives told us that communication in addressing healthcare needs had led to delays in their family members receiving the support they required. We have made a recommendation regarding this.

Suitable arrangements were not in place to ensure that medicines were managed safely. Gaps were present in some medicine recording and staff did not sign records immediately following administration. Guidance for staff in the administration of 'as and when required' medicines were not in place and staff told us they did not always feel confident when administering medicines to people.

People, relatives and staff told us that due to a number of changes in the management of the service there was a lack of communication and leadership. They told us the new manager appeared confident and was listening to concerns. Regular audits were completed to monitor the quality of the service provided. However, where actions were identified these were not always addressed in a timely manner.

There was a system in place to deal with people's comments and complaints however we found that a number of complaints had not investigated, recorded and dealt with in line with the provider's policy.

Staff received trained in safeguarding adults and knew how to report any concerns. They were aware of the whistleblowing policy and how to access guidance. Accidents and incidents were monitored and action taken to minimise the risk of reoccurrence. Safety checks on the environment and equipment used were completed regularly.

The provider's recruitment procedures were robust, which helped to ensure that only suitable staff were employed. Staff completed mandatory training to support them in their role.

People told us that the quality of food was good and a choice was always available. People were supported to maintain a healthy diet. Where people required support to eat this was provided in a dignified and unhurried way.

Staff were caring and treated people with kindness. People's rights were protected and staff spent time with people to gain consent prior to delivering care. People's privacy and dignity was respected and visitors to the service were made to feel welcome. There was a range of activities available although people, relatives and staff told us they felt a more varied programme was needed to meet people's needs and preferences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were insufficient skilled staff deployed to meet people's needs effectively. There was a high use of agency staff which impacted on the care people received.

People were not always protected from the risk of avoidable harm.

Medicines were not always administered and managed safely.

People were safeguarded from the risk of abuse as staff were aware of their responsibilities.

Appropriate checks were undertaken when new staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive a suitable induction when starting work at the service and staff supervision was not completed in line with the provider's policy.

People were supported to maintain good health and had regular access to a range of healthcare professionals although communication regarding people's needs requires improvement.

The provider acted in accordance with the requirements of the Mental Capacity Act 2005 to protect people's legal rights.

People were provided with food and drink in line with their preferences which supported them to maintain a healthy diet.

Is the service caring?

Good

The service was caring.

People told us that staff treated them with kindness.

People's privacy and dignity were respected.

Visitors were welcomed to the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not accessible to all staff and lacked detail regarding people's life histories and preferences.

Complaints and concerns were not always recorded, investigated and responded to.

Comprehensive assessments were completed prior to people moving into the service.

People had access to a range of activities although improvements were required to ensure individual needs and preferences were supported.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A lack of consistent management had led to concerns regarding the quality of the service provided.

Quality assurance audits were completed although actions were not completed in a timely manner to improve the quality of the service people received.

Records were not available to all staff which meant that people's needs were not always know to the staff supporting them. Records of the care people received were not completed by staff who had delivered the care.

Kingsbury Court

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.

The inspection took place on 11 August 2016 and was unannounced. The inspection was carried out by two inspectors, a nurse specialist and an expert by experience. The nurse advisor specialised in the supporting older persons. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with seven people who lived at the home and observed the care and support provided to them. We spoke with three relatives, six staff, the manager and members of the senior leadership team for the provider. We also reviewed a variety of documents which included the care plans for seven people, five staff files, medicines records and various other documentation relevant to the management of the home.

This was the first inspection of Kingsbury Court since it opened in April 2015.

Requires Improvement

Is the service safe?

Our findings

People felt secure in the home and safe when permanent staff supported them. One person told us, "I feel quite safe. It's only been open since last year so the equipment here is tip top, I know that I'm in safe hands. But there's not enough staff around here at all. " One relative told us, "It's safe and secure, that's not something I have concerns about. Staffing is the crux of the issue. All the shortfall is taken up by agency so there are constant new faces and no consistency."

People were not supported by sufficiently skilled staff who knew their needs well. The manager told us that the recruitment of care staff had been difficult and there was currently a high level of agency use. On the day of the inspection there was one senior carer on each floor acting as shift leader. The remaining staff were all provided by an agency and had varying levels of experience of working at the service. Rotas showed that this was the regular staff pattern with the majority of staff cover being provided by agency staff. Staff told us that this had an impact on the care they were able to provide as they needed to spend time inducting and directing agency staff. One staff member said, "There's been times when it's felt quite dangerous because all the agency have been new. They are more consistent now but it still means we don't have the time to spend with people." Another staff member told us, "It doesn't feel like there's enough staff because we spend all our time organising what the agency staff are doing and then checking it's been done." The manager told us they worked closely with the agency to ensure that wherever possible the same staff were provided.

People did not always receive safe care as staff were not provided with direction regarding their responsibilities. The manager told us they used a dependency assessment to determine the staffing levels required. Whilst these levels were consistently met there was a lack of organisation and staff did not always know what they should be doing. During the morning people living on the ground floor were asked if they would like to watch a film in the cinema room upstairs. Staff accompanied four people to the cinema which left only one staff member supporting the remaining 12 people on the ground floor. Staff had not communicated where they were going which meant the remaining staff member was looking for staff to support them in providing someone's care. During this time people in the lounge area were left without support available to them for fifteen minutes. One person told us that it was often difficult to know where staff were. They told us, "They all seem to be downstairs when you need them. I've waited up to 45 minutes for them to come because they've all been downstairs." Another person said, "Last week (staff member) was on their own up here and all the bells were going. In the end they had to leave this floor entirely to go and get them from downstairs."

The manager and regional manager told us they recognised that the high level of agency use had led to difficulties. They said that as far as possible regular agency staff were used to help provide people with consistent care. They had recently recruited to 400 staff hours and planned to introduce up to two care staff each week over the next few months. Until satisfactory levels were reached they would not be admitting any new people to the service.

Failing to ensure that sufficient numbers of skilled staff were deployed in the service was a breach of

Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of harm as staff were not always aware of the risks to their safety and how these should be managed. One person had a risk assessment in place which highlighted they were at high risk of falls. A pressure mat had been placed beside the person's bed to alert staff when they got up. However, staff did not monitor the person's safety when they were in the lounge area. On two occasions we observed the person trying to stand up when there were no staff present. They appeared unstable and we intervened to reassure the person and encourage them to remain seated until staff became available. One staff member told us that no one on the ground floor needed the use of a hoist. A more established staff member told us a number of people required the use of a hoist regularly as their mobility varied at different times and one person's file viewed confirmed this. This meant that people were at risk of harm as staff were not aware of the potential risks and measures to take to keep people safe.

Staff were not always provided with guidance regarding the risks to people's safety and well-being. The manager told us that all staff, including agency staff, were able to view people's care files on the electronic system. We asked staff how they learnt about the risks to people's safety. They told us they did not have access to the electronic files and learnt from speaking to other staff members. This meant that although risk assessments had been completed staff did not have access to the guidance provided in order to mitigate risks to their safety.

Risk assessments within people's care files were detailed and covered areas such as skin integrity, mobility, falls, nutrition and maintaining a safe environment. Regular reviews were completed to ensure that the information and guidance was up to date. Where systems were in place to ensure control measures were met we observed these were followed. For example, a list of people's dietary requirements was available to staff in the dining area and we observed people received support in line with their needs.

Safe medicines practices were not always followed which meant people were at risk of not receiving their medicines in line with prescribed guidelines. Each person had a medication administration record (MAR) in place. We found a number of gaps in the recording on MAR charts and staff did not always complete MAR charts immediately following the administration of medicines. During the lunchtime medicines round we observed staff signing for one person's medicines which had been administered in the morning. Where handwritten entries had been made these were not easy to read and were not always signed by two staff members to confirm the information had been correctly transcribed. There was no guidance for staff regarding how or when PRN (as and when) medicines should be administered to ensure people received medicines when they required them and in a consistent way. Staff responsible for the administration of medicines told us they did not always feel confident and would regularly be interrupted during medicines rounds. One staff member said, "I feel it should be the responsibility of nurses when there are this many people. I'm doubly careful with things but we always get interrupted. It really worries me mistakes will be made."

Not ensuring that all reasonably practicable steps were taken to mitigate risks to people's safety and not following safe medicines practices was a breach of regulation 12 (1)(2)(b)(c)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were monitored to minimise the risk of reoccurrence. The manager completed monthly audits of all accident and incident records and control measures were implemented where required. One person had suffered a fall at night time due to them attempting to get up when they were unsteady. A sensor mat had been placed beside the person's bed to enable staff to monitor when they attempted to get up. There were no recorded falls since this measure had been implemented.

There were procedures in place for safeguarding people and staff were aware of these. All staff had received training in safeguarding people and were able to describe the steps they would take to report any concerns to senior staff or the local authority. There was a safeguarding policy that guided staff on the correct steps to take if they had concerns and staff knew how to access this. All staff demonstrated they understood the whistle blowing policy and said they understood their responsibility in reporting any concerns. Where concerns had been raised these had been reported and appropriate action taken.

Safe recruitment practices were followed before new staff were employed. Checks were made to ensure staff were of good character and suitable for their role. The four staff files we looked at contained evidence that the provider had obtained a Disclosure and Barring Service (DBS) certificate for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff files also contained proof of identity and references to demonstrate that prospective staff were suitable for employment.

The service was maintained to a safe standard by a member of staff employed specifically to oversee these areas. Checks were carried out on equipment such as the fire alarm and emergency lighting and any actions required were recorded and completed. Other checks and servicing were carried out by professional contractors as required, such as the gas boiler, passenger lift and hoist. There was a business continuity plan in place to ensure that people would continue to receive care in the event the building could not be used. Staff were aware of how to access contact numbers and were informed how people should be supported to evacuate the building.

Requires Improvement

Is the service effective?

Our findings

People's views on the skills of the staff caring for them varied. Comments included, "I wouldn't say that the staff are correctly trained, no. I think its lack of experience really", "I do believe that the staff here have the correct training to look after me", and "Some of the staff are more qualified than others, I have my favourites". Relatives told us staff skills varied greatly due to the high use of agency staff. One relative told us, "They're all very pleasant but it's difficult to establish how competent they are when you rarely see the same people twice."

Staff did not always receive a comprehensive induction in order to meet people's needs safely. The manager told us that prior to working independently staff were required to complete e-learning training and spend time shadowing more experienced staff members. We found that this did not always happen in practice and staff did not always receive appropriate levels of support. On the day of the inspection the shift leader on the ground floor had worked in the service for five days. They told us that they had spent their first day completing e-learning training and had shadowed another shift leader on the morning of their second day before leading the afternoon shift on their own. They had then completed two further days of shadowing and e-learning. They told us, "It would have been nice to have more time but I'm experienced and feel confident in what I'm doing. I can ask upstairs if I need to know anything." Despite this we found there was no evidence that their knowledge of people's needs and competency to lead a shift had been assessed prior to them working independently. It was clear they had learnt a lot about people's needs in the short time they had worked at the service and were confident and caring in their approach. However, they had not been given access to people's care plans and some of the information they shared with us regarding people's moving and handling needs contradicted guidance within care plans and information shared by more experienced staff members.

Another staff member had started work at the service on the day of the inspection and were scheduled to shadow other staff. This meant they were being inducted by a shift leader who was also still on induction and shadowing agency staff. On one occasion we observed a person ask them for support to use the bathroom. The staff member asked an agency staff for support, the agency staff directed them to the bathroom and began to walk away. The staff member expressed concern saying they didn't know how to support the person. They appeared anxious and had to call the agency staff back and ask them to accompany them. The lack of support and induction for new members of staff meant people were at risk of their needs not being met.

Staff were not provided with consistent support and their individual skills and performance were not regularly discussed. The provider's policy stated that staff should receive a minimum of six supervision sessions each year. We viewed four staff files which showed that two staff members had received one supervision session in the past 12 months and two staff members had not received any supervision in this period. The manager told us they were aware that staff had not received regular one to one supervisions due to the changes in management and planned to put systems in place to address this. One staff member told us that the lack of supervision had affected their confidence in carrying out their role. They said, "I'd like more feedback on how I'm doing. Having so many managers and not much feedback makes you feel

nervous. You don't know what they think of you or what their expectations are."

Failing to ensure that staff received a comprehensive induction and regular supervision was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had access to training to support them in their role. Training records were well maintained and showed that staff had completed mandatory training including safeguarding adults, moving and handling, health and safety and first aid. In addition, staff undertook dementia training to guide them in supporting people living with dementia and staff told us this had been valuable in their role. One staff member said, "The dementia training was excellent. It helped me understand the different types of dementia and different ways of supporting people." The manager told us that the staffing agency used ensured that all staff provided had completed mandatory training.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other relevant health care professionals. People's care files contained evidence that they received appropriate support from healthcare professionals including the district nursing team, opticians, speech and language therapy and the community mental health team. People and relatives told us that prompt action was taken if they were unwell. One person said, "The doctor comes every week but they don't wait if you're ill, they just ring them." Staff were aware of people's healthcare needs such as diabetes and guidance was available to staff on how to monitor people's well-being. The service is registered to provide support with nursing needs although the provider had taken the decision not to open this area of the service until staffing levels improved. No one living at the service had been assessed as requiring 24 hour nursing care. The district nurse visited the service when required to provide support people with healthcare needs such as changing dressings.

People told us they liked the food and were able to make choices about what they had to eat. One person told us, "The food is very good, much better than I thought it would be. If you don't like what you've chosen they're happy to make you something else." Another person said, "The chef is wonderful, will do anything for you. (Chef) takes notice if you've liked something and remembers. If you don't like it then it's changed." One relative told us, "The food is very good and if we've been out they will always save something for when we get back."

Where people required specialist diets staff ensured their nutritional needs were met. The chef was knowledgeable about people's dietary needs and kept records of people's individual preferences. Guidance from professionals regarding specialist diets was shared with staff and we observed this guidance was followed. People were weighed regularly and any concerns regarding weight loss were acted upon in a timely manner. People were able to choose where they ate their meals and staff were attentive to people's needs. Where people required support to eat this was done in a caring way and people were not rushed. The food looked and smelt appetising and the chef took time to speak to people individually to check they had enjoyed their meal. Drinks and snacks were offered throughout the day and, where required, staff monitored people's food and fluid intake.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. People's records contained mental capacity assessments and best interest records regarding specific decisions around their care and wellbeing. These included decisions regarding locked doors to the area, supporting people living with dementia and the need for constant support and supervision. Best interest decisions involved staff, relevant professionals and family members involved in people's care. Where appropriate DoLS applications had been submitted to the local authority in a timely manner and gave detailed information regarding the decision and how it had been reached. Staffs had received training relating to the MCA and DoLS and were able to demonstrate their understanding. One staff member told us, "It's about making sure that people have understood decisions and if they don't, discussing what's best for them to keep them safe."

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring and treated them with kindness. One person told us, "I think the carers generally are exceptional. They'll do anything for you; they're prepared to put themselves out for you." A relative told us, "The staff are lovely with people, they sit and cuddle them when they're upset and they're always cheerful when they talk to people." However, people said that the high use of agency staff impacted on their care. One person told us, "It's not that they don't care, I'm sure they do. It's just not the same having new faces."

The atmosphere in the service was calm and relaxed and staff spoke to people in a respectful and friendly manner. We observed staff interacting positively with people, sitting or kneeling next to people when talking to them. One person was anxious and upset as they did not know when they would next see their family member. Staff spent time talking to the person and reassured them when their family member would be visiting next before engaging them in an activity. Another person made it clear from their vocal sounds they did not want to eat their lunch with others in the dining room. The staff member reassured them and supported them to eat in the lounge area.

People privacy and dignity were respected. Staff told us that they would always knock on people's doors and wait for a response before entering. We saw this was the case throughout the inspection and people confirmed that staff waited to be invited into their rooms before entering. Staff told us how they maintained people's dignity, especially when attending to personal care by ensuring bedroom doors and curtains were closed. One staff member told us, "I always make sure that bedroom doors are shut when we're doing personal care and cover people with a towel so they're not exposed." People confirmed that this was the case and that staff supported them to maintain their dignity. One person told us, "They're very good, they don't make you feel at all uncomfortable."

People were supported to maintain their independence. One person told us that staff encouraged them to maintain their mobility, "They encourage me and check that I've done my exercises every day to keep me moving." At lunchtime people were encouraged to be as independent as possible when eating their meals. Staff told us that no one required adapted crockery to eat. We observed that where required people were offered adapted cups and beakers to enable them to drink independently. Staff told us they recognised the importance of enabling people to remain independent. One staff member told us, "They choose if they want a shower or a wash. If they are able to wash it's important they do that themselves."

Visitors to the service were made to feel welcome and there were no restrictions on the times people could receive visitors. One relative told us, "Staff are all friendly, polite and chatty. It has improved now there is always someone on reception." Another relative told us, "They know me well now. They're always friendly and I always get a cuppa. They know I don't like to think of her being upset so they ring me and I can chat to her if there's a problem and it calms everything down." One person told us that their family member had recently moved into a nursing home, staff had supported the person to visit them which they told us had made them feel much better and reassured them they were safe.

Requires Improvement

Is the service responsive?

Our findings

We received mixed opinions from people and relatives regarding how responsive the service was to meeting people's needs. One person told us, "The staff knew exactly what to do when I had a fall, they really looked after me." Another person said, "I was involved in my care plan and they come and talk to me about it. I'm sure if we had the same staff things would be good."

Care plans were repetitive and staff did not have access to the information they required to support people. Prior to moving into the service each person had a detailed assessment to ensure their needs could be met. However, this information was not always transferred into people's care plans and information regarding people's life histories was not always completed. One person's care plan stated they would benefit from hourly contact with care staff to prevent social isolation. The person told us this care was not provided and this was confirmed by our observations and review of records. Three people's files stated that staff should engage people in conversation using information from their life history books. We found that these books were not completed for these people and the staff supporting them were not able to describe the people's needs and interests. Four people's care files repeatedly stated the aim of the care plan was to, 'support (Name) and encourage participation' in relation to a range of needs including diet and nutrition, behaviour and skin integrity. It was not clear how this aim related to the care plan and what action staff should take to support the person.

People told us they were involved in developing their care plans and staff involved them in reviews. One person told us, "I did help set up my care plan. It's updated on a regular basis, I know because they talk to me about it." However, where people lacked the capacity to be involved in planning their own care there was no evidence within care files that their relatives had been involved. Relatives told us that they had been involved in gathering information regarding their family members care during assessments but had not been involved in developing or reviewing care plans.

The failure to ensure that appropriate care plans were in place to meet people's individual needs and preferences was a breach of regulation 9 (1)(a)(b)(c)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As not all staff had access to people's care plan on the electronic system, profiles of people's care had been developed which were accessible to all staff. These included basic details of how people preferred their care to be provided and we found that these were followed by staff. One person's file stated they did not like to get up early and preferred to have hot drinks rather than cold. We observed the person stayed in bed for the majority of the morning and were supported promptly by staff when they chose to get up. At lunchtime the person was offered a hot drink with their meal. Another person's profile directed staff to talk about a family pet when they became anxious. Staff followed this guidance which reassured the person and supported them to feel calm.

Complaints received were not always recorded or responded to in line with the provider's policy, which meant that people's care did not improve as a result of complaints being addressed. A complaints log was in

place which recorded five complaints had been received. The log did not record what action had been taken following the receipt of complaints. There was no evidence available that complaints had been investigated or responded to. We also found evidence of two complaints which had not been logged. One person's care records noted that their relative had complained that their family member was not receiving personalised care. We spoke to the relative who told us they had not been responded to and no action had been taken to address the concerns raised. They told us, "I've raised concerns regarding my Father's care but I've never had a response, verbally or in writing. There have been so many managers so whoever I've complained to has been gone the following week and nothing has been done." The regional manager told us that managers were expected to inform them of all complaints received on a monthly basis to ensure they had been effectively managed. However, we found they had not been informed of all complaints and were therefore not able to respond to how the concerns had been managed.

The failure to record and address complaints in a timely manner was a breach of Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a range of activities although people, relatives and staff told us they felt more could be offered. The service employed an activities co-ordinator to cover five days per week. The manager told us that care staff were expected to support people with activities for the remaining two days per week. One person told us, "I like all the activities. We're shown what's on offer and we choose what we do." On the day of the inspection people were offered the opportunity to watch a film in the cinema room during the morning and a Thai Chi exercise session in the afternoon. An agency staff member also entertained people with a hoola hoop display to a professional standard. There was an activity programme in place which included visiting professionals and entertainers in addition to crafts, puzzles, quizzes and card games.

However, some people told us they often found themselves bored with nothing to do. One person told us, "The activity lady is lovely, I do enjoy the Thai Chi but we often just sit with nothing to do." Relatives and staff also told us they believed more activities could be offered. One relative told us, "There's nothing much for people at weekends." One staff member told us, "There's not enough going on, especially for people with dementia. I've spoken to the new manager and they agreed we could buy some games and things to play with people. I'd be upset if it was my parents just sitting here doing nothing."

We recommend that activities provided to people continue to be developed and take into account people's hobbies and interests.

Requires Improvement

Is the service well-led?

Our findings

People and relative told us that due to the changes in management of the service they did not believe the service was well-led but had seen improvements since the appointment of the new manager. One person told us, "This place is not managed at all well. I like the new manager and they are definitely trying. Given time I can see it will improve." Another person told us, "I certainly think that (manager) is starting to show some positive movement here. It's all looking quite good. I'm certainly happy here and would most certainly recommend it to anyone." A relative told us, "There have been fundamental flaws with the management of the service. The new manager appears to have their feet on the ground so we're hopeful."

There was no registered manager in post and there had been a lack of stable management since the service opened in April 2015. The regional manager told us the organisation had found it difficult to recruit a manager with the right skills and experience in managing a new service. This had led to a number of senior managers overseeing the service which had not provided the stability required. They told us the new manager had been recruited due to their previous experience of managing new services and they were confident they had the skills to implement the changes required and move the service forward. There was a detailed induction programme in place for the new manager which included support from the organisational team including HR, quality assurance and administration. The new manager told us they felt supported in their role and requests for resources were being actioned. For example, the deputy manager had recently left the service and the manager had requested support whilst waiting for the newly appointed deputy to start work. The organisation had agreed that support would be offered from another deputy manager within the organisation. The manager had worked at the service for approximately three weeks at the time of the inspection. They told us they had begun the process of registration with the CQC and our records confirmed this. Our discussions with the manager showed they had formed a good understanding of the concerns in the service and how these should be addressed. They had spent time with people, relatives and staff to gain an understanding of their concerns and had action plans in place to address these.

There was a lack of communication with people and relatives regarding the management and development of the service. People and relatives told us that they had not been kept informed of the changes in management which had led to a lack of confidence in the service. One relative told us, "There have been numerous managers and we're never informed when one leave or arrives. At the last meeting we were told that there would be a monthly newsletter sent out but this has never materialised and the new manager knows nothing about it." Relatives and residents meeting minutes showed that people had expressed concern regarding how the service was managed. The regional manager told us that they were aware of people's concerns and believed the appointment of the new manager would offer the stability people required.

Staff told us that did not always feel supported in their roles but felt the new manager was approachable. As reported there was a lack of supervision and staff meetings had not been held regularly. Staff told us they felt there had been a lack of leadership which had at times made them feel vulnerable and not valued. One staff member told us, "There hasn't been any direction and we feel as though we're constantly trying to suit different managers rather than knowing the right way to do things. It makes you feel insecure." All staff we

met with told us that the new manager had started to make changes and they felt things would improve under their leadership. One staff member told us, "(Manager) seems to be good, I'm hopeful." Another staff member said, "I think things will improve now."

Systems were in place to monitor the quality of the service provided although areas found to require improvement were not always addressed. There was a schedule in place of audits to be completed by the manager including the auditing of care plans, health and safety records, medicines and infection control. Previous audits had not been effective in highlighting concerns regarding care plan recording and medicines recording which meant these actions had not been addressed. In addition audits were completed by the provider's quality assurance team which looked at all aspects of the running of the home. The last audit completed in July 2016 identified concerns regarding the management of medicines, care plan information, staff support and the sharing of information with senior managers. An action plan had been developed with target dates for completion set for the end of July 2016. However, we found these concerns had not been addressed and that improvements in the areas continued to require improvement. The regional manager acknowledged that improvements were required in the timeliness of response to areas highlighted with audits and had asked for additional support from the senior managers to assist the new manager in implementing the changes required.

Records of care given were completed by staff who had not delivered people's care which meant people were at risk of not receiving the care they required. Daily care records were maintained which detailed the care people had received. However, as agency staff were unable to access the electronic monitoring system brief notes and verbal feedback was provided to the senior on duty who then recorded this on the system. We found that daily notes were repetitive and did not reflect individualised care was being provided. The manager told us that they had ensured that all agency staff had access to the system and were in the process of implementing this throughout the service.

The lack of consistent leadership, communication, effective quality monitoring and accurate record keeping was a breach of Regulation 17 (1)(a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider notified CQC of all significant events that happened in the service in a timely way. This meant we were able to check that the provider took appropriate action when necessary.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that appropriate care plans were in place to meet people's individual needs and preferences.

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 had failed to ensure that reasonably practicable steps were taken to mitigate risks to people's safety. The registered provider had failed to ensure that safe medicines practices were followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had failed to ensure that complaints were recorded and addressed in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure that consistent leadership and effective quality monitoring systems were in place.

	The registered provider had failed to ensure that accurate records were maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure that sufficient numbers of skilled staff were deployed. The registered provider had failed to ensure that staff received a comprehensive induction and regular supervision to support them in their role.