Akari Care Limited

Dene Park House

Inspection report

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20 June 2017

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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

This inspection took place on 15, 16 and 20 June 2017. The first day of the inspection was unannounced which meant the provider did not know we would be visiting. We last inspected the service in November 2016 where we found two breaches of our regulations relating to complaints and good governance. The provider sent us an action plan following the inspection which we reviewed at this inspection. We carried out this inspection due to concerns we had received about the service and we wanted to make sure people were safe.

Dene Park House is situated in Gosforth and close to the town centre and local amenities. Residential and nursing care is provided for up to 52 people. There were 42 people using the service at the time of our inspection. Accommodation is provided over three floors.

There was no registered manager in post at the time of the inspection, as they had left the service in March 2017. A new manager had been appointed and the service was being supported by a regional manager and an experienced home manager from another Akari service.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Not all aspects of the service were safe. Staff did not always maintain a safe environment. Doors which should have been locked were found to be left unlocked during our inspection and hazardous substances were not always stored correctly. Boxes of archived care records were stored unsafely, however these were removed before we completed our inspection. Infection control procedures were not always followed. A small number of wardrobes were not secured to the wall which posed a potential risk of tipping. These were secured before we completed our inspection.

Medicines were found to be managed safely, and records were satisfactorily maintained. New improved records of the administration of medicines prescribed 'as and when required' had been developed but were not in use on each floor on the first day of our inspection. These were introduced to all floors before we completed our inspection, but this procedure was not fully embedded. We have made a recommendation to monitor compliance with the new procedure.

There were suitable numbers of staff on duty during our inspection. There had been some concerns raised about staffing levels prior to our inspection, and we found there had been an increase in staffing on each shift including at night. There was a shortage of permanent nursing staff, and the service was relying heavily on agency nurses. Four new nurses had been appointed, and were awaiting checks prior to starting employment. Recruitment of additional care staff and a deputy manager was underway. Experienced staff from other services including a manager and senior care staff, had been brought in to the service to help

support and stabilise the home. Although some people and their relatives told us they had noticed an improvement in staffing levels, some people remained concerned. We have made a recommendation to continue to monitor staffing levels closely.

We found that there had been an increase in the amount of equipment in use for the safe moving and handling of people, and occupational therapists were involved in assessing risks and ensuring correct handling plans were in place.

We observed people being supported at mealtimes, and found that where people were found to be losing weight that advice had been sought from a GP and dietician. Records of people's weights on each floor contained gaps, and did not always record people's full details. Weights were recorded in people's individual care files. The regional manager had recognised a lack of oversight of people's weights and was collecting this information to monitor people's dietary needs more closely. Despite recognising weight loss and addressing this through specialist support, the kitchen had not been made aware of the changes in dietary requirements and people requiring fortified meals with added calories, were still recorded in the kitchen as receiving a normal diet. We found that in practice, however, that staff were giving people supplements and additional snacks.

There was evidence of health checks being carried out and a GP told us that timely advice was sought, however poor communication particularly between nursing staff could cause some difficulty. Important health related records including Do Not Attempt Cardiopulmonary Resuscitation orders had not always been reviewed and updated. We spoke with the regional manager about this who told us they would be reviewed as a matter of urgency. We were given assurances that this had been carried out.

The service was operating within the principles of the Mental Capacity Act 2005. Records of applications to the local authority to deprive people of their liberty were held including those granted. Care records contained information about the level of support people needed to make decisions, although this could be more detailed. Records did not always clearly record where other people had been granted legal authority to support with their relative's financial and care decisions, such as power of attorney.

Staff told us, and records confirmed they had received regular training. A system of supervision and appraisal was also in place to support staff and identify development needs.

People and their relatives told us, and we observed, that most staff were kind, caring and attentive. We observed a small number of interactions with people that were well intended but 'bossy' in tone. We also heard some staff referring to clothing protectors as 'bibs' which could compromise people's dignity.

Care plans were in place which had been evaluated monthly. We found, and the regional manager had recognised, that these could be more detailed. They had introduced a new format and also a 'personal profile' for each person, which outlined their previous experiences, interests, likes and dislikes in more detail. There were gaps in some care records and where paperwork had run put, some staff had written on scraps of paper or the back of other documents despite master copies being available.

An activities coordinator was in post, but had been absent from work during which time there had been a reduction in the number of activities available to people. Some people and their relatives told us there were insufficient opportunities to take part in activities or to meet people with similar interests. Additional activities coordinator hours were being made available for recruitment. We observed people enjoying activities during our inspection.

People and their relatives recognised there had been a period of deterioration and instability in the service, but there was general consensus that things were improving. Staff also confirmed that morale was improving. The senior management team and manager were aware of shortfalls and were addressing issues in order of safety and urgency. They recognised that communication and record keeping was poor. Several improvements had already been made or were being introduced to address these issues. Experienced staff, including an assistant nurse practitioner had been appointed to support with the oversight of clinical care. A practice development nurse was also due to be based at the service to support with improvements.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance.

You can see what action we told the provider to take at the back of the 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

Not all aspects of the service were safe.

People had access to areas considered dangerous by the provider and hazardous substances were not always stored securely. Infection control procedures were not always followed.

Staffing levels had been increased, and there were suitable numbers of staff on duty during the inspection. We received mixed views about the availability and deployment of staff and recommended this remained under close review.

Medicines were managed safely, and there were new procedures in place to ensure the use of topical medicines such as creams, were recorded correctly.

Staff had received training in the safeguarding of vulnerable adults and were aware of what to do if they identified any concerns.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Records related to people's dietary needs were not always fully completed or updated.

Regular drinks and snacks were offered throughout the inspection.

Staff received regular training, supervision and appraisals.

The service was operating within the principles of the Mental Capacity Act (MCA) and clear records were maintained.

Is the service caring?

Good

The service was caring.

Staff were observed to be kind and caring. They were attentive and responded to people's needs sensitively, and showed good knowledge of individual's needs.

We observed that some terminology used was not always person centred, but generally staff were polite discreet and respectful.

People were supported to make decisions and maintain their independence where possible. People who were very frail and unwell were comfortable and relaxed.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Person centred information was available, and care plans were in place which were up to date and regularly reviewed. This information was not always fully shared between staff.

Relatives told us there had been an improvement in the way their complaints were responded to. The complaints procedure had been updated and was accessible to people, relatives and visitors.

Visiting professionals told us staff sought timely support and were quick to respond to people's needs.

Is the service well-led?

Requires Improvement

The service was not well led.

The service had deteriorated and managers were actively trying to address a number of shortfalls in quality and safety. Questions were raised about the systems in place prior to this, which had allowed such a slide in standards resulting in reactive correction. New systems had been put in place to avoid reoccurrence of this at the time of the inspection.

Records were not adequately maintained, and new systems introduced were not embedded in practice at the time of the inspection.

The senior management team had developed a clear risk based action plan to address issues identified and were working closely with people relatives and staff to communicate these.

Dene Park House

Detailed findings

Background to this inspection

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

This inspection took place on 15, 16 and 20 June 2017 and was unannounced. This meant the provider was not aware that we would be visiting.

The inspection was carried out by two adult social care inspectors.

Prior to the inspection, we spoke with the local authority safeguarding and commissioning teams. We were advised that due to a number of concerns received over a short space of time, the service had been placed in organisational safeguarding procedures. This meant the service was being closely monitored and supported over this period to ensure people remained safe.

We checked information that we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales.

We spoke with eight people who used the service and six relatives. We spoke with 14 staff, including; the operations director, regional manager, manager, three agency nurses, a senior care assistant, three care assistants, and activity coordinator, housekeeper, laundry assistant and a cook. We also spoke with a number of care professionals who visited the service on a regular basis, including; a GP, team lead from the care home support team, two district nurses and two occupational therapists. We looked at five care plans, four staff recruitment files and a variety of records related to the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. Comments included, "I'm quite happy with everything. The staff are good, I'm well looked after" and "The main thing is, if I need anything because I'm not well, someone's here. I feel safe here."

We carried out observations around the home and found the environment was not always safely maintained. Doors which should have been kept locked were left open which meant rooms were accessible to people. On the first day of the inspection, we found the laundry had been left unlocked, there were no staff present and a bottle of bleach and cleaning spray had been left in an unlocked cupboard under the sink. We alerted the regional manager and manager who locked the door and removed these items. On the second day of our inspection we found the laundry door unlocked and a bottle of cleaning spray which had been returned to the cupboard below the sink. Other doors including those leading to storage rooms or dirty utility were also left unlocked and staff did not appear in the habit of routinely securing these areas. This was contrary to the provider's own health and safety risk assessment.

Water temperature charts were kept in people's en-suite facilities and communal bathrooms, but these were blank or had not been completed for several months. Staff told us they checked water temperatures before bathing people, and thermometers were available but they were not completing the records.

Infection control procedures were not always followed by all staff. We found the home generally clean with the exception of some bed tables which had not been cleaned and we found evidence that food including biscuits and fruit left on people's tables was not always fresh. Some staff wore excessive jewellery on their hands and wrists which meant effective hand washing was not possible. Some people and relatives told us however, that the cleanliness in the home had generally improved.

We found a large number of boxes and papers containing records for archiving, stacked in an office on the top floor. This posed a potential fire hazard, and meant the office could not be thoroughly cleaned. It also posed a risk to staff using the office due to the cluttered environment. The boxes were removed to an external secure location before the end of the inspection but staff told us the boxes had been stored like that for a number of months.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found two wardrobes which were not secured to the wall in people's rooms. Serious injuries can occur from wardrobes tipping onto people. There was a heavy glass vase on top of one of the wardrobes which was above the person's chair and would have caused serious injury if it had fallen. We spoke with the regional manager and a maintenance staff member who checked all other wardrobes and found another two which were not secured. These were immediately made safe and heavy items were also removed. The regional manager advised us that routine checks of wardrobes to ensure they remained secured to the wall would be added to regular maintenance checks.

Prior to the inspection, we had been made aware of concerns about staffing levels. During our inspection there were suitable numbers of staff on duty, and we were advised that staffing had been increased by one extra staff member on each shift. We were with two people when they happened to use their call bell to summon staff. We timed the staff response and on each occasion it took less than four minutes for them to respond. We heard mixed reports about staffing from people and relatives. Some people told us they had not noticed any significant difference with the addition of new staff, others said they had. A relative told us, "There has been a massive difference over the last six weeks or so, there seems to be a lot more staff." A staff member told us, "Staffing is brilliant now. I assumed it was always like that in other homes. It was too busy. It's been great [the increase in staffing] it means you can spend a lot more time with the residents."

Despite some positive feedback about staff, the issue of staff leaving a floor in pairs to go for a cigarette break was raised. We spoke with the regional manager about staffing and staff deployment. They advised us that staffing levels exceeded the number of staff recommended by the provider's dependency tool. This tool provides a guide to the number of staff required based on people's varying needs and abilities. They had some vacancies and had agreed that they would over recruit to ensure they had enough staff hours to cover absence and leave. They also told us they had been aware of the concern regarding breaks, and were monitoring this as they felt some of the issues with staffing related to organisation and deployment and not necessarily numbers.

We recommend that staffing remains under review in light of the mixed views and satisfaction with current staffing levels.

At the time of the inspection, there was high usage of agency nursing staff which was causing issues with communication and consistency of care. Four nurses had been recruited, however, and were awaiting pre-employment checks prior to starting work.

We checked four staff recruitment files and found that safe procedures were followed. Staff completed an application form which included their employment history, and a minimum of two references were obtained. The identity of staff was verified, and checks were carried out by the Disclosure and Barring Service (DBS). The DBS checks the suitability of applicants to work with vulnerable people. This helps employers to make safer recruitment decisions.

We checked the management of medicines and found that safe procedures were being followed. At the last inspection, we found the provider had introduced a new electronic medicine administration and recording system. At this inspection, we found that use of this system had been suspended due to the high number of agency nurses and fears that this could compromise safety. The manual system had been reintroduced and was being used appropriately. We found no concerns with the storage, administration and recording of medicines. New forms had been developed to improve the recording of topical medicines, such as creams or lotions. These were being introduced gradually on each floor and were in use in all areas by the end of our inspection. Checks were being carried out by the manager to ensure these were being completed correctly.

Staff told us and records confirmed staff had received training in the safeguarding of vulnerable adults. One staff member told us, "I have never seen any bad practice; I would say straight away. Wouldn't hesitate." The safeguarding and whistle blowing procedure was prominently displayed. A number of safeguarding concerns had been alerted by the regional manager. Due to the number of concerns, the service had been placed in to organisational safeguarding which meant they would be closely monitored and supported by the local authority safeguarding team. The regional manager and operations director for the service told us they welcomed this level of scrutiny to support them to make the necessary changes and improvements to the service. A safeguarding log was maintained which clearly documented each concern and the person(s)

responsible for investigating these as agreed via the safeguarding process and any lessons learnt.

Individual risks to people were assessed, recorded and reviewed regularly. These included risks related to their physical condition, skin integrity or falls for example. We observed that there was close collaboration with the managers and district nurses regarding one person's very complex needs and risks. They worked closely to devise a proactive plan of care to suit the needs of the person, and to reduce the risks to them and staff involved in their care. A record of accidents and incidents was maintained and reviewed regularly by the manager to check for any patterns or trends.

A number of safety checks to the premises and equipment were carried out. We were provided with certificates which showed electrical, gas and water safety checks had been carried out. Fire safety procedures were in place and equipment was regularly and maintained. Personal emergency evacuation plans [PEEPS} were in place. These outlined the level of support people would need in the event of an evacuation. Equipment used for the moving and handling of people had been checked to ensure it was safe to use, and additional equipment had been provided.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that staff were not always accurately recording people's food and fluid intake. At this inspection, we found that forms were up to date and completed daily. We found a variety of methods of recording people's weights, on each floor in the home. Some weights were recorded in a book, others on charts or on pieces of paper held in a 'weights' file. We found gaps in these records, which were not recorded each month and did not always include details of the person, such as their full name. We could not always be sure to whom the record was referring. We identified some people who had lost weight or were at risk of losing weight. We found that in each case, their weight was recorded in their individual care record, and action had been taken to address the risks identified. This included nutrition care plans being put in place and referrals made to a GP or dietician.

The health needs of people were met but records were not always readily available or accurate. We spoke with a number of visiting professionals and records showed that people had access to a range of different services and specialist staff. A GP told us staff contacted them in a timely manner for support and advice. Their main concern was obtaining information from agency nursing staff as they did not know people well, and communication could be poor. The GP told us, "Good quality information is hard to get as files are kept in a disorganised manner. As the agency staff don't know people well, we have to resort to looking in files, then you can't find the file because it is in an office on another floor." They told us that this had improved however, in the last two weeks. Other professionals also told us communication could be poor, saying staff would cite returning from days off, or being new to the service as the reason they did not have certain information. This led them to question the effectiveness of handover of information between shifts. Important documents including Do Not Attempt Cardiopulmonary Resuscitation Orders had not always been reviewed and updated within the required timescale.

We spoke with kitchen staff and asked them if they had been made aware of people requiring support to maintain their weight. They should receive diet notification forms to alert them when people are losing weight or have any other special dietary requirements. We identified two people that were receiving supplements and required a fortified diet to increase or maintain their weight. Records held in the kitchen had not been updated, it was still recorded that these people required a normal diet. We did, however, observe people receiving milk shakes and additional snacks during our visit. It was difficult to accurately assess whether people's dietary needs were being adequately met due to the poor quality of the records available. We spoke with the regional manager about this who gave us copies of new weights records they had introduced to help to address this issue.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

We sat with people during two mealtimes and observed staff supporting people sensitively and discreetly with their meals. Staff were aware of people with special dietary needs including pureed meals. A four week menu cycle was in place and had been reviewed since the last inspection. Most people told us they enjoyed the food. One person told us they would like more variety of vegetables as they had too many peas and

beans. We passed this information to staff. People were consulted about what they wanted to eat and waste food was monitored to by kitchen staff to see which choices appeared the most popular. If people did not like what was on the menu, we saw they were offered an alternative choice. We observed regular drinks and snacks being given out throughout the inspection. People and relatives commented they were pleased to see the return of tea trolley, and addition of fresh fruit as a choice. We were told that the tea trolley rounds had not always been taking place but were reintroduced when the new manager came into post. Supplies of tea and coffee were available for relatives to make themselves and their family member hot drinks during their visit.

Some relatives told us they visited the home to support their relation to eat their meal. Due to a protected mealtime's policy, they had to sit in the person's bedroom while they ate their meal and were not allowed to support them in the dining area with other people. They told us this made them feel they were isolating their relative as they felt they would benefit from being with other people who were eating as it may encourage them to eat their meal and interact with others. Protected mealtimes are in place in some hospitals and care homes to reduce disruption of the mealtime experience and to afford staff the opportunity to support people uninterrupted. It applies to professional visitors also, who are asked to avoid visiting at mealtimes if possible.

We spoke with the regional manager about this and they told us they were reviewing the protected mealtime's policy and were considering making use of the 'bar' area in the home as an additional dining area to be used by people and their visitors. This would allow people the opportunity to socialise while avoiding congestion in the dining areas.

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 so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider kept an up to date list of DoLS applications, authorisations and renewal dates. Care records made reference to capacity and consent. Decisions made in people's best interests continued to be documented. The level of support people needed to make choices was also documented. Some assessments were generic in style and could contain more detail. We discussed this with the regional manager who told us new documentation being introduced would be more detailed and where family members had specific legal authority such as power of attorney, this would be more clearly documented. People told us they did not feel restricted. One person said, "We have a degree of freedom of course, we can choose what we want to do."

Staff told us and records confirmed they had received regular training. Training considered mandatory by the provider including fire and food safety, moving and positioning, medicines, basic life support, safeguarding, nutrition and hydration and MCA and DoLS had been provided. Staff received regular supervision and an annual appraisal. All staff had recently met with a senior manager for a 'significant discussion' which outlined the concerns that had been raised about the service and the specific actions and

responsibilities of all staff to address these.

We asked about the training and skills of agency nurses and how these had been verified. The regional manager told us they had requested full skills profiles from the agency and was also in discussions with one agency that visited their staff on site to carry out their own supervision and checks. We saw the regional manager was proactive in ensuring that agency staff booked had the necessary skills to support the people living in the home prior to confirming their shifts.

The premises were generally clean and well maintained. A number of areas in the home had been recently redecorated. There was access from the ground floor to a safe outdoor space and a conservatory leading to outdoors where we observed a number of people sitting to get some fresh air. Not all bedrooms had a name or photograph to aid people in recognising their rooms. On a number of doors that did have signage, these could not be seen as the door was held back by a magnetic door closure device. We found plans were in place to address this issue. A staff member spontaneously pointed out to us that plans were underway to move signage to a more prominent location outside people's rooms to aid way finding as they had recognised this was not currently working.

We recommend best practice is followed in relation to effective signage for people, particularly those living with dementia.

Good

Is the service caring?

Our findings

People told us they felt well cared for. One person told us, "Staff are very caring. Very kind." Another person told us, "I'm very happy. The care is good here, we are very well looked after." A member of staff who had recently started work in the home, but had previous care experience told us, "There are some brilliant carers here. I think things had slipped a bit but I have no concerns about the care, people are well looked after." A relative told us that one of the reasons they chose the home was due to being made to feel so welcome, and the 'nice feeling' the home had when they came to visit.

We observed staff were attentive and kind in their interactions with people. They were observant and regularly checked that people were comfortable. One staff member asked, "Are you warm enough? Would you like a cardigan?" Another person became restless during their meal, a staff member noticed and asked, "Do you want me to cut up your fish?" People were nicely supported during their meal. One person became upset and started to cry. Staff immediately responded and they said they were upset because they were missing their friend. Staff comforted the person then provided distraction and diversion which led to an impromptu sing along. Staff clearly knew the person well and used this knowledge to good effect. We also observed staff showing concern for people. We heard one staff member telling another, "I'm a bit worried about (name) can you check her for me?"

We observed that people looked clean and comfortable and well cared for. One relative told us they had been unhappy with some aspects of their relation's personal care, but had raised this with the regional manager and it had been addressed. We saw one person who was unshaven. We spoke with him and asked him about the care and support he received. He told us, "I'm very happy, nothing to complain about at all. I'm very well looked after here." He told us he had chosen not to have a shave that day.

The privacy and dignity of people was generally maintained. Staff knocked on doors and asked permission before entering rooms. People were addressed in the way they preferred, and were given privacy and a means to summon help when necessary. We heard staff, and saw writing on a box which referred to clothing protectors used at mealtimes as 'bibs'. We spoke with the regional manager about this who agreed this was potentially patronising or upsetting to people and said they would ensure staff were aware of how this could make people feel.

Confidentiality was maintained. Records were kept in offices which were locked when unattended. We did not overhear any discussions which should have been private during our inspection and staff were polite and discreet when offering support with personal care for example. People were involved in decision making throughout the day. They were consulted about where they would like to sit and what they would like to do. Staff also provided explanations to people about what they were doing so that they didn't cause alarm, for example while using a hoist to reposition people. Staff supported people to do as much for themselves as possible to maintain their skills and independence.

End of life care was provided by the home. Plans were in place for people approaching the end of their lives, and anticipatory medicines were prescribed in advance to be used when necessary, for example for the

relief of pain or distress. This meant there would be no delay in receiving these medicines if people needed them. We spent time with a person who was very unwell at the time of our inspection; they were very relaxed and comfortable and responded to us with smiles. They had received regular support and care throughout the day.

No one was receiving support of an advocate during the inspection, but staff knew how to access this service should it be required. Advocates provide independent support to people to make decisions and share their views.

Equality and diversity training was provided. Staff told us they would provide support to people with diverse needs as required. A list of church services and communion was displayed on noticeboards throughout the home.

Requires Improvement

Is the service responsive?

Our findings

People and professionals told us that staff responded to people's needs. An occupational therapist told us, "Staff are very quick to respond and make referrals to us if there is an issue. They have always been good referrers and we are getting even more recently."

Care plans were in place which were evaluated regularly. A new one page profile had been introduced which contained personalised details such as life experiences, preferences, likes dislikes, and hobbies and interests. This meant staff had more information with which to initiate conversations. It also gave them more of an understanding of people and the way they preferred to be cared for. Despite this, we found that there were problems with communication which impacted upon the ability of staff to care for people effectively. This was mainly in relation to communication between agency nursing staff, and between agency staff and visiting professionals. Some agency staff had been working in the home on a more regular basis so knew people better. Other agency staff that we spoke with did not always feel they were given enough information about the people they cared for, and handover information was not always sufficiently detailed. We spoke with the regional manager about this who told us the one page profile was designed to improve this, and when their permanent nurses came into post this would be less of an issue.

We recommend that agency staff are provided with adequate opportunities to review information held about people until permanent staff come into post.

At the last inspection we found that an effective system was not in place for recording, handling and responding to complaints. People and relatives did not feel their complaints had been acted upon. At this inspection we found improvements had been made in this area, and information about how to make complaints was displayed and readily available. One relative told us, "Things seem to be getting done now. If you made a complaint before, things didn't seem to improve. I feel more confident because I feel like I'm being listened to now." We checked complaints records and found that these had been responded to within the timescales set out in the company policy. Another relative told us they had made a complaint and said, "I received a very prompt response from (regional manager)." One relative was unhappy with the way their complaint had been handled. We passed this information to the provider. The relative was aware of their right to take their complaint to the Local Government Ombudsman (LGO). The LGO are the final stage for complaints about adult social care providers.

A 'You said we did' board was displayed. We read that people had complained about a lack of activities, and untidy wardrobes and drawers. A response from the provider was displayed which assured people that action had been take to rectify these concerns. We looked in a number of drawers and wardrobes and found these were tidy and well organised.

We received mixed views about the activities available. Some people told us there were insufficient activities available. This was particularly concerning for one person who tended to become worried and anxious if left alone to ruminate for long periods. Their relative felt that more frequent contact, distraction and interventions from staff might help to prevent them becoming preoccupied with worries and ultimately

distressed. Other people were happy with the activities available, or did not wish to participate. Other relatives told us that activities may be available, but their relative would immediately refuse if invited to join in. They did not feel their relative was always aware of what they were refusing and had observed that when they had been encouraged to attend they had become 'infected' by the atmosphere and reactions of others, and had thoroughly enjoyed it. The activities coordinator had recently returned to work after a period of absence, which might help with this particular issue although we raised this as a potential training need for other staff. On the first day of the inspection, the activity coordinator came to the home on their day off, to help the home participate in The Alzheimer's Society cupcake day, to raise awareness about dementia. People and their relatives attended and enjoyed the activity. We saw that a number of activities were planned, and a staff member commented that it was nice to have the activities coordinator back to work because of the laughter they could hear. We spoke with the regional manager who had clear plans about the type and quantity of activities that should be available to people. They had a plan of action to address issues in the home, and activities were included. They were, however, prioritising safety and care issues at that point. They told us they planned to provide additional hours for activities to support the current coordinator.

We recommend that the activities available to people are monitored closely to ensure they meet people's individual needs.

Requires Improvement

Is the service well-led?

Our findings

The management of Akari Care was taken over by another company in September 2016 There were changes to the executive and senior management team, and a number of new regional managers had also been appointed. The registered manager left the service in March 2017. The regional manager has been based in Dene Park House since April 2017 and had been working with a new manager. People, relatives and staff told us there had been a deterioration in the service, and a period of instability for some time. The regional director and regional manager acknowledged they had also found that aspects of the service were not up to the required standard and were taking steps to address shortfalls. They were honest and transparent about areas of concern, and were keen to work closely with the relevant statutory authorities to ensure the necessary improvements were made and sustained. We received positive comments about the management team which also included a manager from another Akari home, who was supporting the service. Comments included, "I think there are going to be vast improvements. I have seen the regional manager, and they have their work cut out. They are very determined though and I am happy to go along with them because it will all be for the good." A district nurse told us, "I have seen a massive improvement in things like moving and handling, more things going on for the residents, the décor; it just seems better managed at the moment."

At the last inspection, we found that quality assurance and feedback systems were not sufficiently robust. At this inspection we found that although the provider's quality assurance systems had not identified all of the shortfalls we found such as the accessibility of unsafe areas and storage of hazardous substances, we found that an action plan had been developed which did identify most things we found. We found numerous shortfalls, however, in the maintenance of records relating to people's care and treatment. These included gaps in care records such as nutritional and handover information, and inconsistent methods of recording. Practices relating to the storage and use of correct care documentation were haphazard, untidy and unprofessional. While we acknowledge that these issues had been identified and a plan was in place, these improvements had not all been made or embedded in practice at the time of the inspection. Some changes that had been introduced were not always being followed by staff. Relatives also questioned why these problems had not been picked up sooner by the organisation. One relative said, "There was a failure here. Why was it not picked up sooner? Akari is a big company, surely there must be systems within systems?"

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

The views of people and relatives had been sought, including through a number of meetings held recently in the home. Comments included, "It went downhill, and still feels unsettled. The area manager is trying to change things. It needed a shake up and it's getting that now. We have regular meetings to hear what is happening" and "There's been a massive improvement in the last six weeks or so. We have had resident and relative meetings with (regional manager). A lot of issues have been brought up. I feel a lot more confident; hearing how things are going to be tackled" and a visiting professional told us, "(Regional manager) has made a massive difference and for us it's lovely to work with someone so passionate about making a difference." We were told that surveys would be carried out later in the year but at present face to face

meetings and regular one to one contact with people and relatives were important. We spoke with a resident forum representative who told us they helped to express the views of other people living in the home. They were also involved in meetings and had one to one discussions with the managers.

We spoke with a number of staff who told us changes in the home had impacted upon staff morale, but most staff felt this was improving. One staff member said, "It is a good home. The only thing I would change would be to have the order and routine for a settled period." Another staff member told us, "Things are getting there. It has been a bit up in the air but morale is getting better. (Name of manager) seems lovely and very approachable. I think it'll get back to normal."

The regional director and regional manager shared with us their plans to support the service to improve. This involved bringing experienced managers and senior care staff from other service and providing supernumerary staff to work alongside existing staff to support them while new practices were put in place. Our discussions with them showed there had been great care and attention given to amount of support individual managers needed and could give, without compromising standards within their own services. There was careful and considered use of resources, and the provider was able to explain to us their wider strategy for their aim to achieve long term sustained improvement.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. Control measures were not always in place to mitigate risks to people. Procedures to prevent and control the spread of infection were not always followed by staff. Regulation 12 (1) (20 (b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance An effective system to assess, monitor and improve the quality and safety of the service was not fully in place. Records relating to people were not always complete or accessible to authorised persons in order to deliver people's care needs and keep them safe. Regulation (17 (1) (2) (a) (c)