ADL Plc

Allambie Court

Inspection report

55 Hinckley Road
Nuneaton
Warwickshire
CV11 6LG

Tel: 02476383501
Website: www.aldcare.com

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 26 October 2017 and was unannounced.

Allambie Court is registered to provide accommodation with nursing and personal care for up to 30 older people who are living with dementia. At the time of our inspection visit there were 23 people living in the home.

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

The home was last inspected on 22 February 2017, when we found the provider was compliant with the fundamental standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, the home was awarded an overall rating of 'requires improvement'.

At this inspection, we checked to see if improvements had been made. We found improvements had not been made, and we had increased concerns as to the safety of the care provided and the leadership and oversight of the manager and provider.

People did not always receive their medicines safely and as prescribed. Systems designed to record and check medicines administration were not effective.

Assessed risks were not always managed effectively, and staff knowledge of how risks should be mitigated was not always consistent. This posed a risk to people's health and safety.

There were not enough staff to support people safely and meet their needs effectively.

Staff did not always receive the training required to ensure their skills and knowledge remained up to date. The risk of malnutrition and dehydration was not always well managed, and records designed to monitor and help address these risks were not always completed consistently.

Care records were not always updated or completed, which meant we could not be sure people were supported consistently. People were not consistently supported to maintain activities, hobbies or interests.

There were quality monitoring systems in place to identify any areas needing improvement, but these were not used consistently or accurately. They had not identified the concerns we found during our inspection, and governance of how the home was run was weak and ineffective which meant it had not improved.

People were comfortable with the staff who supported them. Staff received training in how to safeguard

people from abuse and understood what action they should take in order to protect people from harm. The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people who lived in the home. Staff told us they were not able to work until these checks had been completed.

The provider ensured staff had information on the level of support people needed with decision-making so people were protected. The registered manager had a good understanding of the Mental Capacity Act (MCA), and the need to seek informed consent from people before delivering care and support. Staff had a limited understanding of the MCA, but understood the importance of consent. Where restrictions on people's liberty were in place, legal processes had been followed to ensure applications for legal authorisation had been sent to the relevant authorities.

Staff were respectful and treated people with dignity and respect, but staff did not always take opportunities to engage with people to enhance their well-being. People experienced a lack of interaction and engagement, as support focussed on tasks to be completed.

Complaints were managed effectively.

Staff and relatives did not always feel well supported by the registered manager

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not administered safely or as prescribed, and systems designed to ensure accurate administration of medicines were not effective. People's health and safety were at risk as assessed risks were not always managed effectively. There were not enough staff to keep people safe or to respond to their needs.
Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse.
Appropriate recruitment procedures were in place to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive the training they needed to maintain their knowledge and skills. People at risk of dehydration or malnutrition were not always supported as required.
People had access to health professionals.
People were able to make their own decisions, and were supported by staff who respected and upheld their right to do so. Staff had a limited knowledge and understanding of MCA and DoLS legislation. However, staff knew how to manage this and supported people with decision-making appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported with kindness, dignity and respect, but staff did not always take or have time to engage with people to enhance their well-being. People experienced a lack of interaction and engagement, as support focussed on tasks to be completed.
People who were independent were supported to remain so.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records designed to ensure people received safe and consistent support that met their needs, were not always completed or updated. Systems designed to inform staff of changes were not effective.
Whilst activities took place, day to day engagement and interaction was not promoted, and people's need to be supported to maintain activities, hobbies and interests, was not consistently met.
People knew how to raise complaints, but were not always confident about the response they would receive.

Is the service well-led?

Inadequate

The service was not well led.

The systems to monitor the quality of the service provided and to identify any areas needing improvement, were not used consistently and were ineffective. Concerns we found during our inspection had not been previously identified by the provider.
Governance of how the home was run was weak and ineffective which meant it had not improved.
Staff and relatives did not always feel well supported by the registered manager, and did not always have confidence their concerns would be taken seriously.

Allambie 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 visit took place on 26 October 2017 and was unannounced. The visit was conducted by two inspectors and a nurse specialist advisor. We brought the planned inspection forward due to information of concern we received about people's safety, and about leadership of the home.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

We did not ask for a provider's information return (PIR). This is a form we ask providers to send to us before we visit. However, during our inspection visit, we gave the provider the opportunity to give some key information about the service, what the service does well and improvements they planned to make.

During our inspection visit, we spoke with two people who lived in the home. People who lived at the home were not able to tell us, in detail, about their experiences of living at Allambie Court. This was because they lived with dementia. To help us understand people's experiences of the service we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We spoke with four relatives. We also spoke with the registered manager, two members of nursing staff, two care staff members, a senior care worker, and one member of kitchen staff.

We reviewed ten people's care plans, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider

gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Inadequate

Is the service safe?

Our findings

Medicines were not always administered safely or as prescribed. The day of our inspection visit was the first day of a new monthly cycle of medicines. We checked the medicine administration of nine people. We found staff were not always administering medicines correctly from the blister packs (this is sealed packaging in which medicines are stored before being administered). The packs made it clear to staff which day and time each medicine should be administered. We found for two people, the registered manager had not dispensed the medicines on the days identified on the pack. We were concerned this could cause confusion for staff, and might cause errors to be made; meaning people might not receive their medicines as prescribed. We asked a member of nursing staff if dispensing from the wrong day caused concerns. They replied, "Of course. It can be very confusing."

We also found physical stocks of some medicines did not match those documented on the Medicines Administration Record [MAR] sheet. We counted the medicines to check the amounts remaining in stock, matched those on the MAR. We found for two people there were more tablets in stock than there should have been. For example, one person's records showed 28 tablets for one medicine had been received, with 26 tablets recorded as administered. This meant there should have been two tablets left, but we found there were three. Another person was prescribed medicine in the form of a patch for pain relief, to be applied every seven days to their skin. Records showed one patch had been applied on 12 October 2017, and the next was applied on 21 October 2017, which is nine days between applications. We were concerned this indicated medicines may have been signed for but not given, and had not been administered as prescribed, posing a risk to people's health and well being. We were also concerned the person may have experienced pain as a result of this error.

Staff told us they did not think they needed to record when they had applied 'barrier' creams for people at risk of skin breaking down. This meant we could not be sure that people were having the creams they needed to prevent skin from getting sore or breaking down. The registered manager told us staff did have to record this and was surprised this was not happening. They told us they would look into this. We also found one person who had been prescribed a cream, had not received any applications since the start date of 23 October 2017. The registered manager could not explain why this was not available.

MAR sheets lacked detail about where and when prescribed creams should be applied. For example, instructions for one cream stated, "use when required on dry skin". There was no further information available to staff. We also found not all prescribed creams had the date of opening recorded. This meant we could not be sure they remained effective.

We were told two people had their medicines administered covertly. Covert medication is the administration medicines in a disguised format, for example in food and drink. As a result, the person is unknowingly taking medicines. However, one person's care plan did not include information about which medicines had been approved to be given covertly, or how these should be given. There was also no detail on the person's MAR sheet to show which medicines could be administered covertly. There was a GP letter on the person's MAR file giving authorisation for covert administration, but no specific detail on which

medicines this was for, or how they should be administered. The registered manager told us the person 'always' took their medicines, but that, if necessary, they could be 'crushed or put in a sandwich'. Where medicines are crushed or given with food, it is important to discuss with a pharmacist to ensure they remain effective. The registered manager told us, "I asked [the pharmacist] who confirmed this verbally, but we don't have it in writing. I know I should have chased, I know if it's not written down it hasn't happened."

There was no evidence in the second person's care records of consultation with a pharmacist to ensure the medicines remained effective when crushed or given with food. We asked the registered manager if there was any record of discussion with a pharmacist and they told us, "Only verbally. I know I should have chased it. I know if it's not written down it hasn't happened."

Risks to people's health and well-being were not always managed safely. One person had been assessed as being at risk of choking. Their care plan stated, 'I still remain at risk of aspiration [accidental sucking in of food particles or fluids into the lungs]; liaise with GP or Salt as necessary within my best interests.' Whilst the care plan also stated, '…feed me little and often, offer me my diet when I am alert, ensure I am sat up right', there was no further information for staff to inform possible signs of aspiration and actions to be taken. There was a letter dated 18 October 2017 on the person's care plan from the Speech and Language Therapy (SALT) team, who had determined the person must have a pureed diet, and have their fluids thickened to 'stage 2' to reduce the risk of aspiration.

Whilst this information had been incorporated into the person's care plan, staff were not aware of the instructions from the SALT team. Staff gave us different versions of the person's needs, which did not correspond to their care plan. For example, one staff member said, "[Person's name] is on a normal diet and stage two fluids. No he is not at risk of choking." On the day of our inspection visit, we observed a staff member provide the person with a soft meal, not pureed. We raised this with a nurse and the registered manager. Both agreed this put the person at risk of choking, and the nurse assured us they would take action to ensure staff were aware of the requirements.

One person had been assessed as at risk of falling out of bed and sustaining injury as a result. Their care plan stated the person's bed should be left on its lowest setting, and a 'crash mat' (soft mat) should be placed at the side of the bed to reduce the risk of injury. On arrival at the home we found the person was in bed. There was no crash mat beside the person's bed, as this had been replaced with a very large bean bag. An alert mat with trailing wires was placed on top of the bean bag. The bed was not placed at the lowest setting. The positioning of the bean bag meant if the person rolled or fell out of bed, their whole body would not have been protected. The combination of equipment in use posed a risk to the person. This was discussed with the registered manager, who said they would ensure equipment was used in line with the risk reduction instructions in the person's care plan.
Prior to our inspection visit, concerns had been raised with us that people's weight loss was not being addressed. At this inspection, we found there was not always evidence of action taken in response to people's weight loss. Records showed that, from July to October 2017, 16 out of the 26 people who were weighed regularly had lost weight. Five of those people had lost two kg's or more during that period. Records showed one person had lost 3kg's over a six week period. There was no evidence in the person's care records of any action taken to investigate or address the reasons for the weight loss and to put measures in place to increase weight. We raised this with a member of nursing staff who acknowledged this. They assured us they would refer the concerns around the person's weight loss to the GP the following morning, and would also raise with the registered manager. Another person had been identified as being at risk of dehydration and malnutrition, and their care plan stated food and fluid charts should be completed. However, we found these charts had not always been completed as required so it was difficult to determine

whether the person was eating and drinking enough to keep them safe.

Where people were at risk of losing weight, tools designed to assess the level of risk and reduce it, were not properly used. Some people's care records included a MUST (Malnutrition Universal Screening Tool). This uses certain information such as people's weight and height to calculate their level of risk. We found two of the completed MUST tools we reviewed had not been scored correctly, so people's risk had been reduced incorrectly. This posed a risk that people would not receive the support they needed to keep them safe if their assessed risk was wrongly reduced.

We identified other people who had lost weight recently, and where the recording of their food and fluid intake would have helped identify and reduce risk. Food and fluid charts had not always been introduced for these individuals.

We found damage to people's skin was not always investigated to ensure risks of recurrence were reduced. When we reviewed one person's care plan, it included a photograph of a large bruise on the person's lower arm, dated 9 May 2017. We did not find any information in the person's care records to show who had noted the bruise, and on what date. Neither was there any evidence of an investigation into how the bruise might have been caused, or of any treatment. We raised this with the registered manager, who told us they were not aware of what action had been taken in relation to the bruise. They told us there should have been an incident form and a 'body map' in the person's care records, but could not produce either during our inspection visit.

A number of people had damage to their skin in the form of 'skin tears'. A skin tear is a wound caused by shear, friction and/or blunt force resulting in the separation of the skin. Whilst there was evidence in their care records that these were treated effectively, there was not always evidence that any investigation into the possible cause of these had been undertaken. This would have helped reduce the risk of recurrence, and would have helped staff keep people safe.

This was a breach of Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe Care and treatment.

There were not always enough staff available to meet and respond to people's needs. Relatives told us there were not enough staff. Comments included, "I come in regularly, mainly to help out. They [staff] are so busy as so many people here need help.", "To me, they are always short staffed. It must be difficult to recruit.", and, "Staff are about but they are very busy, but if you need them and ask they will come."

When we arrived at the home at approximately 9:30 a.m. there were two people out of their beds and dressed for the day. We were told by a senior member of staff that everyone else liked to have breakfast in bed. However, there was no evidence from people's care records, that this was a choice people had made. One staff member told us, "If we are short staffed we know those clients who like to stay in bed. It's safer for them to remain in bed, if they agree."

Staff were not always available to support people. For example, we saw one person in the upstairs lounge alone, with no staff present. The person was seen trying to wind up a loose wire by the window. This went on for a few minutes until the person started to wind the wire around their arms. The wire appeared to be from a TV aerial, there was a sharp point at the end. There were no staff available to alert about the person's potential risk to their safety. We were concerned the person was at risk of cutting themselves with the sharp end of the wire.

Staff told us there were not always enough staff to keep people safe or to spend time interacting with

people. One staff member commented, "Sometimes there are not enough staff to keep people safe. We can get behind with helping people eat, helping keep people clean. It would be great to have five staff on shift. I don't know if it is the owner's decision."

One person's care plan stated that, due to risk of falling, it had been agreed with commissioners funding would be increased to provide individual staff support to the person between 10 a.m. and 4 p.m., as these were the times identified as being highest risk to the person. On the day of our inspection visit, the person was not in receipt of individual support, and spent the day in bed. Four staff gave us different answers about the person's needs. For example, one staff member said, "Yes, [person] has 'one to one' between 11-3pm. We do hourly obs." Another staff member said, "One to one support is not always available for [person's name] as there's no staff."

We raised our concerns with the registered manager, who confirmed the person required individual support, and that commissioners had funded this. We reviewed the staff rota for the week of our inspection. This showed individual support had been scheduled for the person for two out of seven days. The registered manager told us, "We don't have the staff to cover." After our visit, we informed commissioners what we found.

This was a breach of Regulation 18 HSCA (Regulated Activities) Regulations 2014 Staffing.

Relatives told us they were confident people were safe with staff, and that staff treated people well. We saw staff interact with people who lived at the home. People were relaxed and comfortable around staff and responded positively when staff approached them.

Risks such as those linked to the premises, or activities that took place at the service, were assessed and actions agreed to minimise the risks. Records showed the provider checked electrical and gas items to ensure they were safe, undertook regular testing of emergency lighting and fire alarms, and had recently updated their fire risk assessment.

Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. Staff were able to give us examples of what might be cause for concern, what signs they would look out for and what action they would take. One staff member told us, "I would report any concerns to the senior, if I didn't think action was taken I would report to the [registered] manager. If the manager did not act, I would contact safeguarding myself. But, I am not worried about that here."

The provider's recruitment process ensured risks to people's safety were minimised, and that staff with the right skills, knowledge and values were brought in to work at the home. Staff told us they had to wait for checks and references to come through before they started working in the home. Records showed the registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about potential new staff. The DBS is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they thought staff were well trained, and supported people effectively where they had time to do so. One relative commented, "The staff are spot on. When the staff are told what to do by [senior care staff] or [senior nurse], they do it."

Some staff were positive about the training provided. One staff member told us, "Training provided is very good. I've done a four month distance learning course on dementia." Other staff told us they did not feel the training they received was sufficient to ensure their skills and knowledge were up to date. One staff member told us there was a lack of 'specialist' training provided, for example around catheter care and tissue viability.

We looked at the training records held by the registered manager, but it was not possible to establish what training staff had completed or when training which refreshed staff knowledge, was due. Following our inspection visit, the registered manager sent us updated training records. These showed there were significant gaps in the training considered essential for people's health and safety staff had undertaken, so we could not be sure staff had their skills and knowledge updated as required. For example, 'moving and handling (competency)' was listed, no staff members had completed this. This was also the case for 'whistleblowing', 'customer care', 'diabetes', 'meaningful activities', 'tissue viability', 'continence management', 'behaviour that challenges', and 'Parkinson's care'. There was other basic training listed which had not been completed by the majority of staff. For example, 'care planning records' had only been completed by three out of 34 staff listed, 'dementia awareness' by 13 staff, and 'person centred care' which had only been completed by three staff members. Training records also showed that annual medication competency assessments were overdue for all staff. Of the five staff who had their competency assessed, four had last been assessed in May 2015, whilst the fifth had last been assessed in February 2016. We were concerned this had contributed to some of the issues we found when we looked at the management of medicines.

Prior to our inspection visit, concerns had been raised about moving and handling practices within the home. However, we saw on a number of occasions staff supported people to use a hoist safely, in line with best practice techniques.

The registered manager told us new staff received an induction, which included working alongside experienced staff, as well as undertaking training they considered essential to their role. They also told us people's induction included working towards completing the Care Certificate. The Care Certificate assesses staff against a specific set of nationally agreed standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. There were no new staff available for us to speak with at the time of our inspection visit, and induction records were not included in the training information the registered managed sent through to us, so we could not be assured induction took place as planned.

Staff told us they had regular opportunities to meet on a one to one basis with senior staff to ensure they

were up to date and had the opportunity to share their views. One care staff member told us, "We get regular supervisions with [senior care]. We can share ideas and suggestions. [Senior care] will listen and we give things a try." Staff also told us their practice was checked by senior staff, who observed them and gave feedback on what they did well, as well as any areas for improvement. A senior member of staff explained, "I do regular supervision with the girls. It's really important." "I regularly work with the girls so I am always watching and checking. I do specific observations and record these." Staff confirmed these observations took place, and that they received feedback on their work.

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.

Staff asked for people's consent before supporting them. We observed how staff approached people and explained what they were about to do. There was clear communication, and people were asked their opinions about how they wanted to be supported.

The registered manager had an understanding of the legislation in relation to the Deprivation of Liberty safeguards (DoLS). Where restrictions on people's liberty had been identified, the registered manager had made DoLS applications to the relevant authorities so they could be legally authorised. This protected people who could not make all of their own decisions by ensuring restrictions were proportionate and were not in place without the relevant authorisation. For example, where people were given medicines covertly, we found their capacity to agree to this had been assessed, a decision to administer medicines covertly had been documented in their 'best interests', and DoLS applications had been submitted to authorise this.

Staff had a basic understanding of MCA and DoLS. They knew people who lacked capacity needed to be supported where decisions needed to be made in their 'best interests', for example. One staff member told us, "If someone can't make their own decision, you should always ask, it doesn't matter. It's a person. Where someone cannot make a big or important decision, we escalate this to the nurse." Another staff member said, "Some of our clients have capacity and others don't. We can make day to day decisions and the family make the big decisions." Staff were not aware family members could only make decisions on people's behalf where they had been legally authorised to do so. However, the registered manager understood this.

People who needed support to maintain good nutrition and hydration did not receive this consistently, as information was not always available. We spoke with kitchen staff about how information was shared about people's nutritional needs (for example, people who were on diabetic, high calorie, and gluten free diets), likes and dislikes. They told us they received very little information from staff about people's nutritional needs and as such had not provided any additional calories in food to help improve the weight of those at risk of weight loss.

At meal times, people could not always choose where they wanted to eat. One care staff member explained people who sat in specialised chairs would stay in the lounge as opposed to the dining lounge, "Because we just can't fit them all in [the dining room]." Others were able to choose, and were supported by staff in doing so. For example, one staff member said, "Let's see how [person's name] walks, he might want to come and eat in the lounge."

There was a 'menu board' on display in the dining room. This had been updated on the day of our

inspection visit to reflect the meal choices on offer that day. People were verbally told the choices of meals, but, where people found it difficult to make or understand this choice, staff did not use plated up examples of the dishes on offer to help people decide. People living with dementia can find it easier to make choices based on visual cues rather than verbal ones, especially where verbal choices prove ineffective. A senior care worker told us they asked people what they wanted to eat just before lunch and again at the point of plating up meals to check their choice. They explained where people were unable to express a preference, staff would use information from relatives about what foods people had always enjoyed, as well as staff's own knowledge and observations of people's likes and dislikes.

We saw, where people needed support to eat, staff did not always provide this. For example, one person eating in the downstairs lounge called out to a staff member. The staff member stopped and asked, "Shall I stop and help you?" The person replied that they would like this and we observed the staff member stayed with the person to support them and ensured they had eaten. However, in the upstairs lounge, one staff member explained, when talking about someone who ate in their room, "We can't send theirs [meal] as yet as no-one is available." We asked if it was usual that there were not enough staff to support people at mealtimes, and were told it was.

Most people were dependent upon staff providing them with drinks and snacks. There were no facilities for people who were able to access drinks independently. We saw drinks were available in some bedrooms. However, these were not in reach of people who were in bed. For example, two people had drinks on top of a vanity unit on the other side of their room.

Relatives told us people were supported to access health professionals when required. One relative commented, "[Person's name] sees a chiropodist and other health professionals when they need to." Care records showed people were supported to access health professionals routinely, and when changes in their health occurred. However, recommendations had not always been incorporated into people's day to day care. For example, where people had lost weight, there was evidence of conversations with the GP, but this had not always resulted in changes to people's care plans, and information such as recommendations made by SALT had not always been made available to staff and acted on.

We found two DNACPR records (These record decisions about whether or not people will be resuscitated in the event of a medical emergency) that had been completed for people before they moved to the home. They included the address for the people's previous homes, and had not been reviewed. We raised this with the registered manager, who agreed they should have been reviewed and updated to ensure they remained valid. They assured us they would do so.

Requires Improvement

Is the service caring?

Our findings

We saw people interacting on a one to one basis with staff. One staff member was particularly good at interacting with people, and people responded positively to them. They were patient and kind and repeated information each time someone asked them as if it was the first time they had asked the question. Staff clearly knew the people in their care well.

People liked engaging with staff but only had the opportunity to do so when any sort of intervention was required. Staff were busy with tasks that needed to be completed, and did not always have time to spend meaningful time with people. People spent long periods of time without staff engagement or interaction, and on some occasions staff missed opportunities to engage with people. For example, we saw staff coming and going in communal areas of the home. Whilst staff were clearly busy and did not always have time to sit and talk with people, they did not always greet people when they entered communal areas. On one occasion a member of the domestic staff team was cleaning the floor, and did not speak to or acknowledge anyone sat in the lounge.

For almost two hours, one person sat in a communal area. There was no music or any other stimulation for the person, and they spent the time talking to themselves. During this time period, one staff member came into the lounge and asked another person, "Would you like some music on?" The person replied, "Yes I don't mind." The staff member then left the lounge and did not put any music on."

Staff were aware they did not always have time to spend with people to engage them. One staff member said, "I like to entertain people and chat with them but I really don't have time." Staff knew what made a caring service. One staff member explained, "It [being caring] is treating everyone with dignity, a bit of love. Like I would want my Mum and Dad to be treated."

People's care plans included information about their likes, dislikes, backgrounds and history. There was a 'social eulogy' section which included information people and their relatives had shared which staff could use to understand people and build a rapport with them.

Relatives felt staff were generally kind and caring. Comments included, "Yes, they [staff] are brilliant, very caring. I have never seen anything untoward." They added, "The staff who are here regularly know [name] very well, and when they talk to [name], her eyes light up.", "[Staff name] is really, really caring. She is a real diamond. You cannot fault the staff.", and, "It's a very caring home. It may not be the most as luxurious as some but its dementia nursing. It never smells."

We saw staff knocked on bedroom doors and identified themselves rather than just entering, all of which were positive indicators of an environment which respected individual needs and wishes and promoted dignity.

Relatives told us staff encouraged people to be as independent as possible. Staff supported people in ways that made it possible for them to do things for themselves. One relative commented, "[Person's name] does

not really need assistance to walk so they [staff] support her to do that safely. They do not try and stop her."

People were supported to maintain relationships with family and friends. Relatives told us there were no restrictions on when they could visit or how long they could stay for. On the day of our inspection visit, a number of relatives were visiting people, and we saw they were comfortable with staff and were made to feel welcome.

We saw people's personal details and records were held securely at the home. Records were filed in locked cabinets and locked storage facilities, so only authorised staff were able to access personal and sensitive information.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that care plans had been reviewed, but they did not include evidence of how people, family, friends or advocates had been involved in these reviews, or of how their views and opinions had been reflected in changes to people's care plans. When we reviewed care plans, we found this remained the case. However, relatives we spoke with told us they were involved in reviewing and updating people's care plans. One relative commented, "We meet once a month to look at the care plan." Another relative explained, "Yes, I am involved in reviews of the care plan. We have agreed they [staff] can suggest changes, let me know and if I agree we will give it a try and see how it goes."

Staff told us care plans and supplementary records were not as up-to-date, which meant we could not be assured people's needs were responded to consistently. Staff said this was because they did not always have time to do so. One staff member told us, "I know our records (supplementary) could be better." One person had been assessed as needing one to one support, and there were records staff should complete to show when this support had been provided. We found this was not done consistently, with some entries left blank and some partially completed. This meant it was not possible to determine whether the person received the support they needed in response to their assessed needs.

Another person had been assessed as exhibiting behaviours that could challenge. Staff told us the person would regularly exhibit such behaviours when staff attempted to support them. As a result, charts were in place that staff were expected to complete, so an accurate picture could be established, which would help to meet the person's needs. Staff told us these were not always completed. One staff member commented, "The charts don't get filled in because some staff just don't bother. We should record everything. If there are no issues we should put something like "Ok with all interventions." We reviewed these charts and found no entry had been made between 30 September 2017 and 3 October 2017, and between 4 October 2017 and 23 October 2017.

Records were also in place for staff to record when people had been assisted with their personal care. However, these were not always completed. For example, one person's personal care record had no entry for 9,13,14,21 or 23 October. One person had a catheter, and staff had to change the catheter bag on a regular basis. In the person's daily notes, staff had been advised, "Staff to change weekly." There was no evidence of this change being recorded anywhere. Whilst we did not identify any issues with the person's catheter, there was no way for staff to know when and if the bag had last been changed.

We asked staff if they had time to read people's care plans. They told us this was not always possible. One staff member said, "To be really honest, yes, but not very often because when I start I don't stop. But I know the client very well. My main concern would be if something has changed and we are given all this information in handover." Staff confirmed handovers took place, but told us this was done verbally and was not always recorded. The registered manager confirmed agency staff were used to fill gaps in staffing levels. We could not be assured they had time to read people's care plans, some of which were not up to date, or that a verbal handover was sufficiently detailed to give them the information they needed. The registered manager told us they recognised this risk, and was considering introducing a 'grab sheet' for people, which

would include important key information staff needed to know. However, they acknowledged this work had not yet been started.

Relatives told us they were generally confident that people's needs were responded to, but some relatives had concerns that staffing levels might mean people were not attended to as required.

On the day of our inspection visit, we saw one person seated in the lounge, asleep at approximately 9:30 am, holding an empty cup. The person remained seated in the lounge with the cup until 11.40 a.m. when a staff member asked if they could take the cup away.

The registered manager told us they employed one staff member who took overall responsibility for helping people maintain activities, hobbies and interests. The person was not on duty when we visited, but we were told they worked flexibly so people could be supported as and when needed. For example, we noted a visit to the theatre was planned that evening for two people, which the staff member would support them to go to. Relatives spoke positively about activities that had taken place at the home, and told us they had been present when singers and entertainers visited, for example.

An 'activities board' on display in the home which told us a coffee morning was on offer in the morning, and a 'pamper session' in the afternoon. Neither of these activities took place, and we did not see staff engaging people in any activity during the course of our inspection visit. We asked the registered manager what should happen when the staff member employed to work on activities was not on duty. They told us care staff should engage people in activities, but acknowledged this did not always happen.

Relatives had mixed views on their confidence the registered manager would deal effectively with complaints. Some told us the registered manager could be dismissive and did not always take concerns seriously. However, one relative said, "I've never raised a concern but I would phone the home and speak to the person in charge. I'm very confident any concern I raised would be addressed." Staff understood their responsibilities to support people and relatives to share any concerns. The senior care worker told us, "It is our priority to make sure clients [people] and relatives are happy. We would deal with any complaints straight away." The provider's complaints policy was accessible to people which informed them how to make a complaint and how to pursue it if they were not satisfied with their response. Records showed that complaints received within the last 12 months had been logged and managed in line with the provider's procedures.

Inadequate

Is the service well-led?

Our findings

The current manager first 'registered' with CQC in January 2016. We inspected Allambie Court in March 2016, and again in February 2017. At both inspections, we awarded a rating of 'Requires Improvement' overall, and the 'well-led' question was rated as 'Requires Improvement' at both inspections.

We discussed with the registered manager that, at our previous inspection, they had found it difficult to maintain effective and regular audits to check and improve the quality of service. They told us, "Nothing has changed since the last inspection", and explained this was due to sickness of senior nursing staff who could have provided support. They added they were exploring the possibility of utilising the skills of senior care staff to help them fulfil management roles such as auditing and checking the quality of the service provided. The registered manager explained they had recently 'passed back' all 'HR' matters to the provider, to help them focus on running the home. They told us they felt well supported by the provider and by one of the directors in particular.

Systems to audit and check the quality of the service to help it improve were not effective, and had not been completed regularly and consistently. For example, care plans had not been audited since 16 April 2017. Medicines had been checked in September and October, and had not identified any of the issues we found during our inspection.

We reviewed the most recent action plan for improving the service at Allambie Court. This had been completed by the registered manager, and was dated 2016/2017. The action plan had not been updated since 16 February 2017, and did not include any information or analysis of audits completed since that time. We asked the registered manager if there was an updated action plan, but none was made available to us on the day of our inspection visit, and we have not received one since.

Tools used by the registered manager to help them run the home effectively had not been used properly. For example, we looked at the tool the registered manager used to determine the number of staff required per shift dated 22 October 2017. We found this had not been properly completed. The tool included a number of calculations that had to be made to determine the number of hours staff time required over the course of a week, based on the needs of people living in the home. One part of the tool included a section to add hours where one to one support was required. We found the six hours per day of one to one support required for one person, as per their care plan, had not been entered onto the staffing calculation sheet, and was not being factored in when staffing levels were determined. The sheet included a hand written note, completed by the registered manager, stating the home was short of care staff due to 'sickness and leave'. The hand written note stated the home needed to recruit more care staff. We raised this with the registered manager, who told us a recruitment exercise was underway.

A maintenance log was kept by a staff member who was employed by the home. This log was overseen by the registered manager. We found the home was not always properly maintained. The home's maintenance log showed that, on 1 September 2017, a light fitting needed to be replaced in a shower room. When we checked the shower room, we found the light fitting still did not work. The home supports people living with

dementia, so there was a risk that someone would enter the shower room, lock the door and find the light did not work. This could have caused confusion and disorientation, and could have posed a safety risk, as people would not have been able to see where they were doing once inside the shower room. The maintenance log had also recorded a number of cold water taps were not working. When we checked one cold water tap in a person's room, and one in a shower room, they still did not work.

On 1 September 2017, the maintenance log documented that some of the ceiling tiles in one person's room were damaged. We looked at the ceiling in the room and found some ceiling tiles were black with mould and mildew. In one corridor on the first floor of the home, a hand gel dispenser had been removed from the wall, plaster was missing causing rough edges, and screws that had been holding the dispenser in place were protruding from the wall. We raised this with the registered manager, who told us they could not understand why it had been left in this state, and that they would make sure it was 'sorted.'

Paper based training records were stored in two folders. When we reviewed these, it was not possible to establish what training staff needed to complete to be effective in their role, when they had completed this, and when they were due to refresh this training. The folders included training attendance certificates for individual staff members, and did not provide an effective overview. We raised this with the registered manager, who acknowledged it was difficult to monitor staff training based on these records, and they agreed they would send us electronic training records following our inspection visit so we could establish whether or not training was up to date.

Relatives had mixed views on how effective the registered manager was, and how responsive. One relative commented, "[Registered manager] could do better. They can be rude. They talk to you sometimes, but ignore you the next." They also told us they were aware staff 'were not happy', and that morale was low. They explained they had overheard staff talking about this. However, one relative said, "They [registered manager] hold meetings for families. I never go, as if I have a problem I go and see [registered manager]. The response from them has always been fine."

Staff also had mixed views on the support they received from the registered manager, and on how effectively the home was managed. Whilst there was evidence that staff met as a team, this was not always viewed positively by staff. One staff member told us, "Following the previous inspection and the issues that were raised, there was no feedback or information given to staff, and no action plan was put into place." They added, "[Registered manager] needs to earn respect and show they are leading." When we asked another staff member about the registered manager and the support they received, the staff member shook their head. They told us they could not answer the question.

However, one staff member said, "I do get support. I can go to the manager and they will listen. We talk things through and sort it out together."

We raised our concerns with the registered manager over the course of the inspection visit. We found they were not always knowledgeable about the people living in the home, and were not able to provide us with the information requested.

This was a breach of Regulation 17 HSCA (Regulated Activities) Regulations 2014. Good governance.

The registered manager understood their legal responsibility for submitting statutory notifications to us. This included incidents that affected the service or people who used the service. These had been reported to us as required throughout the previous 12 months. The registered manager had clearly displayed the rating from their previous inspection, as required.