Kingsley Care Homes Limited

Allonsfield House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 August and 4 September 2017. The previous inspection in September 2015 had rated the service as Good. However, this inspection identified areas where the service needs to improve.

The service provides care and support for up to 42 people. On the dates of our inspection there were 40 people living in the service, some of who are living with dementia. It is divided into two units Allonsfield and Ashfield.

The service is required as a condition of registration to have a registered manager. On the dates of our inspection there was not a manager registered with the CQC in post. There was a manager who had applied to register. 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.

There were not always the number of staff on duty that the service had assessed as necessary to support people safely and effectively. This included the number of night staff and staff with a specialist role, for example activities staff.

Staff training was not effectively monitored to ensure staff had received the required training and that training was up to date. Staff had not all received effective training in areas in which the service provided care, for example, dementia care. Staff received supervision sessions where they could discuss concerns or development needs.

Staff had received training in keeping people safe from abuse and were confident they would be able to identify and respond to any concerns.

The provider had invested in a new care planning system. This was computer based with care staff inputting information via a smart phone. The amount of time it would take for care plans to be put onto the computer and for staff to become competent in the system had not been effectively assessed by the provider. This has resulted in care plans which did not always contain full information about the care to be provided and staff not being able to fully access information on the system.

Appropriate checks were carried out before staff started providing care to ensure they were suitable for the role.

Medicines were managed safely to ensure that people received their medicines as prescribed. The service did not comply with the Mental Capacity Act when administering covert medicines, that is when disguised in food.

People had mixed views on the quality of the food provided. Care plans contained information on people's nutritional needs.

People were supported to maintain good health and access other healthcare professionals.

Staff respected people's privacy and dignity when providing care and support. However, as an organisation dignity was not promoted with linen being old and tired and a lack of crockery.

The service did not have a planned programme of meaningful activities either for people as individuals or for the service as a whole.

The manager and the provider carried out a variety of audits. However, these had not always identified areas of concern. Where the audits had identified shortfalls action to address these had not always been put in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always sufficient staff to ensure people were safe.

Medicines were managed and administered safely. However, there was not always information as to when medicine prescribed to be administered when required should be given.

Risk assessments were brief and not always linked to the relevant care plan.

A new care planning system had been implemented and staff were not always able to access required documentation in a timely manner. This presented a risk if urgent information was required.

Staff had received training in safeguarding vulnerable adults from abuse and were confident they would be able to put it into practise should the need arise.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always have the training they required to provide effective care.

Decisions about people's care and support were not always taken in accordance with the Mental Capacity Act 2005.

People had mixed views on the quality of the food and the choices offered.

People were supported to maintain good health and access health care services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff respected people's privacy and dignity. However, the

organisation did not ensure people's dignity.

People were supported by staff that were considerate and caring.

People were involved in decision about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not regularly engaged with meaningful activities.

People's care plans did not always provide sufficient information about their care and support needs and how their needs should be met.

The service had a complaints policy.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The culture of the service was not always open and empowering.

The service was re-active rather than pro-active in identifying areas for improvement.

Audits did not always identify shortfalls. Where shortfalls were identified these were not always addressed effectively.

Allonsfield 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 checked 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 29 August and 4 September 2017. It was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience at this inspection had experience of caring for a person who used this type of service.

Before the inspection we looked at all the information we held about the service. This included information about events happening within the service and which the provider or registered manager must tell us about by law, these are called notifications. We also looked at information we held about the service including previous inspection reports. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 11 people who used the service, five relatives and observed how staff supported and interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with six members of care staff, the housekeeper, the manager and the provider's quality manager.

To help us assess how people's care and support needs were being met we reviewed three people's care records. We also looked at other records regarding the management of the service, for example staff rotas. We looked at the systems for assessing and monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in September 2015 this key question was rated as Good. At this inspection of 29 August and 4 September 2017 it is rated as Requires Improvement.

Before this inspection we received concerns that there were not sufficient staff. At the inspection people told us that there were not enough staff. One person said, "At the moment there seems to be a shortage of staff, people leave, you miss them. Staff are very hard to get." Another person said, "I can't fault them beyond the fact that the owner doesn't provide enough staff."

During our inspection we observed that people were seated in the dining room waiting for their breakfast for 25 minutes. We observed that on two separate tables people became irritated with the person sitting next to them during the wait for their meal. This resulted in a number of negative interactions between people and increased the possibility of incidents of challenging behaviour. We also observed a similar wait at lunch time. During the lunch meal we observed one person choking on a piece of food. We alerted staff to this as there was no one present. After this a member of staff remained in the room and assisted the person to finish their meal. Had we not been available to alert staff this could have been a serious incident. Staff did not have time to sit with people requiring one to one support with their meal. They sat with people for a short time but then had to move on and support somebody else. These incidents demonstrated that there were not sufficient staff to support people safely at meal times.

The service was divided into two units Ashfield and Allonsfield with a reception area and a secure door dividing the two. We asked the manager how the staffing levels were assessed. They told us that they used a dependency tool which assessed people's needs and this was reflected in the staffing levels. They told us that the current assessed staffing levels were six care staff, three on each unit between 7am and 8pm and four care staff, two on each unit between 8pm and 7am. We told the manager about our concerns during meal times. They told us that they were recruiting a person to work 10am to 2pm which would cover the lunch period. However, this would not impact on the breakfast meal. They also told us that they did not have any activities staff or a handyman, but that they were actively recruiting to these posts.

We checked the rotas for the service for the month previous to our inspection. These showed that for one week in August the service had had only three night staff on for five nights out of seven. For another week there had only been three night staff for four nights out of seven. The service was regularly falling below its own assessed requirements. With only three care staff on for two units this left two staff for the two units when staff were taking their breaks. The service had people who required two care staff to support them. With the service divided into two units if two night care staff were providing support to a person in one unit and the remaining member of staff was on their break this left no member of staff covering the second unit and available to provide support if people required it.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was implementing a new care planning system during our inspection. The new system was a computer based system which contained an assessment tool for areas such as skin integrity and nutrition. The system then generated the required risk assessment to be completed by staff. The manager told us that the previous care plans had been printed and were available to staff and that information regarding risks to people from using care were being transferred to the new care plans. We looked at the computer system with the manager. We checked three people's care plans and found that they did not always contain sufficient information to ensure people received safe care and support. For example one person had been assessed as being at high risk of developing pressure ulcers. There was no risk assessment in place to address the risk and show what had been put in place to mitigate the risk. In other care plans we found that risk assessments had been carried out but these were brief and had not been linked on the system to the related care plan. This meant that when reading the care plan staff may not be aware of the related risk assessment and actions to take to mitigate any identified risk to people's wellbeing. However, staff we spoke with were aware of what to do to mitigate risks such as pressure ulcers due to their knowledge of the person.

The computer system was new to all levels of staff from the area manager to care staff. We found that in some instances staff were struggling with using the system. For example we asked if people had a personal evacuation plan (PEEP). A PEEP identifies the support that people require to evacuate the building in an emergency, such as a fire. The manager could not access these on the new system. The risk to people in this instance was mitigated as the manager had copies of the PEEP's from the previous system. However, we were concerned that if up to date information was required quickly from the new system this may not be accessible.

People told us they received their medicines as they required. One person said, "They order our prescriptions and bring them to us. We don't have anything to do with it, oh yes they tell you what medications are for." Another person said, "I'm happy with the tablets, it's all done from the list, all okay."

There were systems in place to ensure that people received their medicines as prescribed by health care professionals. Medicines were stored in a designated medicines room which could only be accessed by staff responsible for administering them. The refrigerator in the room where medicines were also stored was locked to ensure that they were stored securely. The medicine room temperatures and medicines fridge temperatures were monitored and recorded and we noted that they fell within safe ranges. There was a system in place to dispose of unused medicines appropriately to reduce the risks of increasing stocks of medicines that were no longer needed and out of date.

The medicines administration records (MAR) showed that people were receiving their medicines when they needed them and any reasons for not administering medicines as directed was clearly recorded. However, for one person there was no information as to when they should receive the medicine that had been prescribed to be given as required (PRN). The medicine was for pain and the person was not always able to express when they were in pain. Information was required so that staff knew what behaviour the person may exhibit when they were in pain and that pain relief was administered consistently. We spoke with the manager who assured us they would put a PRN protocol in place immediately.

There were safeguarding and whistleblowing policies and procedures in place which detailed the action to be taken where abuse or harm was suspected. Staff had received training in keeping people safe, and they told us they were confident about identifying and responding to any concerns about people's safety or well-being.

The manager told us that prospective staff were interviewed and two suitable references obtained and a disclosure and barring service (DBS) check was carried out before they started work. DBS checks return

information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Staff we spoke with confirmed that these checks had been carried out before they started work.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in September 2015 this key question was rated as Good. At this inspection of 29 August and 4 September 2017 effective was rated as Requires Improvement.

The service had a specialist unit called the Ashfield unit which supported 19 people living with dementia. The manager told us that a number of people living in the other main house, Allonsfield, may be also be living with dementia. We observed staff supporting people with dementia. Although these interactions were kind and caring they did not always demonstrate that staff had received training in how to support people living with dementia effectively. For example a member of staff in the lounge of the specialist unit gave a person a copy of the local newspaper. They pointed out some stories in the paper but did not sit down with them and use the opportunity to develop a conversation with the person. The person soon became bored with the paper. During the lunch meal we observed care staff asking people about their choice of main course. They were using printed menu's, there were no visual references on the menus to assist the understanding of what was on offer to people who may be confused. In the lounge of the specialist unit the television was on with the sound turned down and there was music playing war time songs. This could have been quite confusing for people living with dementia or with impaired hearing. A relative of a person living with dementia told us, "For a long time [person] didn't have like to have a bath or a shower, it took a long time to do it and it wasn't good here for a while [lack of dementia knowledge]. We had to show them [staff]."

We asked the manager what training care staff had received to support people living with dementia. They told us that the service used a dementia training programme supported by Sterling University. However, when we checked the training record for the service we found that only six of the 29 staff shown as care staff had received training entitled 'dementia awareness'. The manager was unable to provide details of any other staff training in dementia. The quality manager told us there were plans for further staff training in dementia but as yet these had not been implemented.

The manager provided us with a spreadsheet of dates staff had received their training in areas such as manual handling, safeguarding and food hygiene. We noted that there were significant gaps in some areas, for example moving and handling practical training. We spoke with the manager about this and they told us that everybody had received practical moving and handling training. They also confirmed that the spreadsheet they had provided us with was how they monitored if staff required refresher training. We also noted that one member of care staff had not received moving and handling training since 2015. The manager confirmed that this should have been refreshed yearly. The service was not effectively monitoring that staff were receiving regular refresher training and was not able to confirm that all staff training was up to date. This meant that we could not be sure that staff supporting people were using current best practice.

When they began working in the service staff received an induction. This included shadow shifts where the shadowed an experienced member of staff so that they could get to know people before providing care and support. Staff told us that they received regular one to one supervision sessions where they were able to discuss any concerns or development needs.

People told us that they thought care staff had the knowledge required to meet their needs. One person said, "I think they've [staff] been doing it for enough time to know people." Another person said, "I'm really luck with the staff, they are good, I'm happy with it."

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 authorisation 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. We found that, where appropriate, the service had made applications to the relevant authority. None of the authorisations that had been granted had any conditions on their authorisation. The manager had a system in place to ensure that the authorisations, which are time limited, were reviewed when necessary.

We found that one person in the service was receiving their medicine covertly. The person refused to take their medicine and it was concealed in food. The person lacked capacity and was unable to understand the risks to their health if they did not take their prescribed medicine. Guidance from a recent court judgement states that covert medicine should only be administered in exceptional circumstances. There should be best interest's decision which includes the relevant health professionals and the person's family members. If it is agreed that the administration of covert medication is in the person's best interests then this must be recorded and placed in the person's medical records/care home records and there must be an agreed management plan including details of how it is to be reviewed and that all of the above documentation must be easily accessible on any viewing of the person's records within the care/nursing home. For this person none of this was in place. This meant that the service was breaching the person's human rights and had not put the appropriate safeguards in place under the MCA. We spoke with the manager and provider's quality manager about this. They have confirmed that they have been in touch with the person's GP and that a best interest decision has been taken and the appropriate recording is now in place.

The service had two dining rooms. One in the Ashfield unit and one in Allonsfield House. We observed lunch in the Ashfield unit. Staff were constantly coming and going from the room in a rushed fashion. We observed one person trying to eat gravy with their fingers as no staff were in the room they were not encouraged to use the available cutlery. This did not support people to eat an enjoyable meal.

We also observed lunch in Allonsfield House. There were not always staff available in this dining room and there was an occasion where we had to alert staff to a person choking. One member of staff was observed to place plated food in front of people without any conversation. They later offered people more food by standing and saying loudly, "Did you want any more before I move it [trolley]?" They then called to another staff member in the adjacent lounge, "Have you checked all up here?" This did not contribute to a relaxed and sociable dining experience.

People told us that there was a menu which they could choose from. We saw, on the day of our visit that people had a choice of lunch meal. On the day of our inspection people told us that they had enjoyed that

meal. One person said, "I like the quorn, that's what I had today. We had quorn sausages a few weeks ago, they're really tasty. There's always a choice." However feedback we received about the quality of the food and choice was not consistently good. One relative said, "[Person] does not like the food at all." Another person said, "Breakfasts are poor, just a choice of cereal and toast which I feel isn't enough. You've got to say 'can I have an egg next Tuesday?' You have to request it."

People's care plans contained information on their nutritional needs. A relative told us how their relative now required liquidised food. They said, "They now liquidise [person's] food, they present it as a meal with the vegetables separated."

People told us that they were supported to maintain good health and access healthcare. A relative told us, "They [staff] spotted [person's] eye infection very quickly." One person said, "They get him here [GP], they come to weigh us and take our blood, we have a sight test [pointed to adjacent room]. I think they know I'm alright." Due to the changeover of care planning systems we were unable to see where referrals had been made to other health care professionals. However, we discussed this with the manager who was able to tell us when and how they made referrals to services such as the dietician and occupational therapist.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in September 2015 this key question was rated as Good. At this inspection of 29 August and 4 September 2017 Caring was rated as Requires Improvement.

People told us that their care was provided by staff that were caring and kind. For example one person said, "The carers are all very good. Oh yes, they take an interest." Another person said, "They do it, [care] cheerfully, open, friendly. They're always like that."

The organisation did not respect people's dignity. This was because the linen was old and discoloured and there was insufficient crockery. We looked in a linen cupboard and found that the bed linen was old, thin, faded and in some cases of indeterminate colour. Duvets were hard and the covering was discoloured. Pillows were old and lumpy. We checked the bed linen in people's bedrooms and found it to be the same as that in the linen cupboard. We were also noticed that when serving tea people were being given cake on serviettes and not plates. When we asked the member of care staff why this was we were told that if they used plates for afternoon tea there were not enough for tea in the evening. We asked the housekeeper about the deficiencies. They told us that they had meant to do an audit of the bed linen but had not had time. This was because, due to the lack of activities staff, they had been organising some activities. They agreed that much of the bed linen required replacement and that they were short of crockery. On our second visit the provider's quality manager told us that new bed linen and crockery was being ordered.

There was a friendly atmosphere in the service and throughout our inspection we saw staff interacting with people in kind and caring ways. For example, we watched one staff member asking someone if they wanted brown or white toast. The person was unable to make up their mind which they wanted. The member of care staff showed them the brown and white bread. The person was still unable to decide. The member of care staff then agreed with the person that they would make them one slice of each. On another occasion we saw a member of staff noticed that a person was cold. They took their hand and offered to go and get them a cardigan.

People told us they were able to be involved and make decisions about their care and support. One person said, "I knew what I wanted to do [coming here], they're very kind. They're always saying could you do this [person] could you do that? I do feel involved." Before people moved into the service an assessment was carried out with the person and their family, if appropriate, by a senior member of staff to collect information about the person's needs and preferences.

The manager told us that the provider's policy was that care plans should be reviewed with people and their family if appropriate, every six months. They told us that they were behind with some reviews but that they were in the process of planning review dates and sending letters to family members to invite them to a review meeting.

People told us that individual care staff supported their privacy and dignity. One person said, "They [staff] try and be kind, keep me covered." Another person said, "I think they respect us, they come into our room to

talk privately, they always knock."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in September 2015 this key question was rated as Good. At this inspection of 29 August and 4 September 2017 it is rated as Requires Improvement.

During this inspection of 29 August and 4 September the service was in the process of changing from one care planning system to another. The manager told us that all but one person's care plan had been created in the new system. The old care plans had been printed out and were available for reference if needed. The manager told us that, as yet, not all information had been transferred onto the new system but there was sufficient information to provide people's care. However, the new care plans were the ones that were being used by staff on a daily basis with the printed versions kept in the manager's office.

The new care plans we looked at did not contain sufficient information to enable staff to support people as they required and respond to their needs. For example one person was living with diabetes. There was no plan of care as to how this person was supported with their diabetes. There was no foot care plan, no eye care plan or information about the diagnosis. This meant that staff may not know how to respond if the person became hypo or hyper glycaemic.

People had mixed views as to whether they received their care and support as they preferred. For example, one person told us that they could choose the day they had a shower but when asked if they got it at their preferred time they said, "You just have to wait until they can fit you in."

Before our inspection a relative had raised concerns with us about the lack of social engagement experienced by a person living in the Ashfield unit. They told us that the person spent a lot of time sitting alone in their bedroom. At the inspection we found that due to the lack of staff very few socially stimulating activities were carried out on a regular basis. We observed that staff tried to engage with people but were regularly called away to provide care and support to other people meaning that they were not able to fully engage with people. For example, we saw that one person wanted to fold serviettes for the dining room. A member of staff gave them some paper serviettes and stood by them as they folded one in half. However, they were then called away to support somebody else and the person folding the serviettes, without any support, very quickly became bored and disengaged with the activity. They then left their chair and began to walk around the corridors. We did observe several people to be undertaking what they perceived as 'jobs.' One person was walking around with their shopping bag filled with various items and another person was seen cleaning the carpet with a manual sweeper. Whilst these individual examples were good they were initiated by the person rather than being part of a planned programme of care.

We spoke with the manager about the lack of activities and they told us that they were trying to recruit an activities co-ordinator but at the moment were unsuccessful. There were no regular activities either taking place or planned. The housekeeper had engaged some outside activities to visit the service. However, this had taken them away from their housekeeping duties. We observed a musical activity on the first day of our inspection and people were joining in with dancing and singing.

The service had recently held a barbeque and family meeting to gain people's views of the service and advise people of changes to the management of the service. A barbeque had been held to encourage people to attend as no relatives had arrived for the previous relatives meeting. This had been an informal gathering where people had been advised of change in manager. We saw photographs of this event displayed in the service which showed people having a good time.

People told us they knew how to complain and would make a complaint if they felt it necessary. A relative said, "If I had any queries I'd take it up with the manager and I would hope they'd sort it out. [Person's] been here [x] years and we haven't had a problem." A person living in the service said, "We'd go to her [manager], yes resolve any problem." There was a complaints policy in place which was available to people in the reception are of the service. This set out how to make a complaint and timescales in which the provider would deal with any concerns. Complaints had been investigated and resolved in line with the policy.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in September 2015 this key question was rated as Good. At this inspection of 29 August and 4 September 2017 it is rated as Requires Improvement.

The culture of the service was not always inclusive encouraging people to voice their views and experiences. When speaking with one person they told us, "I wouldn't ask because I wouldn't feel confident." When asked if they had been involved in giving feedback about the service another person said, "Not really, we're having a meeting but not many people attend." Staff gave a mixed reaction as to whether they were able to express their views and be listened to. One member of care staff said, "I would not speak at staff meetings. I am not confident they would take much notice." Some staff did tell us that they felt they were listened to at meetings and were able to express their views. However, the mixed response did not demonstrate an open and empowering culture running through the service.

During our inspection we witnessed some staff displaying compassion and promoting dignity within the service. However, this did not run through all the interactions we witnessed. We heard one member of care staff calling down the corridor to another using inappropriate language when describing the support they had given to a person using the service. At meal times the atmosphere was institutional with care staff standing and going from table to table and at times speaking to the whole room rather than individuals. We discussed our concerns with the manager and quality manager who did not display an awareness of the issues.

At this inspection there was no registered manager in post. The previous manager had been promoted by the provider. The new manager had been promoted from the deputy manager position and had been in post for two months. They had applied to the CQC to register as the manager. Although there had been a barbeque held by the service to inform people of who the new manager was not everybody was aware of the change. One person said, "I think [manager has] taken over now." Another person said, "I don't think there's any one particular person in charge but all staff seem to know what they're doing." This did not demonstrate open communication with people who used the service.

At this inspection we found that the service was reactive rather than pro-active in responding to concerns and identifying areas for improvement. One relative told us, "[Named manager] has been reactive, something is done, it might need another phone call, a lot of prompting but they would resolve it." This was demonstrated during our inspection. For example we identified that linen was not of a good standard. This had not been identified by the management team. After we pointed this out on the first day of our inspection we were told on the second day that new linen was on order. We also spoke with the quality assurance manager about the appearance of a patio area which had broken furniture and a dirty table in it. Later in the day we saw that the broken furniture was being removed from the area. Again this had not been identified by the management audits.

The provider had introduced a new computer based care planning system with care staff inputting information about people's care contemporaneously on a smart phone. Staff had received training on the

new system and care plans had been input onto the new system. The previous care plans were available in the office for care staff to consult if required but they were using the new system on a day to day basis. One member of staff described the care plans as, "A work in progress." They went on to say that they were, "Learning how to work the system." Other staff also told us that they were still finding things out about the system. Senior staff were also not confident with using the system. When we asked for particular information from the system it took time for this to be found or could not be found. The impact of the care plan system being a 'work in progress' was low as care staff displayed a good knowledge of people's individual needs. However, if staff who did not know people were on duty, for example, agency staff they may not able to identify people's needs. Also the lack of knowledge of the system by senior staff could impact if up to date information was required quickly. The provider had not fully evaluated the impact that changing care records from one system to another and the time taken for care staff to become familiar with the system would have on the service.

The service area manager attended the service regularly and carried out a programme of audits. These audits had identified some of the issues we identified during our inspection but not all. Neither did they demonstrate that when issues had been identified action was taken to address these. For example the audit had identified that inputting the new care plans was proving to be 'very time consuming'. However, no action had been taken to address this. Recruitment had been identified as a problem and action had been taken to boost recruitment level. However, no action had been taken to ensure that until new staff were recruited there were sufficient staff on duty. The audit had also identified an issue with PRN protocols and that this needed to be gone through with the manager. However, it goes on to say that this was not done due to the time being taken to input the new care plans.

The above examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not always effective and were not used to drive improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient staff to provide safe care and support.