Kingsley Care Homes Limited

Downham Grange

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?	**Inadequate**

Summary of findings

Overall summary

Our inspection visit took place on 27 November, 3 and 5 December 2018. The inspection was unannounced for the first two days and announced for the third day. We went back to the service on the 19 December 2018 to check what actions the service had taken since the first day of our inspection visit.

We last carried out a focused inspection to this service on 12 July 2018 because we had concerns about the service. These included the departure of the registered manager, the clinical lead and one of the operational managers. We felt this would have a significant impact on the stability and safety of the service. There had been a sharp rise in medication errors. Our concerns were shared with the Local Authority and other health care professionals. We also received a number of whistle-blowers who raised concern about the safety of the service. Before the focussed inspection we met with the providers to seek assurances. We also requested a written action plan from the service stating how they would address the concerns and improve the service for people living there.

At our focussed inspection on 12 July 2018 some improvements had been made and a new manager appointed. We received positive feedback about their impact. There was a new clinical lead in post and a reduction in the use of agency staff. There had been no recent medication errors. Despite these improvements we found some shortfalls and three breaches of regulation. We had concerns about insufficient staffing, poor risk management and poor governance and oversight. We rated both key questions, safe and well -led as requires improvement.

Soon after our focussed inspection the registered manager left. The service recruited another manager but they failed to start. The service did not have a registered manager at the time of our most recent inspection. It is a condition on the homes registration to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Downham Grange is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate people with a nursing or residential care need including those people living with dementia. It is registered for 62 people. On the day of inspection there were 56 people living in the service. The service is divided up into three separate units, on the ground and first floor. The building is modern and lends itself to the needs of the people using the service.

At our inspection on 27 November, 3, 5 and 19 December 2018. We found three repeated breaches of regulation including insufficient deployment and skill mix of staff, poor oversight and governance and poor risk management. We identified three further breaches in relation to the care people received which was not

person-centred care and found there was poor oversight of complaints and poor oversight of people dietary and hydration needs.

Management oversight of the service was shared between the service manager, interim manager and regional manager. The clinical lead was in post Monday to Friday and had oversight of the clinical care. Registered nurses led the nursing dementia floor and the nursing unit. The service was almost fully recruited to all staffing positions. Despite this we found there was poor oversight on shift with insufficient deployment of staff at busier times of the day and care being compromised at these times. Not all staff had the necessary skills or training for the job they were expected to do. Staff supervision and personal development was improving but not yet firmly established. On the 5 December 2018 the service manager became the acting manager for the service until a permanent manager could be appointed. They told us they would apply to CQC for registration and being in this post would provide the service with some stability, oversight and continuity. We visited the service again on the 19 December 2018 and were assured that some improvements had been made and a permanent manager had been appointed.

We found the care provided to people focussed mainly on their physical care needs and holistic assessments were not carried out to consider people's preferences and well -being. Care plans and the observed care did not match people's preferences and preferred routines. Activities were provided but peoples experiences of these were varied. Risks associated with people's care were poorly planned for.

Complaints and feedback about the service provided were not routinely collated or used to show how the service acted on people's feedback to improve the service. There was little evidence of audits which took into account observation as a way of judging the care being provided which is important when people might not be able to give verbal feedback. There was an over emphasis of using electronic monitoring as a way of assessing the impact of care.

The service had not had consistent management and this had resulted in a fragmented service without a clear vision or overview. Audits had not identified concerns that we had and were not consistent with CQC standard and regulation.

We found because of staff deployment people were not always adequately supported to eat and drink enough for their needs and people were at risk of not having their health care needs met.

Staff knew how to safeguard people and were not afraid to report concerns. Staffing continuity had improved which meant staff were mostly familiar with people's needs. We did find some information in care records which was out of date and not sufficiently informative.

Staff had enough knowledge of the Mental Capacity Act and were able to support people lawfully and gained consent before carrying out care tasks. Best interest decisions were not always recorded.

Staff recruitment practices were sufficient but we have made a recommendation.

Staff were sufficiently trained in administering medicines and we were assured people received this safely.

The environment was purpose built and suitable for its intended purpose. It was well maintained and clean and risks were reduced because of it.

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 yet safe.

The staffing levels for the service did not match the needs of people using the service. There was insufficient deployment of staff and staff did not yet have the right levels of skills and training.

Risks to people's safety were largely mitigated by regular care interventions but not all records were up to date and risks were not always anticipated. Staff knew how to safeguard people in their care.

There were safe systems to ensure people received their medicines.

Staff recruitment practices were satisfactory.

Is the service effective?

Requires Improvement

The service was not yet effective.

Staff training and development had been poor but was an improving picture. We were not yet confident that staff had the right level of support, training and supervision.

People enjoyed the food but there was insufficient oversight of people's dietary needs or encouragement to eat and drink enough for their needs.

People's health care needs were largely met but there had been some recent omissions in care.

Staff understood how to support people lawfully and support them to make decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and felt able to raise concerns about poor care so

these could be addressed. However, there was insufficient oversight of people's care needs and poor management response to concerns.

People were supported with their personal care needs but there was less focus on meeting people's emotional well- being. Staff spoke with people throughout the day but did not have sufficient time to engage for any time.

People had some input into their care but were not consulted about wider issues affecting the service.

Is the service responsive?

Requires Improvement

The service was not responsive.

The level of activity provision did not reflect people's individual needs or preferences. The service was unable to demonstrate how they supported people to live well.

A holistic assessment was not carried out for each person and care plans did not clearly reflect people preferences and routines.

Complaints and feedback from people was not effectively collated or used to show improvements the service intended to make.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have clear leadership and management oversight.

The quality assurance systems were poorly developed and there was little opportunity for people to feed back their experiences.

Staff development and training had not been robust although this area was improving. Staff however did not feel adequately supported.

There was poor engagement with the community and other stakeholders.

Downham Grange

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 was prompted in part by notifications of incidents which caused us concern. As these were still open to the safeguarding team we did not look at them specifically. The notifications have since been closed.

This inspection took place over one full day and two half days and was unannounced for two of the three visits .They included 27 November, 3 and 5 December 2018. We also carried out an additional inspection visit on the 19 December 2018 to follow up on actions taken by the service since the first day of inspection. The inspection was undertaken by two inspectors and two experts 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. Before the inspection we reviewed information already known about this service including previous reports, action plans, and notifications which are important events the service is required to notify us of. We did not receive a provider information return. 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. We brought the inspection forward so this form was not requested ahead of the inspection. We also spoke with the Local Authority and safeguarding team.

As part of our inspection we observed the care provided across the day. We spoke with the clinical lead, the three senior managers, two nurses, five carers, the activity staff, the maintenance staff, the cook and a domestic. We spoke with 15 people using the service and 15 visiting relatives and friends. We looked at five care records, three staff files and other records relating to the management of the business.

Requires Improvement

Is the service safe?

Our findings

At our last focused inspection visit to this service on 9 July 2018 we found two regulatory breaches for this key question. A breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities 2014) – Staffing. There was also a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities 2014) - Safe care and treatment. We had concerns that people did not always receive their medicines as intended and staff were not sufficiently deployed to ensure people's needs were met in a timely way. We also found risks to people's safety were not always managed well.

At our most recent inspection on 27 November 2018 we still had concerns about staffing levels, the skills mix and the deployment of staff across the different units particularly at busier times of the day.

There were not always enough staff to meet people's identified needs and ensure people received timely care which took into account their needs, safety and care preferences. There were concerns about staffing levels. One relative told us, "I feel there aren't enough staff. It can take two of them 30 to 40 minutes to help with washing and toileting. They should check pads every four hours and I don't think they check and change [our relatives] pads often enough because we often find them wet. When we point things out they do it." Another relative said, "Their (family members) bed could be wet at breakfast and it can be not until 10.30am that they are changed. They need more carers, but when you talk to them about it they say there's more than enough staff."

Staff raised concern about staffing levels both at night and during times of the day. They also said they could not rely on additional support at busy times of the day such as lunch time. Staff said staff sickness affected the service and said they sometimes managed with less staff and this affected the care they could provide.

The senior management team said they had dealt with poor performing staff and changed staff working patterns. They said they had recently increased staffing levels to ensure they had the right numbers of staff but we were not assured this was sufficient to people's needs. Relatives told us about recent changes. One said, "They've lost some people, (staff) and it takes time to get to know the residents. Bells are always going and I think they're stressed and that's why some have left. If they had more staff they could spend more time with people who need it." Another said, "The staff are excellent, but they're asking too much of them. They've got rid of the poor ones, but now they need more for personal care. They're run off their feet and stressed."

We observed poor staff engagement with people. Contact with staff was regular but minimal. Activity staff tried hard to engage people, but did not have enough resources to meet the needs of 56 people. Activities were planned seven days a week with two staff employed with adverts for a third. We were advised that one of the activity staff was working their notice. There were times when activity hours overlapped increasing their capacity to provide activities.

Staff were caring in their approach but it took all morning to assist people with their morning routines. Whilst staff were supporting people with personal care this significantly reduced the availability of staff on

the floor. Staff were busy and meeting competing demands. When staff were administering medicines, they were frequently interrupted by other staff. At lunch time there were no extra support for care staff on some units. This resulted in some people not receiving support or encouragement to eat their meal and we observed people walking off leaving food barely touched. This put people at risk of unintentional weight loss. We also observed people frequently calling out with minimal attention from staff. Up until and after lunch time some people had not engaged in any planned or spontaneous activity. At these times staff said they did not have time to spend with people and encourage them with their routines.

This constitutes a repeated breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety was not consistently managed. Most people spoken with felt safe at the service and well supported by staff but we saw instances where people could not access their call bells. There were risks assessments to determine if a person could use their call bell but not clear actions staff should take if they could not. Call bells were answered promptly but one person had to wait nine minutes which is much longer than the service sets for staff to respond. There were no call bells in communal areas and people said if staff were not in the vicinity they would need to shout. This increased the risk to people's general safety.

A number of incidents had occurred at the service which had put people at risk of harm or worsening health. These had not been identified early enough by staff so effective steps could be taken to reduce the risk. Two people had potentially suffered harm because of it. These were being investigated by the safeguarding team. Another incident had occurred and a person was put under close supervision. It was not until a further incident occurred that the service then considered the use of assisted technology to manage the risk.

Staff were dealing with difficult situations between people they were supporting. We identified some potential risks. Interactions between some people was volatile and staff reported some people striking out or throwing objects which could cause injury. Staff were concerned that there was nothing in place to deal with these situations. There was poor guidance in place for staff to help them manage situations and reduce people's anxiety. Not all staff were confident that there was a consistent staff approach to emerging risks. Staff had received generic training in dementia care but this was not sufficient. Enhanced training had been planned and was ongoing when we arrived at the service on 5 December 2018.

During our subsequent visits to the service senior management could not access the information we asked for to check the status of safeguarding concerns, incidents, accidents and any patterns in people's falls. They told us that since the departure of the manager no one had trained the clinical lead to use the computerised system where this information was logged. The clinical lead had since received training and showed us information requested. Actions had been taken following accidents/incidents but no lessons learnt or trends identified as part of the overall governance process. There were some missed weights and we could not see an accurate picture of the risks associated with unplanned weight loss. A number of people had an unhealthy body mass index. There was no guidance in place for this.

Several people had acquired pressure ulcers at the service. We asked for a root cause analysis to help us understand why these occurred and if they could have been prevented and lessons learnt. We saw some information in respect to this which referred to a number of omissions of care and how this would be addressed in a non-blame, supportive culture.

Care records were generic in their format and were electronically stored. Staff were able to keep a contemporaneous record of how they were meeting a person's needs and any flagged risk staff needed to be aware of. For example, if a person was at risk of dehydration or had poor skin integrity. Records gave

insufficient detail of how the risks identified were being managed. For example, one person was described as able to eat independently and have a normal diet. Their weight record was not completely up to date but showed recent weight loss. Records stated monitor dietary intake with monthly weights. It did not consider a heightened risk and change in appetite. We observed this person being left with food over two mealtimes. They ate and drank very little. The person received minimal support to eat and drink. Their 'diet' described as 'normal' made no reference to requiring supplement to add calories. They were prone to urinary tract infections. There was no guidance in place so staff might identify when the person had an infection. Their obvious distress at times of the day was described as 'usual' behaviour for them so there was a tendency not to respond to them. On our feedback their record was updated.

Documentation was not always complete so we could not assess fully what people's health care needs were or how they would be met. For example, oral health risk assessments were in place and staff confirmed they supported people with their oral health. A record viewed stated the person had some of their own teeth but the form indicated that they did not know who their dentist was or when they last had dental treatment. This meant they could not assess if the person was in pain or had any irregularities or oral health problems. There was no plan to address this.

This constitutes a repeated breach of regulation 12 of The Health and Social Care Act 2008, (Regulated Activities 2014.)

Staff told us they received training in health and safety and were aware of infection control and fire procedures. They said there were regular fire evacuation drills and people had individual fire risk assessments. The individual fire risk assessments were held electronically and there were copies in the reception area as part of the evacuation plan. This was not known by all staff and we found one individual risk assessment for fire incorrect. This was fed back at the time of inspection and the record was updated. The service was designed around the needs of people and helped them stay as safe as possible. For example, fire doors prevented the spread of fire for up to thirty minutes and the home had an internal sprinkler system. The maintenance person carried out regular checks on people's rooms and electrical equipment used for personal use and equipment such as bedrails and hoists.

At our most recent inspection we found people were receiving their medicines as intended. One relative told us, "Tablets are always on time and they had their flu jab today as well.' A person told us, "The care is good, the nurse stays while I take my tablets. "

The service used a bio dose total medication management system which meant medicines were pre-dispensed from the pharmacist in individually sealed pods and these were scanned when administered. They already contained information about the drug being administered. When used correctly it can significantly reduce the risk of errors. We found during this inspection the system was working well because staff had received medication training and competency checks to ensure they had the necessary skills and ability to give medicines safety. This task was carried out by registered nurses and team leaders.

Medicines were kept securely in locked cupboards and staff administrating medicines made sure the medicine trolleys were kept locked when not in use. Nurses described the appropriate process when administering medicines and we observed people being given medicines safely and according to the prescriber's instructions. Weekly medicines audits were undertaken to help ensure there were no discrepancies in administering of medicines. We checked a sample of medicines on the nursing floor only and did not identify any discrepancies. Medicines were stored according to manufacturer's instruction at the right temperature which was checked daily.

We noted staff were not wearing tabards with 'do not disturb' when administering medicines and this was something raised at the last inspection. Staff were being interrupted when giving medicines which could increase the risk of errors.

There had been one recent medication error where a discrepancy of a controlled drug was noted with no ill effect to the person. We were concerned that although this was reported internally and noted the GP had not been contacted for advice. This was fed back to the nurse.

The service was sufficiently clean and free from unpleasant odours. The domestic team appeared well organised and worked under the guidance of the housekeeper. Domestic staff worked over seven days and there were usually three staff, one on each unit. Staff did say this could vary with reduced numbers at times particularly at the weekend. Long term sickness was not covered. Domestic staff reported having the equipment they needed and described clearly how they minimised the spread of infection. There were audits and checklists demonstrating what cleaning was undertaken including daily schedules and more intense cleaning schedules.

People were safeguarded from abuse as far as reasonably possible because staff were adequately trained and able to recognise any possible abuse. The staff spoken with felt able to raise concerns and some had raised concerns and were fully aware of how to go about it and the different agencies they might refer to. Staff could describe what might constitute abuse and how they should respond to keep people safe. Safeguarding referrals were made as appropriate. A recent concern was made where a staff member had not behaved appropriately and this was subject to an investigation. Concerns have been raised by the Local Authority about the internal investigation not being available on request.

Recruitment processes were not sufficiently robust and we recommend the provider ensure all staff records contain relevant and pertinent information. For example, ensure an interview record for each candidate is on file and information collated such as a health declaration is only sought when relevant to the job applied for.

Staff records showed that staff were only employed when certain necessary checks had been carried out to ensure staff were suitable for employment. An employment record with work history was sought. References were requested from the last employee and a personal reference. The employer also asked for a disclosure and barring service (DBS) check which was in place before employment. Any disclosures made by the candidate would be discussed at the time of the job interview as in some circumstances this would make the person unsuitable for employment. There was proof of the persons identification and address.

We noted the service regularly employed agency staff and the service held details of their name and whether recruitment processes had been followed by the agency in respect to references and DBS check. The sheet also said whether staff had completed mandatory training essential to their role.

Requires Improvement

Is the service effective?

Our findings

This key question was not looked at as part of the last focussed inspection. We last looked at this key question during the inspection on 23 and 30 January 2017. It was rated good after that inspection but we have changed the rating at this inspection to requires improvement.

Staff did not feel that they had the necessary skills and access to training to help them be effective at work. Some staff reported working well as a team but were not confident in all staff's ability. Staff gave the example of a recent confrontation where staff were not comfortable managing and deescalating the situation. The clinical lead since coming into post has worked hard to provide additional training to upskill the staff team. The service had set strict timescales for all staff to complete training considered to be mandatory. Most training was provided on-line with some staff completing this at home. The management team stated staff got paid for training but not all staff spoken with were clear this was the case. Training sessions had been identified and booked on various subjects over the coming weeks. This included: continence care, dementia & distress behaviours, wound care, infection control, continence, dysphagia, and end of life care. Some of this training had been an agreed action after recent safeguarding concerns. Multiple training sessions were provided to ensure staff had the opportunity to attend. Training included developing staff to provide their own training in-house- i.e. 'train the trainer courses'.

Training records showed statistics had improved but it was still an area which required some improvement to help install greater confidence in the work force.

Some staff were named as champions and a link person for key areas of practice such as dementia care and infection control. The clinical lead said appropriate training was booked to support them in their lead roles. They said they met quarterly with other staff from homes within the group with shared lead roles. The lead roles were all allocated to staff holding a nursing position or management role. We could not see how this knowledge was shared with all staff as staff meetings were not held frequently or well attended.

Training records showed statistics had improved but it was still an area which required some improvement to help install greater confidence in the work force.

Staff received support for their role and staff told us the clinical lead made themselves available. There was evidence that supervisions were being brought up to date with 95% of staff having had a supervision recently which included direct observation of their practice. The clinical lead told us they completed all staff supervisions. They told us heads of departments and nursing staff would take on the role and supervisions would be shared out. They were confident with a new interim manager coming into place they would be able to continue to adequately support staff.

Some staff we spoke with told us they had not had regular formal support since coming into their role. Some staff described supervision as a bit 'hit and miss and delayed because of staffing issues.

We did not look specifically at induction for new staff but were told staff had a standardised twelve- week

induction programme and opportunity to work alongside experienced staff until confident in their role. Probationary interviews had not always occurred within this period.

People's needs were not consistently met in relation to their hydration and dietary requirements. We observed lunch on the first day of our inspection on all three units. People's experience was variable with people who required the most support not receiving it in a timely way. Additional staff such as the cook and activity staff were said to help where they could but this was not what we observed on the day of our inspection. On the dementia unit we noted most people ate in the lounge area sitting in the chair they had been sitting in all morning with an occasional table in front of them. Several people sat at tables which were nicely laid but no condiments, sauces or salt and pepper were accessible to people on this and the residential unit. Staff did not sit with people unless they needed assistance. If staff sat with people this might have encouraged people to eat more and see meal times as a social occasion.

Everyone was given the same portion size which did not consider people's preferences in the amount they liked to eat. Some of the food on the menu ran out and people were not offered seconds. Where people left food, their plates were taken away and they were not offered an alternative other than pudding. When people finished their meals, they left the table with little or no staff intervention.

The food was served in a timely way and served hot. People were generally complimentary about the food. There were several dietary choices and staff knew people's preferences. One relative told us the food options had reduced from three to two options and there was not a vegetarian option other than jacket potatoes, salad etc. On the menu was cod in parsley sauce or lamb moussaka. Several people had concerns about the choices available. One person said, "I'm fed up with just soup or sandwiches for tea, sometimes I just have a bag of crisps. Another said, "I live on jacket potatoes, I don't like the choices. "We asked the cook how people were able to influence the menu and they produced a book where people could give feedback but there were no recent entries. Resident meetings were not held frequently and we saw no discussion about food or menus. Meal time observations were carried out but these focussed on the layout of the dining room and how the tables were set rather than considering people's preferences and experiences.

There were details for each person of any dietary preferences or allergies. We spoke with catering staff who did not have an up to date list of people's dietary needs, allergies or food preferences which could result in food being prepared which might be unsafe for people and had not considered allergies people might have. Catering staff did not have a current list of people with unintentional weight loss and relied on care staff to tell them. They said they added calories to some foods such as porridge and made homemade smoothies. We asked about finger foods particularly for people who did not regularly eat a main meal. We were told crisps, biscuits and cakes were available. This was not an adequate substitute for a main meal and we did not observe people being offered regular snacks instead of meals which might be more appropriate to their needs.

Records were kept of what people had eaten and drank through the day. This included a record of when fluids were offered. Information varied making it difficult to analyse such as 'ate most', 'ate very little' without stating the actual amount. We asked senior management if they could get a monthly view of people's weights unit by unit as a comparison but senior management were unable to provide this information. This was later provided but meant data was not easily retrievable or regularly analysed.

This constitutes a breach of regulation 14 of The Health and Social Care Act 2008, (Regulated Activities 2014.)

People's health care needs were recorded as part of the persons plan of care. Information provided was limited but included any physical illness or poor mental health or cognitive impairment. Care plans were

computerised and if any care need changed or was missed by staff this would be flagged on the computer. This meant retrospective action could be taken. It was not clear this always happened or what the impact was of missed care interventions.

Staff reported there was enough continence pads which we asked because of a recent concern raised. We did not see full continence assessments for people and there was no detail of the type and size of pad which is important to avoid urine leakage which could cause sore skin.

Staff raised concern about the availability of hoists which did not take into account everyone's needs, with some people having to wait for an available hoist.

People had a summary of their needs in their 'hospital pack' with key information about them. This would enable someone who was not familiar with their needs to be able to provide basic care. Most people spoken with felt their health care needs were met and staff were responsive to them. The clinical lead had contacted a number of professionals to help support staff and ensure their training needs could be met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS)

People had been assessed and where there was a need to, the service had applied to the Local Authority for a DoLS authorisation. People were supported in the least restrictive way and the environment lent itself to people's needs. At least one person was inclined to leave the service when it would be unsafe for them to do so. Staff advised us of this when we arrived and had requested a DoLS for this person. Staff supported them to access the gardens.

Staff spoken with had a reasonable knowledge of legislation relating to MCA and DoLS. Staff said they always asked people if they wanted to get up and asked people's consent before providing care. Some people had power of attorney for care and welfare. This was recorded in people's records. We were unable to see best interest decisions recorded for specific decisions which could impact on people's experience of care. For example, some people had moved bedroom to help increase their safety. It was documented that families had consented to this but there was not a clear record of this or clear rationale for doing so.

The environment was purpose built and fit for purpose. We noted each unit was clean with no obvious odours. The service was nicely laid out with generous communal space and access to an enclosed courtyard garden. There were shrubs and raised flower beds. Bedrooms were sufficiently personalised and people had their own doorbell or door knocker. Some people had their name on the door and some had personalised information about their needs. Doors were colour coded to help people distinguish between their bedroom and toilet/bathroom door. The entrance doors and doors between the three units were key pad controlled. Corridors were wide with hand rails on both sides and were uncluttered.

The service had a reminiscence room set out in 1940's style and there were games and things to help stimulate people and stop them becoming bored.

Requires Improvement

Is the service caring?

Our findings

At the last comprehensive inspection of this service this key question was rated as good. At our latest inspection we have rated this key question as requires improvement.

The service did not take sufficient account of how people wished to receive their care and they were not consulted about the wider aspects of the service. Staff felt pressurised at times and not always able to spend sufficient amounts of time with people which would have enhanced their care and wellbeing. There was poor engagement with no volunteers and no additional staff at busier times of the day which might help to ease the situation.

Staff tended to work on set units which helped them provide continuity of care. Staff were attentive to people's needs but this was variable because staff were busy. We had some concern about the level of inactivity and engagement for some people who required more support to join in a planned activity.

Staff raised concern about recent changes to the service which they said did not reflect the needs of individuals using the service. For example, new crockery replaced people's own mugs and staff said people were no longer permitted in the kitchen which with the right support would enhance their experiences. Staff reported changes to the service were not effectively communicated and there was an obvious lack of consultation with people using the service.

People's care plans recorded people's cultural needs and anything staff should consider when providing care including peoples' wishes around gender specific care. Information was in place about people's sexual needs and preferences but the information did not consider risks associated with people's behaviours.

People were well dressed which gave us confidence that staff met people's personal care needs. People had personal effects with them and were dressed warmly with appropriate foot wear. Staff said they offered showers or baths and this was not done in a prescriptive way but around people's preferences. People had access to a regular hairdressing service based on site. In addition, people had their nails done and staff said they supported people with their oral health.

People were supported mostly by staff who were familiar to them and demonstrated good interpersonal skills. People spoken with said that staff were hard working, friendly and caring. People told us staff were respectful of their dignity and privacy and most were happy in the home. Staff knew people's names and we observed friendly interaction which was not over familiar. Staff were observed always knocking on doors before entering people's rooms.

One person said, "It's a very good place. We're well looked after." Another said, "They come when I need them and I'm quite happy." A relative told us, "We have absolutely no complaints with the staff; they're very kind, very obliging and very caring."

We saw attempts from staff to gain people's consent and offer choices in a way which was meaningful to the

person. For example, staff offered people a choice of drinks by showing them the options and asking them to choose. We noted at lunch time staff gave people their menu choice which was chosen earlier in the day but did not show people a choice of the plated options. This might be a more appropriate way of promoting their choice.

People's independence was promoted but this was not consistent across the service. For example We observed staff supporting some people to eat independently in a way that suited them best, using adapted cutlery, and or plate guards when needed. We however observed some people not receiving any support which might of have encouraged them to eat. We observed people being supported with their mobility and encouraged to walk using aids when necessary.. We saw staff patiently supporting people and taking their time to ensure people had all they needed. We saw good moving and handling practices which supported people effectively with good communication about what was going to happen next.

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection on 23 and 30 January 2017 we rated this key question as requires improvement as we found further improvements were needed in the provision of activities as well as ensuring people's choices were always promoted.

At this inspection we found improvements were still required. The service did not always respond to people's needs in a timely way or provide holistic care. We had concerns that not everyone was getting their needs fully met. We have reached this conclusion from recent incidents within the service and feedback and observation of staff practice.

The level of activity available to people to enhance their emotional well-being was insufficient. This was despite the efforts of designated activity staff. This was a big home with ground floor and first floor accommodation. Activities were not planned each day for each unit and there was reliance on staff taking people to join an activity. Some people felt isolated within the service and were not always aware of what was going on so they could choose whether to participate. Group activities were not suitable for everyone and activities were not designed around people's specific needs and interests. This resulted in people having a differential experience of care.

Some improvements necessary had already been identified by the service. For example, the Introduction of a photograph board subject to consent being in place, issuing a weekly activity sheet to each room so people who spent most of their time in their rooms were aware of what was happening. At the time of the inspection there was a weekly activity board in the communal areas and people were not given an activity schedule or notice of forthcoming events such as resident meetings. This disadvantaged people who were less mobile. One person who spent most of their time in their room said, "On Saturday there were lots of people in the corridor outside my room and I didn't know what was going on." They said they were not told there was a fete and was not asked if they wanted to join in.

On the first day of our inspection there was a pet for therapy dog visiting the service and some people were playing board games but little else. Staff said they had more time in the afternoon and told us recently they had entertainers come in and at the weekend they had a fete with money raised shared between themselves and pets for therapy. A staff member told us how they came in on their day off and took a few people out for coffee. They commented on how much people had enjoyed this and how they wished this was a regular occurrence.

Care plans recorded little in the way of regular activity for some people particularly for people in their rooms. We case tracked one person who spent most of the day in their room and it was not clear if this was their choice. They did not have a radio or television on or anything to engage with. They told us they enjoyed watching other people and sitting in the lounge but this did not happen on the day of inspection. For another person we noted their door was shut for most of the day. Their care plan stated that they preferred to spend time in their room and liked their own company. Their preference was to join in activities in a small group. There was no evidence that this happened regularly. Staff told us they spent all their time in their

room so this did not reflect what their care plan said.

Care plans were not based on a holistic assessment of people's needs which clearly considered their needs, preferences and preferred routines. From the care plans reviewed we found some information which did not reflect the current needs of the person. This could result in the wrong care being provided. There were some important omissions in care plans particularly around managing people's distress or how staff should intervene in any given situation. We were unable to see reasons for people's distress or what strategies staff could use to support people. For example, one person was said to get distressed when receiving personal care but the service had not attempted to establish why or what the persons routines had been in the past. Assessments of people's needs relied on limited information which did not give sufficient information for staff to follow to ensure the persons needs could be fully met. For example, where a person was incontinent and required incontinence pads the size of pad was not recorded or if the person had a recent continence assessment. Ill-fitting or wrong size pads could increase the risk of pressure ulcers. There was no guidance for staff about urine infections and how to identify possible signs of this, where people were prone. Care plans did not give a clear oversight of how the person liked to receive their care and anything pertinent to their needs, including the level of support and assistance they needed to promote their independence and wellbeing. For example, records would say no assistance needed or assistance needed without giving sufficient detail so this was open to interpretation.

The computerised system when used correctly was efficient, but not very personalised. Daily entries tended to be brief, with common phrases being quick and easy to insert. This enabled efficiency in recording but meant the information did not give a detailed picture of the person's day and how their needs were met in a holistic way in line with their care plan. We also noted the records did not accurately reflect the care provided at the time of delivery. Staff recorded the care provided as and when they could so the time against each care task was not necessarily accurate.

Care was mostly seen to be delivered in line with the person's care plan, with any omissions clearly flagged on the electronic record so that these could be picked up by nurses or shift leaders. There was a risk that, when busy, staff could overlook the concerns highlighted on the system about unmet care needs. Nurses led the floor on the upstairs nursing unit and the ground floor nursing/dementia unit, a team leader oversaw the residential unit. They had responsibility for ensuring people's care plans were up to date. They told us they did not get clear time off shift to do this and had competing priorities. Staff delivering the care were not clearly involved in the review of people's needs.

One person was identified as approaching the end of their life and the service said they established people's wishes regarding this. For the care plans seen we did not see any meaningful engagement about people's wishes or forward planning to help prevent hospital admissions and ensure people received coordinated care. The clinical lead told us they had contacted the palliative care team and were in the process of rolling out end of life training to all its staff over a number of sessions.

This constitutes a breach of regulation 9 of The Health and Social Care Act 2008, (Regulated Activities 2014.)

The arrangements for managing people's complaints were not sufficiently robust. We saw a number of complaints which had been responded to by different members of the management team. People had access to the complaints procedure but there was poor engagement with people about their overall experience of care. There was no management oversight of how many complaints had been received in the last six months as they had not been put on to the electronic record but dealt with manually. We spoke with some families who had concerns about the care but had not made a formal complaint. We spoke with other families who had escalating concerns which they felt had not been responded to in an efficient, timely

manner. One relative told us they had raised concerns which were not acted upon and they had a variable management approach to their concerns. Another relative felt their responsiveness could be better. They said for example, their family member did not need help to wash and dress but does have short term memory problems. They said the carer will ask if they want help to wash and they would say no but then forget to wash. The relative said the carers do not check on them and gave another example of dirty clothes not being taken away resulting in them wearing them for a number of days. The family member said they had spoken to the manager about these points but improvements were short lived. One relative said they had raised a concern and this was dealt with straight away but another relative said, "They've got temporary management. You can talk to them, but things don't get done or at least you don't get any feedback on what you've raised with them. We had a residents meeting about three months or so ago when they said that they were going to start having spot checks by management at night and having management in at weekends and other things, but none of that has happened."

We asked about night audits and although this is something the provider said they do, no night audits had been completed at the service. In addition, resident/relative meetings hadn't taken place for more than three months so issues identified had not been followed up or feedback to people about how things were actioned.

This constitutes a repeated breach of regulation 16 of The Health and Social Care Act 2008, (Regulated Activities.)

Inadequate

Is the service well-led?

Our findings

At our last inspection on 9 July 2018 we rated this key question as requires improvement with a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance. We found there had been no long- term stability with regular changes in the management team. This had resulted in poor investment in staff, in terms of training and development and a lack of clear leadership and organisation on shifts.

There was a lack of personalisation of care records and the care was functional and task focused. We did however recognise that care staff were kind and caring and recognised they could not always give the care they would wish to give because staffing levels were not sufficient to meet people's needs.

At our recent inspection on 27 November 2018 we had ongoing concerns about the safety and stability of the service and saw insufficient progress had been made towards the action plan. We have rated this key question as inadequate with a repeated breach of regulation 17. There was a disconnect between the management and the staff with insufficient opportunity for care staff to influence the care they were delivering. For example, none of the care or ancillary staff had lead roles(Champions), care staff did not update care plans, this was done by the nurse or team leaders without evidence of other staff being involved. Staff said they had not been adequately consulted about changes in their working patterns or had consideration given to their individual circumstances. Changes in staff working pattern resulted in some staff including long standing staff leaving. We asked the provider for evidence that staff had been consulted about changes to their working conditions and they were unable to provide this.

Prior to our recent inspection visit we were made aware that the manager had left and a new manager failed to start. This meant oversight of the service was provided by the clinical lead who was still in their probationary period. They received management support from three senior managers with varying knowledge of the service. Staff reported fragmentation and poor change management. Staff said each manager had a different approach and staff received conflicting information about what they should be doing. Some staff and relatives expressed a lack of confidence in the senior management team and reported a top down culture staff said they were not always spoken to well. Since the 5 December 2018 the service manager who knows this service well has applied to be the registered manager in the interim until a new manager starts. This has been working well and the service was showing signs of improvement as noted when we visited the service on 19 December 2018.

Relatives told us about the impact of not having a registered manager. One relative said, "There's no leadership, no organisation since all these management changes. The staff up here seem to be running around like headless chickens sometimes. They need a team leader in charge of each floor to organise the team." Another said, "When they appoint a new manager they need to be on the spot not staying in the office. Who sees what's going on and does something about it."

Staff told us that more recently people's care had been adversely affected and referred to some people not been getting repositioned as frequently as they should be to help prevent pressure ulcers. There were also

concerns about fluid levels for people, staffing levels and the level of activity. Staff spoke about an increase of the numbers of people using the service without an immediate increase in staff which they felt had a knock-on effect of the care they could provide. Staff said staffing levels had increased on some units but not all. Some people had been moved to different units according to their needs and identified risks.

Some staff felt staffing levels were now sufficient, whilst other staff felt they were really stretched and unable to provide safe, responsive care. Some staff who were working both days and nights said they felt a 'little stretched at night' resulting in nursing staff having to support care staff when they had their own duties to do.

Ancillary staff supported care staff when they could at busier times of the day but staff said this could not be relied upon. This meant people potentially had a differential care experience at different times of the day depending on the unit they lived in.

Some staff relatively new to their positions said they received little support when first employed. Some staff with specific roles had jobs they undertook which they were responsible for. Because of recent changes of management there was no clear overview of who did what and there were identified gaps in the care and support people received. For example, catering staff relied on nurses to update them on changes in people's dietary needs but there were very few clinical meetings and no head of department meeting to share information. The kitchen held information about people's dietary needs but this was not up to date, increasing the risk of people receiving the wrong diet. The maintenance role was undertaken by one person and historically records we checked had not been completed between the maintenance person leaving and the new person starting. It was not clear on a day to day basis what the management cover would be. The first port of call would be the clinical lead but this was not clearly communicated to visitors of the service.

We had received a number of notifications and safeguarding concerns about the care a number of people had received. This included people not being stimulated or occupied throughout the day which was reflected by our observations during inspection. There were also concerns about people not receiving the support to eat their meal which again is a concern we had during our recent inspection. We had concerns that care records did not reflect the care people had received.

We found as part of our recent inspection care plans were not sufficiently detailed. We were not clear how staff were delivering the care people needed according to their care plan. We found omissions of care such as missed repositioning increasing the likelihood of a person's skin breaking down. The computerised records system relied on staff checking the dashboard to see any flagged risks for a person such as low fluids. We had concerns that senior management were not able to interrogate the data or provide reasonable explanation as to the potential impact of missed care or the reasons for a change in need. Explanations were provided by the clinical lead who was more familiar with the computerised record but we had concerns that the computerised record was not being used to its full advantage because they were not sufficiently understood at all levels. For example, we saw from a weight graph a person had lost weight with no explanation as to why. They had since increased in weight with no explanation as to how this had been achieved. We also found the data being inputted did not reflect the actual care being provided as it did not support our observations. For example, entries of people's dietary intake said things like they ate 'most' or 'little' of their meal. We observed a number of people who ate nothing or very little and this was not clearly reflected. We saw that an over reliance on electronic records meant people's care was not observed often enough which would give a clearer overview of any shortfalls. For example, visual information would tell if people were warm enough, comfortable and lying on well fitted sheets.

In addition, we were unable to see effective monitoring of the service or how information was effectively

communicated to all staff and people using the service. For example, we asked how changes in the service were communicated to staff and were told emails were sent to staff and there were regular, monthly staff meetings. We asked for evidence of this and were given the minutes of two staff meetings in November and September 2018, with nothing planned before then and no future dates planned.

Relative and resident meetings had taken place but these were not frequent and future dates had not been scheduled. Feedback from these meetings for those unable or unwilling to attend was not provided. Engagement with people, stakeholders and staff was poor. We tried to establish what the providers quality assurance systems were which would help the service determine what they were doing well and where they needed to improve based on people's feedback. We were initially told there was a tablet in reception which could be accessed by visitors and taken round to people using the service to comment. The tablet was set up in a similar way to a CQC inspection where people could click on the five key questions and write their response. Feedback went directly to head office and enabled them to remotely monitor the service and generate actions for the service. When we asked what feedback had been received we were told that none had been received. The service had the technology but were not using it in the way it was intended. We asked about surveys and whether these were routinely used to capture feedback. The senior management said it was their intention to do this and had on the last day of our inspection appointed the service manager to oversee the service. They said they would be sending out surveys as a priority. No one in the senior management team could tell us when this had last been done for this service.

The service has a series of audits to help determine if it was safe and providing good outcomes for people using the service. A number of these were reviewed and included audits on care plans, medication, the environment, the cleanliness and the meal time experience. We commented that the dining room audit focussed on the environment rather than people's experiences and there was little evidence about how people were consulted and how their experiences informed the services action plan. This was even more apparent on the dementia unit where observations of care would provide a meaningful way of determining how effective the care was. Senior management told us they used the electronic records as a means of ensuring people were receiving the care they needed and could see any change of need or flagged risk. Senior staff told us they were present in the service and would do daily walk around to establish what was happening at any one time in the service. This was not recorded so we were unable to see how management responded to the needs of the service across the day.

The above supports a repeated breach of regulation 17 The Health and Social Care Act 2008, (Regulated Activities 2014.) Good governance.

Our concern about management oversight and changes within the senior management team was shared with the service. It was recognised that the service needed a registered manager to take the service forward and were in the process of interviewing for this role. An experienced service manager who knew the service well was stepping in as interim manager to provide some much-needed stability and direction to staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Generic assessments and care plans did not consider people's preferred routines and preferences and how they would like their care delivered. There was not sufficient activity and engagement for everyone living at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Generic assessments and care plans did not consider risks to people health and safety either because records were not up to date or gave insufficient information about how a risk should be managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Not all staff were familiar with people's dietary needs and people did not get the support they needed to eat and drink in sufficient quantities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was poorly managed with insufficient governance and quality assurance processes to help identify improvements required. It took insufficient account of

people's experiences and feedback in the way the service was provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff at times of the day to meet people's assessed needs in a timely way. Staff did not have the necessary training and support to help them effectively fulfil their role.