

# Kingsley Care Homes Limited

## Allonsfield House

### Inspection report

Church Farm  
Campsea Ashe  
Woodbridge  
Suffolk  
IP13 0PX

Tel: 01728747095  
Website: [www.kingsleyhealthcare.com](http://www.kingsleyhealthcare.com)






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### Ratings

Overall rating for this service

Requires Improvement 

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

# Summary of findings

## Overall summary

.This inspection took place on 2 October 2018 and was unannounced.

Allonsfield House is a care home without nursing that provides a service for up to 42 older people living with dementia and/or a physical disability. On the day of our inspection visit there were 31 people living in the service. 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

After the last inspection on 29 August and 4 September 2017, we asked the provider to take action to make improvements to staffing levels and their governance procedure and we have seen a degree of improvement at this inspection. However this has not been as timely as it should have been and we were unable to assess that this had been embedded and effective over time. This report shows areas for further development.

People told us they felt safe living in the service and when receiving care and support. Our previous inspection had found that improvements were needed in staffing levels. At this inspection we found that this had improved but in some instances, there were still not sufficient staff to support people in a personalised way and a peak times of need.

Care files included a range of risk assessments such as moving and handling, nutrition and continence. These were regularly reviewed and updated according to people's needs. However, we found that reporting of incidents was inconsistent which meant that risks to people were not being effectively monitored.

People were protected by the provider's recruitment processes. Safe recruitment practices were followed before new staff were employed to work with people. Required checks were made to ensure staff were of good character and suitable for their role.

People received effective health care and support. Medicines were stored and handled correctly and safely. There were infection control appropriate policies and procedures in place. The service was not always working within the Mental Capacity Act 2005 (MCA). Where people had Deprivation of Liberty Safeguard applications authorised by the relevant authority these were not kept under the review. We found one which had expired. There was a lack of understanding of the decision-making process using relevant legislation and guidance. We have made a recommendation referring the service to the guidance available on the MCA and the decision making process.

Some of the building interior decoration had become shabby and tired. Decoration in the unit which specialised in supporting those living with dementia was not always appropriate. This had been recognised and there were plans in place to improve these areas. However, there were no firm timescales in place to achieve these improvements. Internally the service was clean and hygienic.

There were two new activities co-ordinators in post with plans in place to improve the experience of people with more person-centred activities. However, these plans were still being developed with some people still feeling disengaged with activities.

A range of audits were carried out by managers in the service. Whilst the provider told us that these were used to drive improvement we found that they were not always effective in identifying and addressing deficiencies at an early stage and taking immediate action.

The service used an integrated electronic care planning system. This had been introduced prior to our last inspection and we found staff understanding of the system required improvement. At this inspection we found this had improved and staff recorded day to day activities on the system. However, there was still inconsistencies with how some information was put into the system.

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was not consistently safe.

There were appropriate assessments in place to support people where risks to health had been identified. However, these were not monitored effectively.

Staffing levels were determined according to people's needs.

Medicines were safely administered and accurately recorded. They were stored securely.

### Is the service effective?

Requires Improvement ●

The service was not consistently effective.

People's consent to care and treatment was sought prior to care being given, but knowledge of legislation and guidance needed to improve. Deprivation of Liberty Safeguard authorisations were not effectively monitored.

Staff completed an induction and training programme. Staff training was not up to date.

Staff received ongoing support and development through supervisions and appraisal.

The manager had plans to improve the environment but there was no timescale for implementation or completion.

People's health and nutritional needs were met.

### Is the service caring?

Good ●

The service was caring.

People felt staff were kind and caring.

A key worker system was being implemented to enable people to build relationships with staff.

Relatives felt welcomed into the service.

### Is the service responsive?

.The service was not consistently responsive.

Care plans did not always contain sufficient detail about the person of the care they required or all aspects of their life.

There were not always sufficient staff to meet people's presented needs at peak times.

The service was working toward improving activities and social engagement.

There was a complaints procedure in place which was followed when a complaint was made.

**Requires Improvement** ●

### Is the service well-led?

The service was not consistently well-led.

There had been four managers since our last inspection. This had caused concern in the staff team.

Staff did not always feel they were treated equitably.

Governance and performance management was not always timely and responsive..

The culture of the service was not always open and transparent with appropriate people being consulted.

**Requires Improvement** ●

# 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 2 October 2018 and was unannounced. It was carried out by two inspectors 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 had a background in adult social care.

Before the inspection we looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from stakeholders for example the local authority and members of the public.

A Provider Information Return was not requested from the service. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection visit we spoke with five care staff, the deputy manager, the manager, the service quality manager and the senior business manager. We spoke with eight people living in the service and four relatives. We observed interactions between people and care staff. We reviewed three people's care records, policies and procedures and records relating to the management of the service, training records and the recruitment records of three care staff.

Following the inspection, we received further information from the provider.

# Is the service safe?

## Our findings

Our previous inspection which took place on 29 August and 4 September 2017 found a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as there were not sufficient staff to provide safe care. At this inspection we have found that the service was no longer in breach of the regulation.

We asked the manager how they arrived at staffing levels. They told us that this was assessed using a staffing tool which was the same tool as was being used at our previous inspection. This tool used an assessment of people's care needs to arrive at a staffing level. They told us that they also carried out observations of the care provided to check staffing levels. The staff rota for the four weeks preceding our inspection showed that the assessed staffing level had been met on all but one occasion. The service was recruiting new staff. The manager told us that three new staff had been recruited but they were awaiting employment checks before they could start work. The service was using agency staff to cover some shifts. The manager told us that they were advertising for new staff to reduce agency use. They explained that to ensure people received consistent support the same agency staff were used.

The majority of people we spoke with did not think there were enough staff. One person said, "There is not enough staff if you need help." Another person said, "They certainly don't seem to have enough staff." However, some people did think there were sufficient with one relative saying, "Whenever I'm in here I see plenty of staff." Staff we spoke with told us that there were just enough staff. One member of staff said, "Staffing is just there. No room for error."

Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks. These help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Our previous inspection found that staff were struggling with the implementation of what was then a new computer system. At this inspection we found that the system was still not being operated to manage risks effectively. Staff were not clear of the different criteria for recording falls and accidents and incidents. For example, one person had had a number of falls in May and June 2018, some of these had been recorded on the computer care records, some had not. The falls that had been recorded on the computer care records had been recorded inconsistently with some being recorded as falls and others as incidents or accidents. The inconsistent recording of these falls meant that the risk to the person was not being effectively monitored and evaluated to ensure risks were mitigated. When we were checking the systems used to record this person's falls we found that not all staff were able to effectively access the computer system to check the person's records.

People's care files included a range of risk assessments in areas including falls, moving and handling, medicines, weight loss, nutritional needs, continence care, skin integrity and evacuation in case of emergency. People had individualised risk assessments on behaviours that may challenge and their medical conditions. These provided guidance to staff on how they should support people so that the risk to them could be minimised.

Each person had a personal evacuation plan in place which detailed how they would be supported to leave the building in case of an emergency.

People told us they felt safe living in the service and when receiving care and support. One person said, "I feel safe on the hoist, they know what they are doing." A relative said, "I do feel [relative] is safe because I am confident about the care staff on the floor." The service had a safeguarding policy and staff had undertaken safeguarding training to help them recognise and act on any concerns about people's safety. Staff understood their responsibilities to keep people safe and how to pass on concerns to the right agencies to protect people. Safeguarding and whistleblowing procedures were covered in staff induction procedures. We spoke with the manager and quality manager about a recent safeguarding where a person had left the service. They explained to us the actions they had put in place to ensure the situation was not repeated.

Medicines were managed and administered safely and as prescribed using a computerised system. A senior member of care staff demonstrated the system. There were clear ordering, checking and auditing procedures. This ensured that people's medicine administrations had been completed correctly. Staff who administered medicine had completed training on the safe handling of medicines and their competence to administer medicines was checked to ensure their practices were safe.

Our previous inspection had found that there was insufficient detail recorded to guide staff as to when people required their medicines which had been prescribed to be given as required (PRN). At this inspection records contained sufficient detail to ensure PRN medicines were given safely, consistently and when the person required them.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately. People's rooms and communal areas were clean and tidy. Good standards of hygiene had been maintained throughout the service and there were no unpleasant odours. A member of domestic staff we spoke with explained the cleaning procedures they undertook to ensure the service was cleaned effectively. However, we did note that in the car park adjacent to the building site there were black bin liners with kitchen waste on the floor and open to the elements. This could encourage rodents. Since the inspection the provider has told us that this occurred because of the failure of a contractor and is being resolved.



# Is the service effective?

## Our findings

Our inspection of 20 August and 4 September 2017 found that staff training was not up to date. At this inspection we found that improvements had been made but that not all staff had received the appropriate training. For example, 13 staff were not up to date with dementia training, 17 staff were not up to date with dignity and privacy training and 21 staff were not up to date with nutrition and hydration training. The manager told us, and the provider has confirmed that there is a training plan in place which will capture refresher training and any shortfalls.

Staff told us that they were supported to gain further qualifications in care. They also told us that they received regular support and supervision from the management team. Supervision enabled staff to discuss their practice and any development needs. This was confirmed by staff and the records we looked at. Staff completed an induction into the service before providing care. This included training in subjects such as moving and handling and a period shadowing more experienced care staff.

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 appropriate applications were being made to the local authority for DoLS authorities as required by the MCA. However, DoLS are granted for a fixed period of time. We found that one application that had been granted had expired. The manager was not aware of this. DoLS authorisations were not being effectively monitored. We spoke with the manager who told us they would make an application for the authorisation to be renewed.

There was a lack of understanding of consent to care and treatment being sought in line with legislation and guidance. Where relatives had the legal authority to make decisions for people the service was not always aware of the scope of authority held, for example if it was for care and welfare or for finance. In another person's care plan, we saw that one named person had a power of attorney over their finances. However, the care plan mentioned a different person that the service were consulting regarding their care and welfare. It was not clear if this person had the legal authority to make decisions.

We recommend that the service consider current guidance with regard to decision making and mental capacity.

Not all staff had received training in MCA and DoLS. However, we saw they gained people's consent before providing care and supported them to make choices in their daily lives. For example, asking where they wanted to sit in a room, what drink they would like, and when giving medicines. People were able to make their own decisions about how they wished to spend their time.

People had their needs assessed before moving into the service and care plans were put in place to meet their needs. These were regularly reviewed to ensure that they reflected people's changing needs. Care plans were recorded on a computer system, each member of care staff had a hand-held device from which they could access people's care plans and update the system with the care provided. For example, if the person had participated in an activity or been provided with personal care. The hand-held devices were also programmed to alert staff to people's individual needs. For example, if a person required regular re-positioning staff would be alerted by the device when this was required. The manager was able to monitor if this had been done from their computer.

The service had two dining rooms and we observed the lunchtime meal in both. In the Allonsfield Unit tables were laid with table cloths, napkins, condiments, flowers and wine glasses. Undiluted drinks were on the tables in small bottles, with jugs of water so they could be made to the person's preference. People were offered a choice of meal. We observed one person take a bite of their lunch, they then said they did not like it and were offered an alternative. Staff were attentive, cutting up food and assisting where required. People were offered second helpings if they wanted them.

In the dining room on the Ashfield Unit the room was equally well presented. One person said, "I liked my dinner, it was nice." Another person said, "You certainly cannot grumble about the food." People were offered a choice of meals with staff showing people plated meals so that they could choose. However, people did not always get the support they required with their meal on this unit. We observed one person spend most of the meal time asleep and another person left the dining room before the meal they had requested was brought in. Food was also not served in a way that supported people to remain as independent as possible. For example, we observed two people trying to eat their meal with their fingers. For one person this was fishcakes and for the other it was a chocolate brownie desert served with chocolate sauce. People living with dementia often benefit from bite sized food which can be eaten with their fingers as they may lose the ability to use cutlery.

People's individual dietary needs were assessed and recorded in their care plan. Where people required a special diet, this was provided. For example, we saw that there was a sugar free option of chocolate brownie for those living with diabetes. One person told us, "I do get a vegetarian option."

We received feedback from healthcare professionals about how the service worked with them. One described the staff as always helpful and stated that the service had improved in recent months. People told us they had regular contact with health care professionals such as GP, dentists, opticians and chiropodists when required. We saw the care files of people using the service included records of their appointments with healthcare professionals. One person told us, "I had a place on my leg. The doctor was called and they have looked after it extremely well so that it is nearly healed."

People had access to secure outdoor space. The manager told us that in the summer people had enjoyed accessing this. One person said, "I have a beautiful garden and double doors so I can get outside. I feed the birds. I'm very happy." The manager also showed us some raised beds which had recently been installed and told us that the activities person was working with people to choose the planting. There was an extension being built to the service and disruption to people living in the service had been kept to a minimum.

Internally the service is divided into two units. One unit, Allonsfield is housed in the older building some of which is thatched the second unit Ashefield is a new building. Access to both units is secured with a key pad. Ashefield being an old building has some quite narrow and stepped corridors. The manager told us that only people who had been assessed as independently mobile lived in rooms served by this corridor. Some of the decorations in this unit were shabby and in need of upgrading. The manager shared with us a report of a visit by the regional operations manager and the sales and marketing manager in September 2018 which detailed improvements required. Some of the improvements had been made but other work had been put on hold awaiting the completion of other works on the site.

Ashefield unit was a newer build. This unit supported people requiring more specialist dementia care. Some areas were very plain and lacked stimulation for people living with dementia. For example we observed one long corridor which was one colour with no visual stimulation to provide support for people to access important rooms such as their bedroom. We discussed this with the new manager who had recognised this and had ideas to improve the environment in mind. They told us how they were looking at decorating an area as a bus stop to meet the needs of one particular person. Also, how they planned to decorate an area as a laundry with suitable equipment. However, these ideas were very much in the planning stage and no firm timescales were in place.

# Is the service caring?

## Our findings

Our inspection of 20 August and 4 September 2017 found the service was not caring as people's dignity was not respected. This was because linen was old and discoloured and there was insufficient crockery. At this inspection we found that this had improved. Towels and other linen had been replaced and more crockery purchased. Records showed, and the manager confirmed, that these items could now be purchased when necessary.

People we spoke with all told us they felt well cared for and that staff were kind and caring. One person told us, "They are wonderful, they have a lot of work to do, they go the extra mile; if I want anything from the shop they will get it when they are off duty, an extra cup of tea, they are very helpful." Another person said, "They are all pretty good, they do their best to look after people. I have a shower every morning. I do my face and they shave me with an electric razor, they all do it. The staff are pretty good, one or two are real good mates to me."

People told us that they felt comfortable asking for support because staff always responded to them positively. We saw that people's requests for support were quickly responded to. One person told us, "They look after us well. They are very kind people here, the staff, if you don't feel very well they look after you." Another person said, "I can't see very well and they put things where I can easily get them." Throughout our inspection, we saw positive interactions between the staff and the people using the service. Staff responded to people in a calm and reassuring manner.

The service had recently introduced a key worker system. This was designed to improve communication between the person, their family and the service. The key worker would get to know the person, communicate with the person's family, if appropriate, and provide consistency when care reviews took place. This supported people to build relationships with staff.

People told us that staff respected their privacy and dignity. One person said, "When it comes to dignity they are very good, covering me, closing the door. I am never left feeling vulnerable. They give me a flannel, so I can do my face. I only have to ask for a bath or shower and I get one." However, during our inspection we did identify one interaction where a person was not treated with compassion when one member of staff gave them a napkin and said, "Have this, you will not keep it on but have it anyway." We brought this to the attention of the senior business manager.

The staff and management team understood the importance of confidentiality. People's records were kept securely and only shared with others as was necessary. This was in line with the new General Data Protection Regulations (GDPR). Access to the computerised records was password controlled.

People were able to see their visitors when they liked. A relative said, "We are always made welcome." During the inspection visit we observed relatives joining in with tea and cake.

## Is the service responsive?

### Our findings

Our inspection of 20 August and 4 September 2017 rated the service as Requires Improvement in this key question. This was because care plans did not contain sufficient information and there was a lack of social engagement. At this inspection we found improvements had been made but further improvement was required.

Prior to admission a pre-admission assessment was completed, to ensure the person's needs could be met and gather personalised information to assist in the care planning process. Care plans provided guidance to staff about the care and support people required. This included their likes, dislikes and preferences.

The electronic care plans had been improved since our previous inspection. They contained more detail about people's care needs. However, there was still room for further development. For example, one person had recently had a catheter fitted. They were concerned about the catheter and whether or not it was permanent. The care plan contained no information as to why the catheter was necessary. The care plan gave staff no instruction on how to manage the catheter safely for this individual.

For another person there was one line about their life history. This person displayed quite challenging behaviour on occasions. Some background information about this person would have helped staff better understand any reasons for this and develop positive strategies for supporting them. The care plan did not contain a positive behaviour plan to guide staff in techniques to distract, defuse and pre-empt challenging situations.

The service quality manager told us that deficiencies in the care plans had been identified at a mock CQC inspection prior to our inspection. They told us that actions to address this had been put in place. One of these was the implementation of the resident of the day which had been implemented at the beginning of September 2018 and was due to be reviewed at the end of October. When a person was resident of the day it was planned that more detail would be added to the care plan. We looked at the care plan of a person that had been resident of the day the day before our visit. We noted that despite having been reviewed as part of the resident of the day process this care plan contained inaccuracies and little detail about their life prior to moving to the service. Despite the electronic care plans showing dates of reviews it was clear that not all reviews had identified all of the areas which needed updating.

Not all aspects of people's lives were planned for because people's end of life wishes had not been recorded in their care plan. One person's care plan contained the statement 'To be advised'. A review had stated that a meeting needed to be arranged with the family but there was no details of if this had been done. Another person's care plan stated that this had not been discussed. Failure to give the person the opportunity to discuss their end of life preferences could mean they did not receive the support they may have wished with care at the end of their life. Staff informed us they had good links with end of life professionals and were able to speak about medicines prescribed for pain and symptom relief.

From observation during the inspection we saw that the majority of staff interactions with people were task

focussed and took place while staff were providing care and support. A relative said, "Staff are very good, they try their hardest. They do seem overworked and under staffed."

Whilst staffing levels met a safe minimum there was insufficient staff to provide individualised and personalised support to meet peoples presenting needs at peak times. At our previous inspection we observed that there were not enough staff to give people the support they required at meal time. At this inspection we observed the lunch time meal in both of the dining rooms. In one of the dining rooms we saw a calm and relaxed meal with people receiving the support they required. However, in the other dining room where people required more support there were not enough staff to provide personalised support for people to eat their meal. One person was offered support by three different members of staff over a period of 40 minutes. This was because each time a member of staff engaged with the person after a short time they were called away to a more pressing need. One of the members of staff stood over the person to cut up their meal before moving on to support somebody else. No member of staff had the time to sit down with the person and engage with them as they eat their meal. We observed staff sharing the lunchtime meal with people in the dining rooms and engaging people in conversation. We observed staff sitting at tables with people to eat a meal in the dining rooms. However, they did not sit at the table for the whole meal but came and went with little or no explanation to people sitting at the dining table with them.

The service employed two activities co-ordinators who worked in the service six days a week. During our inspection there was one co-ordinator. We observed they engaged with people and promoted discussion and interaction between people. For example, when sitting speaking with one person another person overheard and joined in the conversation. People told us that social engagement and activities in the service were improving. A relative said, "What [family member] likes best is attention, under the new management they have now started doing that." However, they went on to give an example of something they had put in place to support their relative but which was not being carried out by staff. Some people did not feel engaged or supported to follow their interests. One person said, "I read, I get bored there aren't any activities that interest me. I hope to get involved in the raised gardens, we'll see how it pans out. I used to play the piano, I do play the one here but it's a bit banged up." Another person said, "If I get bored I can get out of my chair and walk about."

The manager and activities co-ordinator told us how they planned to improve activities in the service. For example, they had plans to theme some areas in the corridors which were currently not decorated in a dementia friendly style. They planned one area as a bus stop, a post box and another as a laundry room. Large planters were under construction in the courtyard garden and the activities co-ordinator told us that they were working with people to decide on the planting for these.

Systems were in place to log, investigate and respond to complaints. Where issues had been identified action had been taken to resolve them. Information we had previously received from the service and relatives confirmed that people knew how to complain and any complaints were dealt with in line with this policy.

## Is the service well-led?

### Our findings

Our previous inspection which took place on 29 August and 4 September 2017 found a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because there was not an open and inclusive culture in the service and audits were not effective. Sufficient improvements had not been made.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager who was registered at the time of our last inspection had left. Since that manager left, the service had been managed by three different people, including the providers operations manager. The current manager was the fourth person to manage the service since December 2017. They had been in post for five weeks on the day of our inspection. They were receiving support from the provider's quality manager and regional operations manager, both were present on the day of our inspection.

The lack of consistent leadership meant that staff felt unsettled and did not feel they were treated equitably. Staff feedback was that they did not feel able to approach the management external to the care home such as head office with concerns. We are aware that the provider has processes in place for staff to approach the senior management team but at Allonsfield staff we spoke with did not feel empowered to do this. This lack of consistent leadership had also affected communication between staff and the management team with several issues identified to us as a concern by staff but which the management team told us has been resolved prior to our inspection.

The previous inspection found the culture of the service was not inclusive encouraging people to voice their views and experiences. At this inspection we found little improvement. A relative told us, "I haven't been introduced to the new manager. I don't even know if she knows who [relative] is. She certainly hasn't asked how [relative] is." Records showed there had been two residents and relatives meetings in 2018, one in February and one in May but these had been before the current manager was in post. The management team told us that they were planning a meeting in November to introduce the new manager who had begun work at the service in September 2018. The senior business manager explained that the provider sought electronic feedback by way of a tablet which was available in the service. However, this had not been being used in the period leading up to our inspection. Therefore we concluded that people, relatives were not consistently involved and informed about the running of the service.

Our previous inspection had found that staff were not competent in operating the electronic care planning system. At this inspection we found that staff knowledge and competency with the system had improved. Senior members of care staff were not always able to effectively navigate the system. The provider had not taken adequate action to address our previous concerns.

Our previous inspection identified that the service was reactive rather than pro-active in responding to

concerns and identifying areas for improvement. At this inspection we found that although there had been some progress, this was not timely and we could not identify that improvements were sustained. A mock CQC inspection had recently been carried out and areas for improvement identified with actions taken to address these. For example, the implementation of resident of the day where detail would be added to a person's care plan. Other audits were carried out by managers at various levels of the service. These included audits by the senior business manager, the quality manager and the manager. The operations director told us that these audits were reviewed by the head office team and any major issues addressed promptly. They also told us that there were monthly reviews with managers, the operations team, service quality team and these meetings were often attended by chief executive officer, human resources department, property team and marketing teams.

However, these audits had not been effective in identifying and addressing the issues found at this inspection. For example, the senior business manager's audit covered staff training. It had identified in June deficiencies in staff training levels. Our inspection three months later found concerns remained in this area. Neither had the quality assurance system identified the discrepancies in the reporting of accidents and incidents. The quality manager told us that two care plans were audited each month to check the quality and content. These audits had not identified or taken action with the concerns we had identified with care plans. For example, lack of detail regarding people's end of life care and people's life story. They also told us that two care plans were audited each month. With 31 people living in the service this meant that it was at least a year between each audit of the care plan.

At this inspection we found that the service continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received feedback from the district nurse team that supported the service. They were aware of the management changes in the service but told us the new manager and senior carers were receptive to their input and they were planning to have regular meetings with them to discuss care issues. Everybody living in the service received support from the same GP. They told us that the communication with Allonsfield was as they expected from a care home.



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  The quality assurance processes were not effective in identifying concerns.