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

This inspection was unannounced and took place on 11 July 2016.

During our inspection of the home in January 2016, we found that the provider was in breach of seven Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. These were in respect of sufficient staffing, safe care and treatment, treating people with dignity and respect, the need for consent, providing person centred care, statutory notifications and good governance.

At this inspection, although we found that some improvements had been made we found further and continued concerns. The provider is in breach of Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of this report.

Following the inspection in January 2016, the service sent us a plan to tell us about the actions they were going to take to meet the above regulations.

Downham Grange is a service that provides accommodation and care to a maximum of 62 older people, some of whom may be living with dementia. On the day of our inspection, there were 46 people living at the home.

There was 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.

We found that there were continuing issues regarding the governance and quality monitoring of the service. The provider's quality monitoring did not always identify shortfalls in the provision of care to people, and when it did, did not identify actions that needed to be taken. The registered manager did not have a full understanding of their responsibilities and had not always taken the required actions. We have told the provider that they need to make improvements in the way the service is led and monitored.

Medicines were not always managed safely. On the day of our inspection, there was an avoidable delay in people receiving their medicines on time. There was a lack of guidance about how medicines for occasional use, to assist people who were distressed or anxious were used.
Records of when people received their medicines were incomplete and the registered managers systems to check this was not effective. Peoples preferences about how they liked to take their medicines were not documented, and any allergies and sensitivity's to medicines were wrongly documented. There were numerical discrepancies of medicines and systems to account for them were not being used accurately.

Not all staff had completed training to support them in recognising and responding to suspicions that

people might be at risk of harm. However, most knew what was expected of them and how they should report any concerns. The registered manager did not always identify and take action to manage situations that placed people at risk.

Not all staff had received the training they needed in order to meet people's needs. Training that the provider had identified as mandatory had not been completed by all staff.

People did not always receive the care and support they needed to eat their meals in a pleasant and timely way. Staff did not always know what assistance people needed, or support people in an appropriate way.

People received support from staff who were mainly kind and caring. However, people were not always treated with dignity and respect because staff were task focussed and care took place in a manner that was hurried with little or no interaction.

Improvements had been made to identify peoples preferences about the way they wanted their care delivered. The way in which these were recorded and presented had also improved which meant staff found them easier to use. Interests, hobbies and backgrounds were not always taken into account. There was a lack of activities to meet people's preferences. People were bored, isolated and unstimulated.

People and their visitors knew who they needed to go to if they needed to make a complaint. However, most found approaching the manager to be difficult.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not managed in a way that promoted peoples safety and welfare.

Risks to people were not always identified, managed with actions taken to reduce them.

There were enough staff available to support people in a timely way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not completed the necessary training they required to support people effectively.

Staff did not always gain peoples consent before providing them with support.

People were not always supported to eat their meals in a way that promoted independence.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff interactions were kind and caring but there were times when care was task orientated and lacked care.

People's privacy was not always maintained by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that met their needs and preferences. People felt bored and unstimulated.

The provider had recently facilitated residents meetings at which

people could feedback their ideas or concerns. People knew how to complain

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of managerial oversight of the service as a whole, which meant that people did not receive a consistent safe and appropriate service.

Systems for monitoring, assessing and improving the quality and safety of the service were not operating effectively.

The provider and registered manager had failed to address some of the previous breaches in regulation identified at our last inspection.

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.

This inspection took place on 11 July 2016 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

During the inspection, we spoke with nine people living at the home, six relatives of people, eight care staff, the registered manager and the providers' director of operations. We observed how care and support was provided to some people who were not able to communicate their views to us. To do this, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

The records we looked at included four people's care records, medicines records and other records relating to peoples care, and staff training records. We also looked at maintenance records in respect of the premises and equipment and records relating to how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in January 2016, we found that there were insufficient suitably competent and experienced staff properly deployed to meet people's needs safely. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that improvements had been made in the way in which staff were deployed.

At that inspection, we also concluded that the management of medicines did not properly contribute to people receiving safe care and treatment. This meant there had been a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found further concerns regarding the safe management of medicines.

During this inspection, we looked at how information in medication administration and care records for people living in the home supported the safe handling of their medicines. We found that medicines were stored safely and at the correct temperature. However, records showed people living in the home did not always receive their medicines as prescribed.

We found gaps in the records of medicine administration which did not confirm that medicines had been given as intended by prescribers. This included medicines prescribed for external application. For one person we noted that their pain-relief skin patch had not been applied as scheduled the day before our inspection. Some medicines that had been prescribed and were available to administer were not recorded on the current medication charts. We found numerical discrepancies in the stock of medicines and the systems in place to account for them were not used accurately and consistently. Therefore, safe systems were not in place for the administration of medicines and records did not always confirm that people were receiving their medicines as prescribed.

We observed a member of staff giving people their morning medicines and noted that they did so without the use of supporting information to ensure people's safety. On the day of our inspection the morning medicine round in this area of the home was delayed. This meant some people did not receive their medicines at the scheduled time. We also found that a tablet was located in an open tray on top of the medicine trolley. This placed people at risk of accidental access and harm at times when the trolley was unattended.

We saw that there was limited supporting information available to enable staff handling and administering of medicines safely and consistently. There was a lack of information on people's preferences about how they took their medicines. Information to identify people was not consistently available. We saw that there were inconsistencies about known allergies and medicine sensitivities, which could lead to errors and unsafe medicine administration. When people were prescribed medicines on an as and when required basis, there was written information available for some, but not all medicines prescribed in this way. This is to show staff how and when to give them to people consistently and appropriately. Where people were prescribed more than one pain-relief medicine or medicines to manage periods of distress, there was insufficient information to enable staff to see when they should be used. For people who were unable to talk

about their pain there were no assessment tools to enable staff to give them pain-relief appropriately and consistently. There were additional charts to record the application and removal of skin patches, however these were not always completed. When people had refused their medicines, there were no records to show staff had taken further action to offer them their medicines later. For people self-administering some of their medicines, there were no records showing that staff supported and monitored their safety on a regular basis according to the risk assessments.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, the registered manager told us that some staff, including temporary staff, were living in vacant bedrooms. We observed these staff members accessing communal areas of the home, including living rooms and dining rooms, when off duty. We asked the registered manager if assessments to mitigate any risks from this arrangement had taken place, they told us there had not been. We asked if additional checks were completed to ensure that temporary workers, employed by an agency, had been assessed to ensure that they posed no risks to people living at the home. This was because when living in the vacant accommodation , temporary staff would be unsupervised for long periods of time. The register manager told us that there had not been.

We spoke to a member of the public who was walking around the home. This person told us that they were visiting a friend, who was a temporary worker living in a vacant bedroom. We subsequently learned that this person had stayed at the home overnight with their friend. The registered manager told us that they were unaware that this person was in the building. We were also concerned that this member of the public was in an area where a person living at the home was experiencing a period of crisis, so was very agitated and distressed. This meant that this person's privacy and dignity was compromised because somebody they did not know or consent to being there was present in what should have been a private area. We brought this to the attention of the registered manager who took action regarding this and asked the person to leave.

We also asked the registered manager to complete and send to us risk assessments to ensure that any potential risks to people from staff living in vacant accommodation were managed. We concluded that the registered manager, and the providers senior managers who had approved this arrangement, had not considered the risks posed to people living in the home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that they felt safe. One person told us, "Yes, I feel safe." Most other risks to people's safety had been assessed. This included risks with poor eating and drinking, falls, pressure areas and reduced mobility. There was guidance within people's care records for staff about how these were to be managed and minimised. We saw that actions had been taken to reduce these risks. For example, where people were at risk of developing pressure ulcers, they were regularly repositioned throughout the day. Risk assessments had been regularly reassessed and updated when changes were required for most people.

We saw risks associated with the management of the premises had been assessed and actions to remedy any issues taken in a timely way. We saw that fire doors were kept closed and emergency exits were well sign posted. Testing of fire equipment and the fire alarm had taken place regularly. Staff told us that they knew what to do in the event of an emergency such as a fire. The reviewed emergency evacuation plans for people who needed support to leave the building, and found these to be very clear and detailed. However, although staff we spoke during our inspection could tell us what they would do in the event of the fire, only

14 of the 37 care workers listed on the homes training matrix had completed fire safety training. This meant that there was a risk that not all staff would know what to do in the event of a fire.

We saw records that showed accidents or incidents that took place were recorded by the staff and investigated by the registered manager. Where required, referrals were made to external professionals, for example the falls prevention team. The communal areas of the home were clean, and we saw staff take appropriate precautions to reduce the risks of the spread of infection. The housekeeping staff had a schedule in place that gave clear instruction on what items required cleaning and when. The homes manager met with the housekeeping team on a regular basis, we saw from the minutes of these meetings that changing priorities were discussed and actions taken to meet people's needs.

The staff we spoke with had an understanding of how to keep people safe. Staff told us that they had completed training in the safeguarding of vulnerable adults. They could also tell us who they would report concerns to both at the home and externally for example, the local safeguarding officer or the police. However, the training matrix provided to us by the registered manager showed that of 37 care workers, 15 had not completed any training in the safeguarding of vulnerable adults. Although the staff we spoke with during our inspection did have an understanding of how to keep people safe, there was a risk that not all staff working at the home did.

Staff we spoke with told us about the recruitment process they participated in when applying to work at the home. They told us that they underwent an interview process and completed checks to ensure that they were safe and suitable to work at the home. This included a disclosure and barring service (DBS) check and the provision of references.

At our last inspection, we found shortfalls of staffing in some areas at certain times of the day. This was because staff were not deployed consistently. People's needs had not been fully taken in to account when planning how the home was organised. At this inspection, we received positive feedback from staff about the number of staff on duty. They told us that a reorganisation had taken place so that people now lived in distinct residential units. This meant that people with non-nursing needs, and those people with nursing needs lived separately. Staff were now deployed to a particular area on a consistent basis, and did not have to move to different areas of the home to support other colleagues.

Staff told us that they could meet people's needs in a timely manner. On the day of our inspection, we observed that this was the case. People living at the home told us that they had felt the benefits of this as they were now supported more consistently, and by people they knew. One person told us, "I think there are enough staff." We saw that although people used their call bells to request support frequently, these were responded to in a timely way. At certain points of the day we saw that people had to wait for up to five minutes for a response, but this was at times when there were multiple requests for help at the same time.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in January 2016, we found that people's consent to care and treatment was not always properly assessed. The provider could not demonstrate that decisions taken were appropriately and legally considered as in their best interests. This meant there had been a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that some improvements had been made and that the provider was no longer in breach of this Regulation.

Most staff we spoke with knew how to support people who were not able to consent to their own care. Staff followed the principles of the Mental Capacity Act 2005 (MCA). Actions taken by the staff were made in people's best interests.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

The registered manager told us that since our last inspection, staff had received further training in the MCA and DoLS. Some staff we spoke with confirmed this and were able to demonstrate to us the importance of seeking consent from people before they offered support. However, some staff we spoke with did not have an understanding of the MCA, and could not recollect undertaking training regarding this. One staff member told us, "I have limited knowledge about the MCA, I have never really come across it before." The providers training matrix that we were provided with showed us that 25 of the 37 care workers employed had not completed training in the MCA.

Assessments of people's capacity to consent to certain decisions had been made when necessary. We also saw that applications had been made in accordance with the DoLS where this was considered appropriate. However, staffs knowledge in this area was minimal. Most staff we spoke with could not give us an example of why a person may need a DoLS application made for them. One member of staff told us, "I wouldn't really know what to do for a person with a DoLS application."

Our observations of staff providing people with support showed that generally, staff obtained people's consent before providing them with care. Staff we spoke to told us that people were able to refuse support, and that they recorded in the daily notes if this occurred. On occasions, we saw that support was provided without seeking the persons consent or offering an explanation if the person was not able to. An example of this was when we observed a member of staff assist someone to eat their meal without checking with them if they were ready to do so. The staff member did not show them the meal that had been prepared for them, or explain what it was. Another example we observed was when a person needed to be moved in their

wheelchair from their room to the lounge, staff did not check with the person first if that was okay for them.

We received mixed feedback from people living at the home, their relatives and staff about the training that was provided. We asked one person if they thought staff were well trained. They told us, "They do their best."

On the day of our inspection, staff were undertaking a training qualification with an external trainer. Feedback we received from staff was positive about this. Staff told us that they had received training in various areas such as first aid, food hygiene and the prevention of cross infection. They told us that the majority of training they completed was on line, but that some training was delivered by a trainer in a classroom style setting. Staff told us that they felt that classroom based training was more effective in providing them with the skills they needed.

The majority of staff we spoke with felt that they needed more training to undertake their role. For example, two staff told us that they provided to support to people who used colostomy bags, but had never received training in how to do so, despite requesting this. Some staff told us that they had not completed all of the on line training to be completed that the provider had asked them to do. They told us that this was because the provider expected them to do this in their own time, and at home unless they did not have access to a computer. Staff told us that they were not paid to complete this training. They felt that this was unfair, or did not have the time to do this when off duty due to family commitments. When we spoke to the registered manager about this, they told us that it was the providers policy and expectation that staff did this unpaid and in their own time. We reviewed the provider's policy and procedure for staff training. We saw that it stated 'All staff are entitled to at least three days paid training per year.' This meant that the provider did not follow is own policy of providing training to staff during paid working time.

A member of staff we spoke to told us, "I can't do my on line training until I get home and my children have gone to bed. By then I am exhausted so I tend to put it off. It makes it very difficult to learn. We have had some training here in moving and handling and other updates, but I have not had any dementia awareness and communication training, which would help me." Another member of staff told us that although they had competed training, they did not feel confident in performing that task, and that this was due to the fact the training was not effective. They also told us that new staff received induction training, but that there was not enough of this to ensure they were competent to perform their role.

We reviewed the providers training matrix and saw that a number of staff had not completed training in areas that the provider deemed mandatory. For example of the 37 care workers listed on the matrix, 26 had not completed training in dementia awareness. The same number had not completed training in managing challenging behaviour. None of these staff were identified as having completed training in catheter care.

We reviewed the provider's audit that was carried out two weeks prior to our inspection. This audit identified that there were shortfalls in the provision of training and the assessment of people's competencies. The audit noted that, 'There is no evidence of a training plan. There were some competencies in place.' The audit report noted that this should be actioned, however there was not a date or time frame identified as to when this should be completed by.

We asked staff about the supervision they received. Supervision is needed so that staff have the opportunity to discuss performance, development and support needs. Three members of staff that we spoke with told us that they received supervision but could not tell us how often this took place. Two members of staff told us that they did not receive supervision, one of them unsure what this was. We reviewed the provider's supervision matrix. This record shows that staff did not receive supervision on a consistent basis. For

example, we saw that some staff received supervision every month but this was not the case for all staff. A sample showed us that one staff member that had not received supervision since 10 January 2016. Another staff member did not receive supervision between 12 January 2016 and 9 July 2016. We reviewed the provider's policy and procedure for the supervision of staff. It stated that 'Staff should receive at least six occurrences during the year.'

We concluded that staff did not receive enough adequate training or assessment of their competencies in order for them to fulfil their roles and responsibilities. Not all staff received regular or consistent supervision to provide them with the guidance and support to undertake their role. The provider did not ensure that practice at the home was concurrent with that identified in its own policies and procedures.

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

Most people told us that they enjoyed the food and that they had a choice of meal. One person said, "I get a choice of food, my favourite is the fresh fish we get." They also told us they looked forward to dinnertime. Some people told us that they were not offered a choice and that the food was just brought to them. On the day of our inspection, we observed that choice was offered to everyone.

Relatives that we spoke with had mixed opinions about the food provided. One relative told us, "I have made some complaints but I am not sure the food has improved." The relative went on to say that they found that the food was often very bland, and that some items were too hard to chew for people with dentures. A number of people refused the lunchtime meal of shepherd's pie that was served. One person told us, "This meal is pretty tasteless." We saw that that some of the vegetables served had not been chopped small enough, and would have been difficult for people who had limited independence to cut up themselves.

All the people we saw during our inspection required a degree of support to help them with their meal. Some people needed their meal cut up and given to them with 1:1 support which was provided. Some people had a higher level of independence and only required their meal to be plated and served to them. However, we saw that this was not always provided in a way that ensured they were able to eat their meal. For example one person who chose to eat their meal in their armchair, had the meal placed directly on their lap. The person was not offered a tray or table and could not eat their meal. The person told us that the plate was warm and it was becoming uncomfortable on their legs. We then intervened and removed the plate from the persons lap. We brought this to the attention of a staff member who arranged for a table to be brought over. This was an adjustable table that had not been put at the right height for the person and was too high. The staff member did not check that this was the right height for them and walked away. By the time the staff member had returned and noticed this, the person had decided that they no longer wanted their meal.

On the afternoon of our inspection, but not during the morning, we saw that snacks were provided for people, such as fruit or chocolate bars. These were placed in bowls on tables in communal areas. We did not see these offered to people and not everyone was able to access these by themselves. People who chose to stay in their rooms did not have snacks taken to them. One relative told us, "They sometimes put snacks out, but not on a daily basis."

Where people were at risk of not eating or drinking enough, this was monitored by staff. We saw that people were frequently offered drinks. One person told us, "They are very good at offering drinks." We saw that people who remained in their bedroom had their drinks jugs replenished. Where people were at risk of not drinking enough, this had been identified and was monitored by staff.

People we spoke with told us that their health care needs were met. Their relatives we spoke with confirmed this. People were able to see a doctor, optician or dentist when then needed to. A visiting GP we spoke with told us that they felt that there had been recent improvements by the provider in communicating with the surgery. They also felt that staffs knowledge of peoples health needs was improving.

People's records showed that advice had been sought from other healthcare professionals where this was needed to ensure people's health and welfare needs were met. For example, where people had been identified as having a risk of developing pressure areas, advice had been taken from the community tissue viability nurse. This meant that people had access to healthcare services when they required them.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in January 2016, we found that people were not always treated with dignity and respect. This meant there had been a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that some improvements had been made and that the provider was no longer in breach of this Regulation. However, improvements are required to make sure that people consistently receive care that ensures that their privacy and dignity is respected.

We received mixed feedback from people and their relatives about how they were cared for by staff. One person told us, "Yes there is one staff member who is good who is here most days. They call me by my name. I suppose one or two of them have feeling for me." Other people we spoke with told us that staff were kind. A relative we spoke with said, "They need more 1:1 interaction, they know who [relative] is, but they don't have a relationship with them." Another relative told us, "Most of the staff are very caring and sensitive, although some can be a bit clumsy."

We saw staff interactions with people that were very caring. Staff were reassuring towards people when they were confused or upset, and prioritised peoples requests for care. For example when a person requested a drink, the member of staff stopped what they were doing and made the person a drink, reassuring the person that it was not too much trouble. On another occasion, we saw a member of staff support a person who had become distressed and verbally aggressive towards people. A member of staff stopped what they were doing and approached the person in a cheerful but sensitive manner. They then proceeded to ask the person if they were all right and offered to help them. The staff member calmed the person down by talking warmly to them, distracting them from the cause of the upset by suggesting it would be nice to go for a cup of tea and a 'gossip'.

However, we also observed that some staff did not always have a caring relationship with people living in the home. We observed on occasions that staff had little interaction when supporting someone, and that their approach was task orientated. For example, we observed two members of staff using a hoist to transfer a person from their armchair in a communal area. The person was asleep and the member of staff woke them up, then proceeded to continue hoisting them but did not speak to them or reassure them. We saw that the person became distressed. We saw on one occasion a person was sitting in the lounge area, where three members of staff were. We saw that staff did not speak to the person at any point but spoke amongst themselves. A staff member then moved the person without asking them if that was okay to do, and took them to their room without talking to them or explaining what was happening. On one occasion, we saw a member of staff siting in a communal area next to two people. The member of staff did not speak or interact with any of the people, and was using a mobile phone. We concluded that although staff had caring relationships with people, this was not always displayed. Staff regularly provided care for people in a way that focused on the task they were doing, not the person they were supporting.

We saw that most staff treated people with dignity and respect, and could give us examples about how to promote this when we spoke to them. A member of staff told us how important it was to look at the body language of people and to listen when they spoke.

We saw however, there were occasions when this was not promoted. We frequently heard staff use language and terminology that was not respectful. For example, staff referred to people who needed help to eat their meal as 'feeds', and used the term 'doing' when talking about a person requiring personal care. When we asked a member of staff about how they assist people who needed support to eat, they told us "You just keep feeding them until they say no." We also saw that people who were in bed and not fully dressed had their bedroom doors left open and were in full view to anyone walking past. We asked staff if it was the personal preference of people to have their bedroom doors left open. Staff told us that did not know, but that the doors were left open so they could check on people as they walked past. We concluded that people's privacy was not always upheld and as a result of this their dignity was compromised. This was because staff prioritised efficiency rather than respectful care.

We saw that improvements had been made since our last inspection in the involvement of people when making decisions about their care. Care records we reviewed detailed peoples preferences and choices. Where people were unable to do this, or did not have the capacity to do so, we saw that relatives had been involved in the process. People and their relatives told us that they were satisfied they were able to make decisions about the care they received.

People told us that they could make decisions about how they wanted to be cared for on a day to day basis. This included areas such as making choices about where they wanted to spend their time within the home. For example, one person we spoke with told us that they were able to choose if they wished to remain in their room, or sit in communal areas to eat a meal.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in January 2016, we found that people did not always receive care that took into account their individual needs and preferences and how these could be met. This meant there had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found further concerns regarding how people's individual needs and preferences were met.

Two people told us that staff did not often have time to spend talking to them which they enjoyed. One person said, "I'd like people to talk to me about me and my life, like what you are doing now, but that doesn't happen." A relative told us, "[Relative] wants to tell people about her life story, but nobody comes to listen. A person's visitor told us, "There is no one to one contact between the staff and the people who live here."

Our observations during the day of the inspection confirmed that the staff did not always interact with people apart from when they were performing a task. The staff we spoke with told us they had limited time to spend with people to talk to them or engaging them in activities due to being busy assisting people to get up. For example, although staff regularly checked on one person using a communal lounge in the morning, they did this by looking through the window at them. The person received no interaction with staff at all for 40 minutes and were left in the room on their own facing a TV that was switched off.

We received negative views from people, their relatives and friends regarding the provision of activities to enhance their wellbeing. One person told us, "I would like to get involved in activities but I don't get offered any." Another person told us, "I get visitors every week, but I am in this room the whole time and there is nothing to do so time passes quite slowly. The only activity is TV. I would like to do some exercise, aerobics would be good, but there is nothing like that here."

We spoke at length with one person living in the home about activities. They told us, "I'm never given anything to do. I know am frail, but I'm not in pain and I am still interested in some things. I have no one to talk to. There could be exercise for us, but there is nothing. There could be music and movement for us, but there is nothing. It desperately needs addressing."

One visitor we spoke with told us that they were disappointed that there were no church activities arranged in the home for their friend, as they had been a regular attendee at their local church before. They went on to say that, "They don't seem to do anything for people indoors here." A relative we spoke with told us, "[Relative] needs and wants more stimulation, but doesn't get it. There are no activities. There was an activity person who came in for a while but they have left. She would announce to the room 'who wants to do colouring and sticking then?' like she was talking to children." Another relative told us, "What you see now is what goes on all day, pretty much nothing."

The provider's quality manager recently completed a comprehensive audit of the home on 28 June 2016. The report stated 'The activity lounge on the ground floor has not been used even once for the benefit of residents, but is used for staff breaks.' It also identified that people were mainly sitting and watching

television and that staff were not engaged with people because they were talking to each other and looking at their mobile phones. The action plan written following this audit detailed that improvements should be made, but not what these were and how they would be achieved. There was no timescale or deadline set for this.

An activities co-ordinator who was responsible for providing people with stimulation and activities had been recruited since our last inspection, however they had since left. We asked staff what activities had taken place during this period, but they were unable to describe any to us other than card games. We saw no activities occurring on the day of the inspection and there had been none scheduled. The information boards in the foyer and on the corridors showed the activities that were due to take place in late May to the middle of June. There were five events scheduled to take place. This information was taken down on the afternoon of our inspection.

We asked staff how they ensured that people received activities and stimulation. A member of staff told us, "Personally, I don't think people do anything. The activities room is never used." Another member of staff told us, "No, we don't do them at the moment." Our observations conducted throughout the day confirmed this. We did not see people engaged in any meaningful activity, people were disengaged and unstimulated for long periods of time, usually when not receiving personal care.

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us that most of their preferences in relation to how they wanted to be cared for were met. One person told us staff were able to give us examples of how they offered choice, such as showing people two different plated meals so that they could see what was on offer. Another person told us that they did not want to receive support from male carers, and that this request was acted upon.

We received mixed views from staff about how much choice and control people were able to have. We found that this varied across the different units in the home. In some areas staff felt that people were able to choose when they got up and went to bed. In another unit, staff told us that people were not able to choose, and if they did it would be impossible to achieve this. People living in the home told us that they felt that their needs were met in a timely way, and there preferences on a daily basis were met.

People's care needs and preferences had been assessed and there were clear plans of care in place to provide staff with guidance on the care people required. People's care records had been recently reviewed and the information within them was accurate and up to date. There was a summary overview of people's needs so that staff did not always have to read through a complete and comprehensive care plan to find a key piece of information.

There were effective systems in place for people to use if they had a concern or were not happy with the service provided to them. Staff knew about the homes complaints procedure and that if anyone complained to them they would notify the person in charge. The home had received limited complaints, but those that had been received had been fully investigated and appropriate action taken. The manager told us that they took complaints very seriously and ensured these were acted on as soon as they were raised. They explained that this was so lessons could be learned and action taken to help prevent them from reoccurring.

The registered manager had recently arranged for residents meetings to take place. We saw from the minutes of these meetings that people were able to contribute to the agenda, and that actions were taken. For example, some people commented that the request that staff wear uniforms so that they could be

identified was well received. On the day of our inspection we could see that staff were wearing uniform that identified them as such. A further request was made for staff to have name badges because it was difficult to remember everybody's name. The minutes showed that action was taken and name badges ordered.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in January 2016, we found that the Care Quality Commission had not been notified of certain events that the provider is required to do so. These are called statutory notifications. The provider had failed to notify the CQC when there had been an allegation of a serious safeguarding incident. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found that the necessary improvements had been made and that the provider was no longer in breach of this Regulation.

At that inspection, we also found that governance systems in place were not effective at monitoring the quality and safety of the care being provided or to mitigate risks to people's safety. This had resulted in some people experiencing poor care. This meant that there had been a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) 2014. At this inspection we identified further concerns regarding the effective monitoring of the quality and safety of the care provided to people.

At our last inspection, we found concerns regarding the safe care and treatment of people in relation to managing and administering their medicines. At this inspection, we identified continued concerns regarding this. The providers systems to identify any errors had not been implemented, this meant any errors would not be addressed in a timely way. The provider's director of operations was not aware of this although stated that they had completed a spot check of medicines recently. The registered managers audit of medicines and records relating to this did not and would not identify gaps in records or administration errors because it did not take place frequently enough. The provider's quality manager audit of 28 June 2016 identified that there were gaps in medication administration records. However, no actions had been taken to address this at the time or since then. The action plan did not identify who should be responsible for addressing this and by when. We asked the registered manager and the provider's director of operations to take action regarding this straight away, which they confirmed to us that they had done.

At this inspection, we had concerns that the registered manager did not identify potential additional risks in allowing staff and temporary staff to live in vacant accommodation within the home. Actions were not taken to mitigate these risks until we asked the registered manager and director of operations to take action.

We also found that other issues identified in audits were not actioned. For example gaps in staff supervision, staff training and the provision of activities. Where areas of improvement had been found as needing attention, the provider's plan we reviewed did not fully address the actions required. We also saw that although the plan stated that the person responsible for implementation, timescales for completion and review dates should be detailed, these were not completed.

There had been several of the providers senior managers involved with managing the home since our last inspection. Some were still involved with the service but there had been several changes to who was providing the support to the registered manager and driving the action plan forward. This inconsistent approach contributed to a lack of progress in addressing the concerns identified at our last inspection. In some instances, the provider and registered manager had not taken action to address risks that had already

been identified in their own audits. There was not an effective system in place to monitor all aspects of the care and treatment that people received.

This was a repeated Breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that there was a culture within the home that did not foster open communication between the staff team and people who live at the service. The feedback we received at this inspection was that improvements had started to be made, but that that this was not yet consistently applied. People and their relatives told us that they had received a mixed response to issues raised. One relative told us, "The manager says 'I can only do what I can with the budget I've got', she looks at me as though I am a whinger. My [relative] doesn't feel as though they can talk to her. Things they have been promised by the [registered manager] never turn up." Another relative told us, "I don't think the staff connect as a team, we don't see much of the manager."

Most of the staff we spoke with told us that morale was improving since the last inspection. They told us that this had been mainly due to the redeployment of staff into teams that worked consistently in one area of the home. However, some staff told us that they felt concerned to speak to us because the manager had not encouraged them to be open with inspectors. In the provider's report and action plan following their quality audit of 28 June 2016, we saw that staff had reported that they did not feel supported by the registered manager. They also felt that that they spent the majority of the time in the office away from where people lived or worked. We could not see that any action had been taken regarding the concerns that had been raised.

Staff we spoke with told us that they knew how to whistle blow if they had a concern, but also commented that they were not comfortable in doing this. We were not satisfied that the registered manager demonstrated leadership and management which fostered a culture of openness and transparency, where people could raise concerns.

The registered manager told us that a satisfaction survey had not taken place recently. The provider's quality audit stated that this had not been completed but needed to be. There was no timescale for the completion of this. When we spoke to people and their relatives, they told us that they did not get asked for their opinion of the service on a regular basis. Relatives we spoke to said that they would welcome more information about the home, and we received mixed views about how approachable the registered manager was.

Prior to carrying out our visit to the home, we reviewed the notifications that the registered manager had sent to the CQC. We saw that the registered manager notified us when people had passed away, or of any serious injuries and safeguarding incidents that had occurred. We were satisfied that the manager notified the CQC of the events that they are required to do so.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that took into account their individual needs and preferences and how these could be met. Regulation 9 (1) and 9 (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient suitably qualified, competent, skilled and experienced persons deployed to meet peoples needs safely. Regulation 18 (1) and 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	There were risks to people's safety associated with the way that medicines were managed. Regulation 12 (1) and 12 (2) (a) (b) and (g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems for monitoring and improving the quality and safety of the service, having regard to the accuracy of records and for acting upon the views of others, were not operating effectively. Regulation 17 (1) and 17 (2) (a), (b), (c) and (e)

The enforcement action we took:

Warning notice