Kingsley Care Homes Limited

Downham Grange

Inspection report

Clackclose Road
Downham Market
Norfolk
PE38 9PA

Tel: 01366387054
Website: www.kingsleyhealthcare.com

Date of inspection visit:
08 January 2016
12 January 2016

Date of publication:
25 February 2016

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

The inspection took place on 8 and 12 January 2016 and was unannounced.

Downham Grange provides accommodation and care to a maximum of 62 older people, some of whom may be living with dementia. It is able to deliver nursing care to people using the service. When our inspection started, there were 58 people using the service.

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.

There were shortfalls in the safety of the service because not enough suitable and competent staff were always properly deployed. People sometimes experienced significant delays before staff were available to assist them with the care they required. Risks to individuals were assessed but staff were not always available to address these. We have told the provider that they need to make improvements to ensure people's safety.

Medicines were not always managed safely. Whilst the majority of people received their medicines at the appropriate time, there was a lack of guidance about how medicines for occasional use, to assist people who were distressed or anxious, were to be used. Insulin administration was not always consistent and there was a lack of guidance for nursing staff to support them with this. There was an audit process in place. However, this was partially compromised as balances in stock at the beginning of each month were not always clearly recorded. We have told the provider they need to make improvements in this area to ensure that people receive safe care and treatment.

Not all staff had completed training to support them in recognising and responding to suspicions that people might be being abused. However, most knew what was expected of them and how they should report any concerns to contribute to people's safety.

The service people received was not always effective. Significant numbers of staff had not been properly trained to understand how they should support people who could not make decisions for themselves. There were inconsistencies in the way people's capacity to make decisions was assessed to demonstrate that their rights were protected. Staff were unclear who was subject to any authorised restrictions on their freedom and the manager was unable to clarify this at inspection. We have told the provider that they need to make improvements to ensure consent to care and treatment is properly and lawfully obtained.

Mandatory staff training and induction was not always completed promptly so that staff had consistent underpinning knowledge about their roles and how to support people well. The provider had identified this as an area needing to improve and had a plan to address shortfalls.

People did not always receive prompt and appropriate assistance to eat their meals and drink enough. The mealtime experience was not always as pleasant as it could be in encouraging people to eat. Staff took action to ensure people's health needs were referred for professional advice where necessary.

People received support from staff who were largely kind and compassionate. However, they were not always available to intervene promptly when people needed support and sometimes people's dignity and privacy was compromised. We have told the provider they need to make improvements in this area.

People's needs and preferences about the way they wanted their care delivered were not always acted upon. Their interests, hobbies and backgrounds were not always taken into account. There was a lack of activities to meet people's preferences. We have told the provider that they need to make improvements in the way the service responds to people's needs and wishes. The manager was recruiting staff specifically to assist with activities.

People and their visitors were not always confident they knew who to go to if they had complaints about their care, or that these would be resolved promptly where practicable.

The service people received was not well organised. Duty rosters were poorly structured and information was conflicting about the numbers of staff on duty. Staff morale was affected and team spirit and cooperation varied. Although there were systems for checking the quality of the service, these were not always effectively applied and improvements that had been identified as needed were not always made and sustained. We have told the provider that they need to make improvements in the way the service is led and monitored.

You can see the action we have asked the provider to take at the back of the full version of this 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?

Requires Improvement

The service was not consistently safe.

Staffing was not effectively managed to ensure that staff could meet people's needs promptly and safely and consistently deliver the care required to minimise individual risk.

Medicines were not always managed in a way that promoted people's safety and welfare.

Risks associated with the operation of the premises were assessed and equipment was tested regularly to ensure it remained safe for people and staff to use.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not well prepared to understand how to support people who lacked capacity to make specific decisions about their care to ensure their rights were protected. Other training the provider considered to be mandatory was not always completed in a timely manner.

Mealtimes were not well organised to ensure that everyone received the support they needed to eat and drink enough in a timely way.

Staff made sure that advice from health professionals was sought when there were concerns about people's health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff responded to people in a warm and kindly manner. However, other staff were less aware of people's dignity and privacy and their conduct did not wholly contribute to promoting this for people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their needs and preferences. The provider was taking steps to recruit staff to support people with meaningful ways to spend their time.

People were not always clear about how they could raise concerns or confident that they would be addressed promptly.

Is the service well-led?

Inadequate

The service was not well-led.

Staff were not empowered to express their concerns in good faith and there was a lack of confidence that views and opinions were listened to.

Notifications of events happening within the home were not made promptly.

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

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 started in order to look at concerns we had received about the safety of the service. We decided to complete it in full to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008; to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 8 and 12 of January 2016 and was unannounced. It was carried out by three inspectors.

Before we visited the service we reviewed the information we held about it. The information included notifications about events taking place within the home and which the provider is required to tell us about by law. We reviewed the information we held about concerns or complaints and received feedback from the clinical commissioning group, local authority's quality monitoring team and safeguarding team.

During the inspection we spoke with 13 people using the service and five visitors to the service. We spoke with 11 staff, including three nurses, three senior support workers and five support workers. We spoke with the registered manager. We also spoke with the provider's head of clinical development, director of specialist services and compliance director. We spoke with four visiting professionals including a tissue viability nurse, diabetic nurse specialist, member of the district nursing team and a social worker.

We observed how people were being supported. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed records associated with the care of 11 people and medicines records for six people. We checked recruitment records for three staff and training records for the staff team. We also reviewed records associated with the safety, quality and management of the service.

Requires Improvement

Is the service safe?

Our findings

Before we visited the service we had concerns raised with us from a variety of health and social care professionals about whether staffing levels were always sufficient to meet people's needs safely.

We observed that staffing levels and the way staff were deployed around the home had an impact upon people living at Downham Grange. People expressed concerns about staffing to us. For example, one said, "There are not enough staff on, especially during the day. One or two of the night carers are not very good." The person told us, "The carers are at cracking point; they only have one carer on this corridor, it needs two as a number of people are doubles." This meant that they needed two staff to assist them with their care. Another person who needed assistance from two staff expressed concerns about the availability of staff to support them. They told us, "They are very short staffed. I waited an hour and ten minutes for help but in the end I had to wet the bed because no help came and I was desperate."

We saw that there was one staff member actively assisting people in the part of the home this person lived in. They told us that there were 11 people living in that wing, three of whom needed assistance from two staff. We observed that the nurse and another support worker were both seated at a nearby desk. When they were asked for help we noted that they responded by saying, "It will be at least ten minutes." The staff member did secure assistance from staff in another part of the home but by then the person who needed the support had wet their bed.

On the first day of our inspection we observed that one person who needed assistance to eat their breakfast was being supported with this at midday. The staff member present told us that this was not the person's expressed choice and that usually the person was assisted earlier. They told us that they were very behind on that day. Other staff we asked confirmed that it was sometimes the case that people were not able to be assisted to rise and have their breakfasts until it was nearly lunch time. On the second day of our inspection we noted it took until around 12.45pm before everyone on part of the first floor was able to receive assistance with their personal care and dressing.

Two staff described how sometimes people at risk of falls were left without supervision in communal areas and so their safety was compromised. We observed that a worker who was privately employed to provide support to a person (and so not part of the required staff numbers) needed to intervene with another person to ensure their safety. The person was trying to walk without their walking frame and so at risk of falls. On a further occasion we noted one person trying to pull another from their chair in the lounge. There were no staff present and one of our inspectors had to intervene to stop the person being pulled onto the floor.

Information we were provided with about the numbers of staff on duty was contradictory and unclear. However, we established that staffing was not consistently maintained at the levels the registered manager told us were expected and required. Staff were not always deployed effectively around the service. On the first day of our inspection, the registered manager told us that there were 58 people living at the home and in addition to two nurses, there should be 12 care staff. This number included a one to one support worker. However, during the afternoon of that day, there were nine support staff and the one to one worker making

a total of ten and not twelve staff.

There was one staff member new to care work who had started working at the home on 4 January 2016. They told us they did not know what training would be expected of them but assumed it would include things like how to use the hoist. They told us that they had not completed any training yet but had been 'shadowing' other staff.

The manager confirmed that this staff member was shadowing and should not be included in staff numbers. We reviewed information about staff working in the week leading up to our inspection and found that this was not always the case. For example, we found that the inexperienced and untrained staff member had been included in staffing numbers on 6 January 2016. This was two days after they started work at the home. On the late shift, there were ten support staff listed including the support worker on induction. This effectively reduced staffing numbers to nine, when it was expected that there should be 12 staff on duty in total.

We concluded that there were insufficient suitably competent, skilled and experienced staff properly deployed to meet people's needs safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staff recruitment files had been audited during December 2015 to ensure the relevant checks had been completed. This included taking up references and completing enhanced checks to ensure applicants were not barred from working in care. We found concerns in records relating to two out of three staff members whose files we reviewed. Both staff had been appointed before the current registered manager took up her role in May 2015. We concluded that the provider had not always robustly implemented recruitment processes, seeking clarification about concerns from those providing references or the applicant, and completing relevant assessments of risk where appropriate. The registered manager was aware of these concerns and was in discussion with the provider's personnel department about managing this.

We reviewed the arrangements for storing and administering medicines and concluded that most people received these at the right time. We noted that night staff administered some medicines to ensure people received these in a timely way in the morning. We observed that there was a hand written list left for day staff to show the people who had already been given their medicines. A nurse confirmed that they double-checked this list against blister packs and medication administration record (MAR) charts. However, we found that some people did not have their medicines in blister packs and so the margin for error was high. There was a risk that people may not receive their medicine as prescribed, or could receive more of it if there were recording errors or omissions on the MAR charts.

We found that one person's notes contained a separate record of blood sugar levels which were checked by night staff. A record of the insulin administered by morning staff was maintained. The diabetes nurse confirmed that the gap between testing and administration was acceptable for the person concerned and the type of insulin prescribed. Nurses could tell us how the person's diabetes was managed and monitored. However, there were inconsistencies in the clinical decisions made about whether or not to give insulin, dependent upon the person's blood sugar.

We found that there was no information on the separate insulin recording sheet or MAR chart about what the person's expected blood sugar levels should be or what do to if they fell outside the expected range. We also noted that there was no record or guidance within the person's care plan for nursing staff to follow. A nurse told us that they would give the insulin if the person's blood sugar reading was above five. However,

we found that it had been omitted when the reading was 7.8 showing that practice was inconsistent presenting a potential risk to the person's safety.

MAR charts did not always record the balances of medicines remaining in stock and brought forward when the new MAR charts were started at the beginning of each 28 day cycle. This presented concerns that medicines could not be properly audited to ensure there were no anomalies and that records of administration were accurate.

We noted that there was clear guidance for staff about the administration of pain relief to people who had this prescribed for use when it was needed (PRN). However, there was no guidance in relation to people who had been prescribed PRN medicines to assist in controlling anxiety or agitation to show when its use should be considered.

The registered manager had identified an anomaly in the way that controlled drugs were checked and their administration recorded. These medicines require additional precautions in their management, storage and recording. One person had received 10mg of a controlled drug and not the 15mg that had been prescribed. Although this was an under-dose and had not harmed the person, they had not received the pain relief that they had been prescribed. For two other people prescribed medicines to be applied in a 'patch' form there was a form in place for recording where and when these had been applied. This enabled staff to be sure they removed the old patch or to identify if it had become detached for some reason. One person was due to have their patches changed every 72 hours. Their 'record of transdermal patches' did not show where or whether a patch had been applied between 29 December 2015 and 4 January 2016. For a second person, due to have patches changed every week, there were records of this being applied on four occasions in December but only two of these showed where the patch had been placed. Their MAR chart showed that a patch was applied on 5 January 2016 but this was not shown on the patch record to indicate when and where it had been applied.

During the course of our inspection, we observed that one staff member administering medicine was 'side tracked' by another and accompanied them along a corridor to a person's room. We concluded that the medication round had been completed. We realised this was not the case when we walked around the corner to find the medication trolley in an adjacent corridor. It was locked but there was a capsule in a medication pot on the top of the trolley therefore accessible to people living in the home and unauthorised staff. We also saw that a visiting relative handed a nurse another capsule which they had found on the floor of their family member's room. This indicated that staff administering medicines had not appropriately checked that the person had ingested the medicine that had been offered to them.

We concluded that the management of medicines did not properly contribute to people receiving safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's audit report of 11 January 2016 identified shortfalls and contradictions within care plans about the assessment and management of risks to one individual. They had ensured this was addressed for the person concerned and had an action plan to ensure care records were audited so that any other shortfalls would be identified and acted upon.

We noted that risks to which people were exposed were assessed within the plans of care that we reviewed, but there were inconsistencies in the way care was delivered to address these risks. For example, we noted that one person was at very high risk of developing pressure ulcers and had done so. The person's care plan showed that they should be repositioned every two hours to minimise the likelihood of further deterioration,

to alleviate pressure on vulnerable areas and on the existing ulcer.

We found that, on the first day of our inspection, there were two occasions when the person had not been repositioned for over three hours. At 3.25pm on that day, we noted that the computer record showed the person was last repositioned at 11.40am. We were informed that there was a further paper record in their room and so checked this with a nurse. This showed that they were repositioned at 11.50am and contained no further entry. The nurse checked their position and the record and agreed that the person remained in the last recorded position, showing that they had not been supported with any further change for over three and a half hours. This meant that assistance to minimise risk and avoidable harm had not been given as required until we pointed it out. However, we did note that records showed the pressure ulcer had been improving since a serious deterioration in September 2015. This was confirmed to us by a tissue viability nurse who said that their wound was progressing so they had discharged the person from their case list.

We noted that there were systems in place to assess the risks relating to the premises and for ensuring emergency equipment was tested and maintained so that it would be safe to use. There was guidance for staff about the way individuals would need to be supported in the event of a fire. We noted that mandatory e-learning for this had not been consistently completed in a timely way but practical training for most staff in fire safety had been provided.

People told us that they felt safe in the home. One said, "Yes, I'm safe here." Two other people agreed that they felt safe and had no problems with the staff.

Two professionals contacted before our inspection told us that they had concerns about the way safeguarding issues were handled within the service. During our inspection, we identified concerns for two people about the way that staff had responded to them and which could be construed as neglect. For example, a person had reported to a staff member assisting them that another staff member had not assisted them with the toilet. They said that staff just turned off the bell and put out their light without offering the help they needed so they had wet the bed. We asked the manager to refer these findings to the local safeguarding team.

Staff spoken with told us that there was training for protecting people from abuse available to them by 'e-learning' on the computer. The provider's head of clinical development told us that this safeguarding training was mandatory for all staff. However, we found shortfalls in this training presenting a risk that some staff would not be fully alert to what might constitute abuse and what they should report. The provider was aware that some staff were not completing the relevant e-learning in a timely manner and was taking action to address this with individual staff members.

Staff spoken with, and who had completed the safeguarding training, were able to tell us some of the things they felt would constitute abuse and were clear about their obligations to report this. They knew where to find information about contacting the local authority's safeguarding team should they need to do so.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

The registered manager was aware that consideration was needed of the least restrictive options to ensure people's safety and when an application to deprive someone of their liberty should be made. Applications had been made but we were unable to establish with the manager whether any of these had been authorised. The record of applications made did not always show that the capacity of each person to understand individual risks to their safety had been fully assessed before the application had been made. Records showed that the home had an urgent authorisation to deprive one person of their liberty. This was because they were assessed as at, "extreme risk." We were aware from the local authority that, where a home grants itself an urgent authorisation which is strictly time limited, consideration of the standard authorisation is prioritised by the authority. We found that there was nothing in the person's records to indicate any update to this since 8 December 2015. The manager was unable to confirm whether this had been followed up to ensure the person's rights were protected.

Staff were unable to tell us whether anyone had an authorisation to deprive them of their liberty in place as a result of the restrictions that had been imposed to ensure their safety. This presented a risk that they would not be aware of any conditions they should abide by, to ensure people's rights and freedoms were protected.

The provider's quality assurance audit recognised that people's plans of care contained insufficient information about applications to deprive people of their liberty, the reasons for this and whether they had been authorised. We also found that information about people's capacity was not always clear and sometimes contradictory information was contained within their care records. For example, one person was recorded in their care plan under the heading of 'mental capacity', as having variable capacity. However, the section in relation to consent for their care and treatment recorded that no MCA assessment was needed. There was no guidance for staff within the update showing that the person's capacity varied about how they should seek the person's consent when they offered care.

We found that there were significant gaps in the training that staff received about supporting people who were unable to make decisions for themselves. For example, on one early shift we checked against training completed, we found that half of the staff on duty had not completed training in the MCA and DoLS. One

staff member spoken with confirmed that they had not received training in the MCA and did not know much about it. They told us, "Nursing staff sort it out."

We noted that one person's care records showed they lacked the capacity to consent to their care and treatment. The person's care records stated that a relative acted on their behalf. However, the records also indicated the relative did not have power of attorney to make decisions about the person's care and welfare. Care records made mention of decisions as being in the person's best interests, but were without assessments of the person's mental capacity for specific individual decisions to show that they had been taken properly.

We concluded 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 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative said told us that they felt confident staff spent the necessary time supporting the person to eat and that they had put on weight which they were pleased about. One person told us, "The food is alright but the variety could be better." Another said that the food, "…is very good." However, a further relative said that the person they visited took an hour and a half to eat lunch so they came in each day to help. They felt that although staff were happy to support their relative that they did not have the time to do it properly.

One person on the first floor told us that they were waiting for lunch. However, we noted that they found it difficult to eat in the armchair as the table did not fit close to it properly. We observed that the person was provided with a plate of food on the table (sausages, mash and gravy) with no tray. There was a gap of about two feet from the table for the person to lift food to their mouth. The person told us the cutlery was too heavy and they could not manage. They said, "I'm not going to bother with it."

We also observed that similar arrangements presented difficulties on the ground floor. People seated in armchairs rather than at dining tables were provided with small round 'occasional' tables. These had to be positioned to one side of them as they could not be pulled up to the person over their chair or lap. One person almost spilled food in their lap when they were trying to hold the plate rather than being able to use the table. Others struggled to lift food the distance from the plate to their mouths.

We saw that one person who was supposed to be receiving one to one support was without this for 15 minutes during lunch time when they had only eaten half of their dinner. A different staff member came to them and said, "Oh you have finished." The person was asleep and the staff member then took their meal away. We also noted that another person had their main meal left on a trolley by their bed. This was untouched when we checked, having been served about three hours earlier. That person had also gone to sleep. The senior support worker working in that part of the home was not aware that they had not eaten or been encouraged to do so. The person's records showed that they had not eaten anything since the night before.

Staff informed us that, on the first floor, it took approximately an hour and a half to assist those people who required help to eat. This meant that the meal time did not finish until after 2pm. Tea was served at 5pm so there was not much of a gap between meals for people to regain their appetite.

We noted that people's weights were checked regularly. One person, who we identified had lost a considerable amount of weight, had received advice from a dietician. We also noted that snacks such as crisps, biscuits, cake and fruit had been made available on both floors of the home for the second day of our

inspection. This did not happen on the ground floor on the first day of our inspection and so represented an improvement. We saw that some people were making use of these. The staff member who had arranged this recognised that people living with dementia could expend lots of energy walking around the home and may not find it easy to sit and eat full meals. They recognised that snacks and finger foods were a way of increasing people's food intake. However, one person commented to us that it would be nice if these were offered around. They said, "They [staff] put fruit and biscuits on the tables, but it's never offered around. It needs to be, not everyone can help themselves."

The provider's audit of 11 January 2016 had identified that people's intake of food and drink was not being recorded appropriately and in a timely way. Staff waited until they had time to access the electronic system and then may not accurately remember how much food and drink people had consumed. Between the first and second days of our inspection, we saw that paper records had been introduced on the first floor. This meant that a more contemporaneous and accurate record could be made and any problems could be followed up. The provider had also scheduled a meal time audit to take place on both floors of the home to assess people's experiences and how these could be improved.

We reviewed the information the provider gave to us about both e-learning and practical training. We had concerns that there were significant gaps in the training the provider expected staff to complete and which the provider's head of clinical development told us was mandatory. For example, we found that half of the staff on one night shift we checked had either not completed or were not listed against training for fire safety or first aid. We cross-referenced staff names on duty for one early shift against their e-learning and found that only six of the fourteen staff listed had completed health and safety training. Only four of them had completed the provider's mandatory e-learning in dementia awareness, despite needing to support people who were living with this condition.

We were concerned at the timeliness of completion of training, including the induction staff needed to fully understand how to support people. For example, one staff member appointed at the beginning of October 2015 was not listed for any of the e-learning training. The provider's head of clinical development said this was an oversight and arranged for them to be enrolled. That staff member had only completed three practical training sessions since their appointment, in moving and handling, fire safety and nutrition. Another staff member, appointed eight months before we started our inspection, was still completing an English language course before starting on the required e-learning. These shortfalls presented a risk that staff would not have the skills the provider expected, to meet people's care needs effectively.

The provider's head of clinical development and also the quality audit from 11 January 2016, identified that there were shortfalls in training and that there was a plan in place to address these. However, we noted that the action plan compiled in June 2015 and therefore more than six months before our inspection, had also identified shortfalls in training. This stated that mandatory e-learning for staff was being brought up to date as a matter of urgency. This had not been sustained.

We noted that although some mandatory e-learning training had not been completed, seven staff were working towards completing the Stirling University Best Practice in Dementia Care. This would contribute to enhancing knowledge within the staff team about how to support people who were living with dementia. Staff spoken with, with the exception of one staff member newly in post, had an understanding of the support people needed with their care. Visiting professionals we spoke with told us that they felt key staff, such as nurses or clinical leads, were able to give them relevant information about people's care needs.

Staff expressed varying views about how well they felt that they were supported. One staff member who was responsible for delivering supervision confirmed that this involved discussing people's work as well as

assessing how capable they were to deliver care, such as using equipment appropriately and delivering personal care. They told us that they had not had training to offer supervision and appraisal to staff and had learnt from others who offered them supervision. Two other staff members told an inspector that it varied who did their supervision and they did not feel much thought went into the way it was conducted. They felt it was more about, "…ticking them off the list." They were not able to recall when their last supervision took place. The provider's quality audit showed that improvements were needed to the way that supervision was recorded.

We found from people's records that they were referred for medical advice when they became unwell or their needs changed. For example, they received support from their doctors, dietician, district nursing team, tissue viability nurse and with the management of diabetes. We also noted that one person had been referred for advice about their mental health and how they should best be supported.

However, professionals were not always sure that referrals were made appropriately. For example, one professional we spoke with said that they had been called in to check a person's skin condition after the person had told staff they were sore. The professional said that there was nothing wrong with the person's skin and that staff could have established this as part of routine checks when they were delivering personal care. They felt that sometimes referrals were over cautious and expressed the view that this may be because staff were concerned they did not have the time for routine assessment and prevention strategies.

Requires Improvement

Is the service caring?

Our findings

People living in the home told us that staff were kind to them. One person said, "I'm well cared for. " Another said, "There's no fault with any of the staff. They're always good." A visitor to the home told us, "All the staff are kind to [person] and welcoming to me. They always help her to look nice as she used to do for herself." However, another relative said that sometimes staff left the person for long periods of time with food around their face or clothing, without offering support to deal with this and promote their dignity. The relative said that they felt this was because there were not enough staff and they are always, "…running around". They felt that staff, "...mean well..." and were kind.

We observed that there was variable practice in responding to people who needed assistance or reassurance. For example, we noted that one person was repeatedly calling out, agitated and anxious but staff were not available to intervene promptly and offer reassurance. We observed that another person became restless saying they needed to be somewhere else and about what may have been an experience earlier in their life as they referred to fire arms. Staff did not intervene and made no effort to distract or reassure the person concerned. This did not escalate and the person did calm down on their own.

One person used the call bell to summon assistance to their room, which had the door closed. We observed that two staff walked past without making any effort to respond. On a second occasion we observed that a call bell was ringing for over four minutes. During that time, one staff member checked the call bell panel to see who it was that was calling. They then returned to the lounge to tell a colleague but without offering any reassurance to the person who needed assistance. We also found examples of where people's dignity had been compromised, due to the length of time they waited for support with their continence needs.

We found that there were some occasions when people's dignity and privacy was not properly promoted. For example, we observed there were occasions when staff walked into people's rooms when they had their doors open, without knocking or announcing themselves. We also heard staff asking loudly in communal areas and in front of other people, whether someone needed to go to the toilet. Staff called to one another along a corridor about helping someone with the toilet and used terminology that was not wholly respectful, saying, "I'm just doing [person]."

One person needed support from staff to make a decision about their meal but was addressed in the 'third person', in front of others. There was a protracted discussion between staff about their meal, for example, we heard staff saying, "What will [person] have? Does she want vegetables?" This contrasted with the practice of other staff members who took plated meals to show to people so that it was easier for those living with dementia to make a choice.

A member of the nursing team told us how they had sometimes needed to intervene to prevent other staff from discussing their own personal lives or the needs of people living in the home, within earshot of others. Two people we spoke with confirmed that this happened and one said, "We don't need to hear that."

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

This contrasted with good practice we observed in staff responding to a person who became distressed in a corridor after their relative left to go home. The member of staff offered them reassurance, went with them to their room and sat with them offering encouragement, comfort and support in a kindly manner.

There was variable practice in the way people's views were taken into account in planning their care, with the support of their relatives if this was needed. One visitor to the home told us how they had given staff information about the person's needs and background, but when they had been shown the care plan that staff had put together, this was not accurate. They did say that it had been put right but it presented concerns that people's views about their care were not always listened to and acted upon.

Requires Improvement

Is the service responsive?

Our findings

There was variable practice in how people's needs and preferences were reflected within their plans of care. The provider's own quality audit from 11 January 2016 identified that more attention was needed to showing people's likes and dislikes, life stories and the things that were important to them, within their plans of care. The audit also stated that staff did not consistently understand what was meant by 'person centred care'.

There was good practice from some staff in checking people's preferences. Staff spoken with were aware of the importance of offering people choices, for example, what they wore and ate. We found that there was good information in some plans of care about people's preferences. Some care plans contained detailed information about people's night time routines, including how they liked their pillows, lighting, and whether they wanted their door open, closed or ajar. For another person there was guidance for staff about how they could successfully assist the person to get dressed. This included advice about distracting them with subjects that they were interested in and talking about these with the person when they were unhappy and shouting out.

However, people's needs and preferences were not always met. One person told us that they liked to get out of bed but said, "I can't, as staff don't have time." They also expressed concerns that they could not always understand staff explanations and the information they were being given, because the English language skills of some staff were not good. Another person told us how they had made choices about their preferred time of going to bed and getting up but that this was based on the availability of staff to help them. They said, "I go to bed at 10.30pm and get up at 6am." They told us that if they chose other times they would have to, "…wait for ages."

A visitor told us that their relative was sociable and would benefit from going to the lounge but this did not happen. They told us that there was a conflict between senior members of staff about this about whether the person should be out of bed or not. This meant that the response was inconsistent and did not properly consider the person's needs and preferences or the views of someone who knew them well. The registered manager told us that they did not know why this was happening but would address it.

We received information from another visitor to the service that the home had taken prompt action to secure a mattress of the appropriate calibre and specification needed for pressure relief. This was as a result of an assessment of the person's needs. However, they told us that staff had not ensured that this was put on the person's bed for four days after it was supplied. During that time the person would have been at increased risk of developing pressure ulcers as equipment of the specification identified as necessary to address the risk had not been put in place promptly. The service had not therefore responded appropriately to the person's changed needs.

One person told us that there had hardly been any activities since November 2015, when the previous activities coordinator left the home. The manager informed us that they were recruiting and had recently interviewed for activities coordinators so that people's social and recreational needs could be met. The

manager said that they were intending that some activities should be provided daily. There was no evidence in care records that people's hobbies were taken into account and that they had opportunities to engage in activities they enjoyed. The sensory lounge on the first floor remained unused during our inspection as did the activities lounge on the ground floor. This was despite a bingo session being advertised which was supposed to take place every Friday.

On the first floor of the home a member of the nursing team told us that all but one person stayed in their room because staff did not have time to assist them to come to the lounge. This would compromise the ability of any staff appointed to complete activities with people to engage them properly.

We concluded that people's individual needs and preferences were not properly taken into account in the way their care was planned and delivered. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were not all confident about how they could raise concerns or complaints and who they should speak to. For example, two people told us that they did not feel confident improvements would be made if they did raise issues. One person said, "It doesn't do any good to raise issues." They went on to tell us that they did not know who they should speak to and did not know who the manager was. A visitor to the service explained how they had not received a response to two issues they raised informally until they, "...made a fuss."

Inadequate

Is the service well-led?

Our findings

The local safeguarding team made us aware of a specific and serious allegation that had been raised early in January 2016 and reported by the registered manager to them. However, we received no formal notification to alert us to this as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We were concerned about the culture within the service and how this fostered open communication between the staff team and people using the service. People were not always confident that raising issues would result in action being taken and improvements being made. One visitor said there had been a delay in making improvements they saw as needed.

People living in the home expressed the view that staff morale had declined and we were concerned at the numbers of staff spoken with who were distressed and upset about their work. There were mixed views about how approachable the provider's representatives and registered manager were if staff had concerns, with most of those spoken to indicating there was no point raising issues with managers as things never improved. Over one third of the staff spoken to said that they had felt they were under pressure not to tell inspectors anything that the provider could construe as negative. We outlined to the provider's representatives and registered manager our concerns that the perception of a significant proportion of staff was that they were not listened to and were not free to express their views openly without fearing a bad reaction.

People were not always clear who the manager was. Two people told us that they did not know. Staff expressed some concerns that they were not always sure they could go and speak with her because there was always a notice on the office door saying, "Do not disturb, meeting in progress." We observed that this remained in place throughout our inspection.

We noted that staff, people living in the home and their relatives had been consulted by way of a questionnaire during 2015. An action plan was completed in June 2015, showing how improvements would be made. We found that some of the actions identified as necessary had either not been completed or not sustained, for example in relation to activities and staff training. The action plan from the questionnaire also showed that, "The RGN [registered general nurse] team now wear tunic tops to assist people to identify the person in charge." We found that this had not been sustained and nurses on duty were not wearing uniform tunics. Professionals told us that it was sometimes difficult to identify who they should talk to about the person they had come to see.

The management team were confident that there were sufficient staff but had not identified the issues we found during our inspection. We found it very difficult to establish on both days of our inspection, how many staff were actually on duty and where they should be working in the building. We were given a variety of conflicting information about staffing numbers by the registered manager, an administrator and head of clinical development. We needed to ask for clarification about actual numbers on numerous occasions over both days to establish who was on shift. Duty rosters and information provided did not consistently match

the numbers of staff that were supposed to be on duty.

On the first day of the inspection, a staff member had left their early shift at 10am. The staff member concerned was rostered on duty for a long day and had informed others that they would likely be back later. No effort had been made to clarify this and when the staff member did not return, the afternoon shift was also short staffed. The registered manager said she had not been told that the staff member had left, no one had taken responsibility for checking what was happening or arranging additional cover and the shift was therefore short.

On the second day of our inspection a staff member was redeployed from one floor to another leaving four and not five staff on that floor. We were not able to establish that the staff member who was supposed to exchange places, did so promptly. The layout of the home across two floors and with corridors separated by secured doors meant that it was not easy for staff to summon assistance from another part of the home if this was needed. The head of clinical development told us that the home was over-staffed on that day because one support worker had made a mistake with their shift. However, we found that the new staff member had been included in numbers, despite the manager assuring us that they should be additional to the full staffing complement. This meant that, if the other staff member had not made a mistake, staffing numbers would have been one less than required.

Staff on shift told us that they frequently did not get the breaks to which they were entitled. When staff enquired about their breaks on the second day of our inspection a senior staff member referred them to the 'allocations sheet', which staff could not find. All but one staff member we spoke with felt that there were insufficient staff. This reflected what most people living in the home told us about the way they were supported and what we observed. Staff were frustrated about the lack of time they had to spend with individual people. They were aware of the impact on people outlining that some people were not able to get out of bed, there was a lack of activities and people experienced boredom and loneliness.

Although there was a tool available to the registered manager to assess people's dependency, it was clear from our discussions with staff and the management team that staffing levels were primarily established on the basis of a ratio of staff to people living in the home. The ability of staff to meet people's needs was compromised on occasion in the way they were deployed, a lack of clarity about their roles and a lack of leadership on shift.

The provider's call bell system allowed for it to be checked, to determine what response times there were and so that unacceptable delays could be investigated. As a result of us asking for the information from the provider's director of specialist services, a potential fault was identified. Some calls were listed as being responded to without the call system recording that they had been made. The action plan from the provider's quality audit of 11 January 2016, had an agreed action that the manager would monitor the system weekly. This action could not therefore be reliably taken.

We had concerns that some call bells in certain rooms were recorded as being activated frequently within very short periods of time. We were not able to ascertain from this whether staff were turning bells off without assisting people (as had been reported by one person to a member of staff), or whether this too was a possible fault in the system. We were concerned that anomalies had not been identified as part of routine monitoring of the service and were not picked up until we asked for the information.

We looked at records of incidents and accidents taking place in the service during December 2015, and which the manager had signed as reviewed. In some cases the manager had commented on whether any additional information was needed as a result of this review. However, we found that the analysis was not

always appropriate and meaningful. For example, when people fell there was a checklist for staff to use to establish whether there were environmental factors that might have contributed to the fall. This included establishing whether the height of their chair or bed was appropriate, whether they could access their call bell and whether bed rails were in use. This was appropriate for falls taking place in people's own rooms but had been used when one person fell in a lounge having tripped over another person's walking aid. The checklist was not therefore meaningful and relevant to the circumstances in which the person fell and in identifying how to minimise the risk of it happening again. We concluded that staff completing the checklist did not have a clear understanding of its purpose. We found that another person was recorded as having had two un-witnessed falls on consecutive days over Christmas. The manager's review indicated there was no further action to take. This was despite there being no other accident reports showing that the person had previous falls during December. The analysis did not identify whether any action should be considered in case there were underlying causes contributing to the person falling twice in quick succession.

The provider's head of clinical development supplied us with information about training. They confirmed that the provider's e-learning programme was mandatory for all staff including nurses. We identified that some staff were not listed as due to complete some of the required modules, including nursing staff. One staff member, in post since the beginning of October 2015, did not appear on the list for e-learning at all. The provider's representative agreed that this had been an oversight. We were concerned that the staff member had been in post for three months without this being identified, before we pointed it out. We concluded that the arrangements for monitoring training, reinforcing this with staff and managing it through performance monitoring, were insufficiently robust. There was also a risk that performance monitoring could be applied in an unfair manner in the absence of accurate and reliable information.

Records were not all up to date and consistent, including people's care records but the provider had identified where some improvements were needed to these. The provider's systems for monitoring the quality of the service including record keeping, had not identified the issues we identified in relation to medicines records and audit, training and recruitment.

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

Visiting professionals we spoke with told us that they felt the service was improving under the current registered manager. Between the first and second days of our inspection, there had been a compliance audit completed. This had identified some of the shortfalls we found and action that was needed to address them.

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 did not take formal enforcement action at this stage. 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 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the Care Quality Commission without delay of an incident taking place in the home.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always being treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care and treatment was not always properly assessed and recorded. Decisions taken which were considered to be in people's best interests did not always show due

regard to legal process.

Regulation 11(1)

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 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)

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, suitable staff properly deployed to meet people's needs safely. Regulation 18(1) and 18(2)(a)