Bondcare Willington Limited

Allington House

Inspection report

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Date of inspection visit:
11 July 2017

Date of publication:
11 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 July 2017. This was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting.

The service was last inspected in June 2015 and received a rating of good.

Allington House is a purpose built 46 bed care home. The home provides personal care for older people and also for older people who have dementia. Accommodation is provided over two floors and includes communal lounge and dining areas. All rooms have en-suite facilities. There are garden areas surrounding the building. At the time of inspection 44 people were using the service.

The service did not have a registered manager. The previous registered manager had left in June 2017 after only being registered four months. 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. At the time of the inspection they were interviewing for a new manager. Two regional managers and two regional support managers were overseeing the running of the service. A previous regional manager who had been supporting the registered manager had also left.

Most risks to people arising from their health and support needs or the premises were assessed, and basic plans were in place to minimise them. A number of checks were carried out around the service to ensure that the premises and equipment were safe to use. However some risks were not fully documented to provide staff with sufficient information on how to mitigate the risks. The calibration of the weighing scales was due June 2016 and the electrical safety certificate could not be found.

Medicines were securely stored in people's rooms. However medicines that required refrigeration did not always have the temperatures recorded to evidence they were maintained at safe levels. The service used an electronic medication administration record system (eMAR) and further work was needed with this system to support when required and topical medicines.

There were enough staff to meet people's needs. However, the service's dependency tool had not been updated for two months. Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. Staff were not given effective supervision and the yearly appraisal was just a small number of tick box questions, with no input from the staff member or support for their personal development.

Staff understood safeguarding issues, and felt confident to raise any concerns they had in order to keep people safe.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. We found the provider had taken appropriate action to comply with the requirements of the MCA and therefore people's rights were protected. At the time of inspection 17 people had a DoLS authorisation in place.

Staff received training to ensure that they could appropriately support people, and the service used the Care Certificate as the framework for its training. Staff had received Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) training and understood the requirements of the Act. This meant they were working within the law to support people who may have lacked capacity to make their own decisions.

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for. People told us they had a choice of food at the service, and that they enjoyed it. However where people required weekly weights to be monitored these were not occurring regularly. Food and fluid charts were not always fully completed.

The service worked with external professionals to support and maintain people's health. Staff knew how to make referrals to external professionals where additional support was needed. Care plans contained evidence of the involvement of GPs, district nurses and other professionals.

We found the interactions between people and staff were cheerful and supportive. Staff were kind and respectful; we saw that they were aware of how to respect people's privacy and dignity. People and their relatives spoke highly of the care they received.

People had access to a range of activities, which they enjoyed. However the activity coordinator required additional support, so people were not socially isolated. A plan was in place to provide activities on a weekend.

Procedures were in place to support people to access advocacy services should the need arise. The service had a clear complaints policy that was applied when issues arose. People and their relatives knew how to raise any issues they had. However outcomes were not recorded.

Care was planned and delivered in a way that responded to people's assessed needs. Care plans contained detailed information on people's life history. Care plans were quite difficult to follow and had information that was not relevant to the person such as altered state of consciousness. The regional support manager had recognised the care plans needed work and provided one that they had worked on.

Limited feedback was sought from people, relatives, external professionals and staff to assist with the quality of the service. The service had quality assurance systems in place that had recognised a number of the concerns we identified. We found the quality audits did not have robust action plans in place. For example, there was no named person responsible or a date when an action needed to be done by. Due to a lack of a registered manager and changes in regional managers there was a lack of managerial oversight.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People received their medicines as prescribed. Work needed to be done on the recording of temperatures, topical medicines and when required medicines.

Risks to people were not all recorded.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

The service had not monitored staffing levels recently. Pre-employment checks were completed to minimise the risk of inappropriate staff being employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training to ensure that they could appropriately support people. Staff were not always supported through supervisions and appraisals.

Staff had an understanding of promoting choice and gaining consent and their responsibilities under the Mental Capacity Act.

There were systems in place to support people to maintain their health and people had a balanced diet provided.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity, respect and kindness.

People were supported by staff who knew them well, understood their individual needs and were kind and patient.

Staff encouraged people to maintain their independence, which was appreciated by people and their relatives.

People and their relatives spoke highly of the care they received.

The service supported people to access advocacy services when needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs had been assessed and care plans outlined their personal preferences and how they should be supported. However, care plans could be difficult to follow and had information included that was not relevant to the person.

People were supported to access activities, although further work was needed.

The service had a complaints policy, and people and their relatives knew how to raise issues. Outcomes to complaints were not recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Records and recording needed improvement

Checks to monitor and improve the quality of the service were carried out but action plans were not robust.

Due to a turnover of managers and new managers coming in managerial oversight was not always in place.

The regional managers understood their responsibilities in making notifications to the Care Quality Commission.

Allington House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 July 2017. At the time of our inspection 44 people were using the service.

The inspection team consisted of one adult social care inspector, one specialist professional advisor (SPA) and one expert by experience. A SPA is someone who has professional experience in this area. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider was asked to complete a provider information return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR in a timely manner.

We contacted external healthcare professionals to gain their views of the service provided at the service.

During the inspection we spoke with ten people who lived at the service and three relatives. We looked at five care plans, and Medicine Administration Records (MARs). We spoke with eight members of staff, including two regional managers, two regional support managers, care staff, activity coordinator and cook. We looked at five staff files, including recruitment records. We also completed observations around the service.

Requires Improvement

Is the service safe?

Our findings

One relative we spoke with was concerned about safety in the home. They explained that since their relative was admitted they had suffered two serious falls. The relative said they were waiting for floor sensors which were ordered six weeks ago. We discussed the support this person needed with one of the regional managers, who agreed to look into this and chase up the floor sensors.

We asked to see the record of accident and incidents for the last six months along with an analysis, on the day of inspection. We were told that the administrator had access to these and had gone home. We received a Key Performance Indicator (KPI) for June 2017 which recorded 19 accidents and incidents, 17 of which were falls or potential falls. The accident and incident analysis on this KPI stated nine falls in April, with nothing else completed for the whole of 2017. We asked for this missing information to be sent to CQC. We requested this information again two days after inspection and still did not receive it. We requested it again six days after and again didn't receive it. Therefore, we could not evidence accidents and incidents were recorded and analysed.

During our inspection, we looked at the arrangements for the management of medicines. The service used an electronic medication administration record system (eMAR). We found systems were in place to ensure medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were stored in a locked cupboard in each person's own room.

Medicines that were required to be stored in a fridge at temperature range of between 2 and 8 degrees Celsius were kept centrally. We found the fridge temperatures were not recorded consistently and were showing higher than 8 degrees Celsius. This meant that the medicines may not be as effective as they should be.

The eMAR system provided information to record the application of topical medicines such as creams, but no information on where to apply the creams. The directions said 'as directed.' Medicines to be taken when required (PRN) did not have any protocols in place to state why the medicine could be administered, how often and how long to take for. Where people were prescribed medicines for anxiety or agitation there was nothing recorded to state what steps the staff member should do first such as calming or distraction techniques. The regional support manager said they would speak to the pharmacy to see if any of this information could be added to the eMAR system. The regional support manager updated us after inspection to say PRN protocols and topical administration records were now in place.

We were told that two people received their medicines covertly [hidden]. We could see a discussion had taken place with the person's GP and relative and a follow up letter from the GP was available in the records, but we could see no involvement of the pharmacist. The service's policy stated, "The method and initiation of administering medication covertly must be discussed with the pharmacist and medical officer of the Service User to establish the least intrusive method of administration e.g. changing from table to liquids. Obtain full multi-disciplinary team consent and agreement and hold regular reviews with the multi-disciplinary team (not less than 3 monthly). We saw no evidence of regular reviews. This meant the provider

was not adhering to their own policies. We received information from the pharmacy about covert medicines three days after inspection. The services medication policy did not reflect the current eMAR system and also the fact medicines were stored in a locked cupboard in each person's room.

People were assessed in areas such as falls, nutrition, bed rails and moving and handling. However, records highlighted some more personal risks such as poor appetite, self harm tendencies and one record said 'may not eat meat very well.' We could not see risk assessments with clear guidelines for staff. Risks were in some cases documented in care plans and therefore did not stand out as a risk. For example where one person was prone to depression could have low moods and self harm thoughts, the care plan stated staff were to reassure and keep the person calm. There was nothing documented about how staff were to do this, what actions worked well and what staff should avoid. The regional support manager said they had recognised work to care plans was needed and had plans in place to address this.

Risks to people arising from the premises were assessed and monitored. Fire and general premises risk assessments had been carried out. Required certificates in areas such as gas safety and hoist maintenance were in place. However, the last service on electrical safety showed work needed to take place and there was no certificate to show the work had been completed. The electrical safety certificate was not available for us to see on the day. The regional manager agreed to send this onto us, however the electrician could not locate a copy of this. The calibration of the weighing scales was due June 2016 and a service on a bath hoist was due February 2017. The regional manager was not aware of the weighing scales being out of date but said the bath hoist was out of action. We recommended a notice be put on the bathroom door. Records confirmed that monthly checks were carried out of emergency lighting, fire doors, water temperatures and control of substances hazardous to health (COSHH). A Personal Emergency Evacuation Plan (PEEP) was in place documenting evacuation plans for people who required support to leave the premises in the event of an emergency. However, the evacuation pack that would be grabbed in the event of an emergency had PEEPs for a person that had left the service.

Due to no evidence of analysing accidents and incidents, the high amount of falls, not mitigating risks and the lack of an electrical safety certificate to evidence the electrics were safe, these findings evidenced a breach of regulation 12 Health and Social Care Act (Safe care and treatment) Regulations 2014.

Due to the lack of some records in medicines administration, risk assessments and safety certificate and servicing not being available. These findings evidenced a breach of Regulation 17 Health and Social Care Act (Good governance) Regulations 2014

People we spoke to said they felt safe living at the service. One person said, "This is my room and yes I feel safe." Another person said, "I feel secure in these surroundings."

Staff told us they had fire drills and we saw evidence of this which covered all shift patterns. One staff member said, "I had a fire drill after Christmas. We also practice using the sheets that bring people downstairs; we practice on staff not people."

The registered provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event of an emergency, such as flooding or a fire that forced the closure of the service. This showed contingencies were in place to keep people safe in the event of an emergency.

Staff we spoke to had a good understanding about safeguarding. They told us "Safeguarding is there to protect them [people who used the service]," and "I know the different types of abuse, financial, verbal etc. If

I saw anything I would report it straight away, I would stop it straight away, I know who to report to."

Staff we spoke with said they thought there were enough staff on duty, although said they struggled when people rang in sick. One staff member said, "Sickness is a problem, if we can't get cover, we do what we can do, we manage but sometimes we struggle." Another staff member said, "Most days staffing is okay. If someone rings in sick it is hard to get cover, one less makes a big impact and it is hard work." Two other staff members both said there was enough staff on duty. One person who used the service said, "The staff are very overworked." Another person said, "Staff will sit and chat but they are always busy." A third person said, "Yes, there are enough staff, couldn't ask for more, very lucky to have places like this" Relatives we spoke with said, "There are not really enough staff. They do chat when they come into the room to provide care." And another relative said, "My relative has to wait to go to the toilet." On the day of inspection there were two seniors and four carers for 44 people. The service did use a dependency tool although this had not been recently completed. Although staff were busy we did not hear call bells ringing for long periods.

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form in which they set out their experience, skills and employment history. Two references were sought and a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimise the risk of unsuitable people from working with children and vulnerable adults. We found where staff had been TUPE over when the service belonged to another provider (Transfer of Undertakings (Protection of Employment) Regulations), DBS checks were not updated. One person who had been TUPE over more than 10 years ago had no updated DBS. The regional manager said the provider was planning on implementing a signed declaration by an employee serving longer than three years.

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 supported living settings are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Staff had an understanding of MCA and the DoLS application process. One staff member said, "DoLS is when a person is unable to make their own decisions, in their best interests we do this for them but we give them choice and ask them." At the time of our inspection there were 17 people subject to a DoLS authorisation.

Staff we spoke with said, "We do training nearly every week, I have just done dementia, fire training and food hygiene."

We confirmed from our review of staff records and discussions that staff were suitably qualified and experienced to fulfil the requirements of their posts. Staff we spoke with told us they received training that was relevant to their role. Records showed staff had completed training which included safeguarding vulnerable adults, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), dignity and respect, equality and diversity, fire safety, food safety and moving and handling. Staff also received competency checks in medicine administration.

New staff undertook a twelve week induction programme, covering the service's policy and procedures and using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. From records we looked at, we could not evidence that all new staff received supervision during their 12 week induction, to see how they were progressing and if they required any further support.

Staff were not fully supported through supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. From the five staff files we looked at, one had received no supervisions, three had received supervision but had their appraisal on the same day and the fifth file showed the staff member received five supervisions; three of these were in April. The

appraisal form was primarily a tick list; there was no record of what was discussed or information about the staff member's development plan. We discussed this with the regional manager who said they had recognised the appraisals needed work and was developing a new form which would encourage more involvement with the staff member.

People were supported to maintain a healthy diet. Assessments had been carried out using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk of malnutrition. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. However, where weekly weights were recommended these were not taking place for everyone. One care plan stated weekly weights should be monitored, but there was no pattern as to when the person was weighed. Records showed that when the person was weighed in April they had lost 5kgs in a week. We discussed this with the regional manager who said this will have been a recording error. However, this matter had not been identified and there was no evidence of any action taken. The MUST score was not always updated and food and fluid charts were not always completed. For example, one person was referred to a dietician and it was recommended to offer sweets and snacks between meals and encourage a minimum of 30mls of fluids per kilogram of body weight. We could not evidence this was happening, details were not recorded on the food and fluid charts. This meant staff may not be effectively monitoring people's intake and taking action, as required. However, this person was weighed weekly and showed no signs of losing weight.

Every person we spoke with was very complimentary about the food. Comments included "The food is beautiful, really really good," "The sweets especially the sponges are very nice,","the food is lovely." However, one person said, "The food is to be desired."

We observed lunch on both floors. On the day of inspection the choice was chicken curry with rice and/or chips and scampi, chips and salad. Two gentlemen found the curry too spicy and decided to change to the scampi. The tables were set with condiments although there was no vinegar for the chips or tartare sauce to go with the scampi. We asked why and one staff member said, "Oh we have some somewhere." No attempt was made to find this. We were told that people all sat in the same seats for meals, and this was how they wanted it. We saw that people came to the exact same seats during the tea time meal. The dining experience was calm and unhurried.

We spoke with the chef on the day of inspection and they told us they were aware of each person's dietary needs. They showed us diet notification sheets for each person and explained if there was a change to a person's diet the senior carer informed them. The chief said, "We have one person who is allergic to potatoes so they get more vegetable, rice and pasta." The kitchen prepared a choice of meals for people, the chef sent out a menu sheet for people to choose what they would like to eat. We observed a menu sheet showing this choice. Snacks and refreshments were available between meals with a drink and biscuits in the morning and milkshake, cake or biscuits in the afternoon. The chef said they spoke to each person when it was their turn as 'resident of the day.' They said, "I always ask them if they enjoy the food."

People were supported to access external professionals to maintain and promote their health. Care plans contained evidence of referrals to professionals such as GPs, the district nurse, dieticians, speech and language therapist, dentists and opticians. People we spoke with said, "Yes the staff get in touch with the doctor immediately."

Good

Is the service caring?

Our findings

People and their relatives told us they were very happy and the staff were kind and caring. One person said, "The staff are very pleasant." Another person said, "The staff are marvellous."

One person said they were new to the service and a staff member replied, "You are one of the family now." The person replied, "I hope so." This person looked happy and at ease following this response from staff. They said, "That is so nice."

One relative we spoke with said, "The staff seem to communicate well with [relative's name]." Another relative said, "Staff are top class."

We saw staff were courteous towards people who lived at the service, knocking on bedroom doors prior to entering and dealing with any personal care needs sensitively and discreetly in a way that respected the person's privacy and dignity. We observed staff asking permission to enter even when a person's door was wide open. People we spoke with said, "They [staff] always close the curtains and we have a lot of windows in our room."

One staff member said, "We always close the curtains and keep people covered with a blanket or towel when providing personal care." Another staff member said, "I always knock before entering a room and say, it's me can I come in?" One person who used the service said, "Staff don't just barge in; always ask me first what they are doing. Couldn't want for better, it is home from home, the staff spoil us." Another person said, "The staff always close the door when I am showering."

Staff encouraged people to maintain their independence. One person said, "I do as much as I can for myself. If I do struggle they [staff] are there if you need them, then we do it as a team."

One staff member we spoke with said, "We always encourage people to do what they can. For example, apply creams or wash their own face." Another staff member said, "It all depends on their ability that day, if they can do something themselves we will guide them."

Throughout the inspection we observed staff interacting with people in a kind and caring manner. As staff moved around the service they made an effort to stop and talk with people. Staff clearly knew people well and what was important to them.

At the time of inspection no one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. Information on how people could access an advocate and what an advocate does was on display in the reception.

At the time of inspection no one was receiving end of life care. We found no information in care plans about people's wishes and preferences at this time. One care plan stated this was not needed. The regional manager said they had identified that nothing was recorded and were working on correcting this.

Requires Improvement

Is the service responsive?

Our findings

During our visit we reviewed the care records of five people. Records showed people had their needs assessed before they moved into the service. During this assessment staff checked on their mobility, communication and what support they needed on a daily basis. This ensured the service was able to meet the needs of people they were planning to admit to the service.

People and relatives seemed unsure of what a care plan was or if they had any involvement with it. One relative said, "No, I don't know what a plan is, I have never had any involvement, I feel very much left in the dark, we don't know about our [relatives name] medication or anything."

Each person had an assessment, which highlighted their needs. Following assessment, care plans had been developed. Care plans we looked at were person centred. Person centred care is care that supports the person's own needs, preferences and wishes. Care plans contained information about the person's likes, dislikes and personal choices. Care plans provided guidance to staff about people's varied needs and how best to support them. For example, if a person was at risk of developing pressure ulcers, preventative pressure relieving mattresses were in place and care plans informed staff of the intervention that was required to ensure healthy skin. However care plans were difficult to follow and we found plans in place that were not relevant to people. For example everyone had an altered state of consciousness care plan but stated not needed. We also found that not all records were completed. For example, where people required positional changes the records showing this had taken place were inconsistently completed. One person had their continence needs assessed, however no elimination care plan had been developed. Staff told us that continence pads were checked daily but there was no evidence of this. However, this was down to poor recording as people's skin integrity showed no concerns.

Daily records for each person were poorly maintained and records did not provide enough detail. For example, one person was on hourly observations due to their preference for staying in bed with their door shut, and because they could have a low mood and thoughts of self harm. The daily observation charts just stated awake or asleep, no records were made of the person's mood or how they were feeling.

Handovers were used to promote continuity of care from one shift to the next. However the handover records were limited, which meant that there was a risk that people's needs, daily care, treatment and professional interventions may not be communicated when staff changed duty at the beginning and end of each shift. We found no evidence of a person coming to any harm and this was more of a recording issue. The handover records did not record the person's full name so if a person had the same Christian name as another their care needs could be confused. On relative said, "I don't think the handovers are effective as I have to keep mentioning the same things to different staff, there is no continuity."

Care plans were reviewed on a regular basis to ensure they accurately reflected people's current support needs. However, work needed to be done to record only what was relevant to the person.

These findings evidenced a breach of Regulation 17 Heath and Social Care Act (Good governance)

Regulations 2014

Staff showed good knowledge and understanding of people's care, support needs and routines and could describe care needs provided for each person. It was clear they knew people and their needs well.

People said they were happy with the activities on offer and had choice of whether to join in or not. Activities included entertainers, exercises, arts and crafts, games and trivia and one to one time. People we spoke to said, "I join in with everything, you name it, we do it,", "Yes, there are activities but I don't join in,", "The carers come and ask me to join in, I play cards with staff or anybody." Two other people said, "I go out to the pub, the staff take me," and "I like to go out into the garden."

The spiritual needs of people were also met, the activity coordinator told us that church visitors from most religions came to see people and there was a church service every other month.

The activity coordinator said, "I adapt activities to meet the needs of the residents with one to one activities for people who prefer to stay in their rooms or were confined to bed. I do a quiz for one person who has a degree in a specific field."

The activity coordinator had recently reduced their hours to four days a week and did not work weekends. They said, "I think the managers are deciding on whether to recruit for the hours available, carers have access to my cupboard on my days off so they can do activities. They usually sit and watch videos with them on a night or play dominoes."

We asked staff if there were enough activities going on and if they had time to provide them when it was the activity coordinators day off. Staff told us, "There are not enough activities," "Upstairs need more activities to keep their minds occupied," and "We have enough staff but not always to do activities." Another staff member said, "If there was a time I was not busy I will paint their nails, do their hair or get the giant blow up hoopla out to play, they love that. But I don't get as much time as I would like." We spoke with one of the regional managers about activities and they said they were reviewing them and also looking to get the group mini bus at the weekend so they could go to other homes in the group to join in activities.

There was a policy in place for managing complaints. This set out what would constitute a complaint, how it would be investigated and the relevant timeframes for doing so. The service had received four complaints since January 2017. All complaints were investigated and usually a meeting held to discuss the complaint. However the outcome to the complaint was not documented therefore we could not evidence the complainant was happy with how their complaint was acted upon. We recommend the provider records the outcome of the complaint.

We saw a file with a large number of compliment cards. However these were not dated so we could not evidence when these had been received.

People we spoke with were happy with the care they received and said they would feel comfortable discussing their worries or complaints with one of the managers.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in place. The current registered manager had left in June 2017. We found the managerial oversight at the service to be confused, mainly due to the amount of managers in place. The previous registered manager had support from a regional manager who had only been at the service for three months before leaving. Another regional support manager was then put in place. The registered manager left and a further regional manager came to the service. A new regional manager was then employed and another regional support manager was helping on a day to day basis. On the day of inspection there were four regional managers working at Allington House, although no one seemed to have a full oversight or designated responsibility.

The regional managers carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the operation of the service. Audits were carried out daily, weekly and monthly including checks of areas such as medication, health and safety, staffing levels, infection control and falls analyses. The regional managers had highlighted many of the concerns we found at this inspection. An action plan was developed after each audit. However, there was no person named to be accountable and no timescales identified for when the actions would be completed by.

Due to no one having full accountability records relating to PRN and covert medicines were not complete, old PEEPS were not removed from the evacuation pack when people had left the service, staff were not fully supported through supervision, daily records and handovers not fully completed, no end of life plans in place and care plans not fully updated. We chased up information required on accidents and incidents along with an analysis. However, we did not receive this information.

After the inspection we were informed a new manager had been appointed. We were also provided with the correct information required for medicines.

Due to areas of concern found on the day of inspection these findings evidenced a breach of Regulation 17 Heath and Social Care Act (Good governance) Regulations 2014

External healthcare professionals all expressed they were concerned about the lack of a manager.

We asked people and their relatives what they thought of the management at Allington. One person who used the service said, "I don't know who the manager is to be truthful." A relative said, "We have never met the manager since [relative's name] moved in 12 weeks ago."

We asked staff what they thought of the management. Staff we spoke with said, "The registered manager was lovely but they have left, the others are nice and quite good."

All the staff we spoke with said they were really happy working at the service. One staff member said, "I love it, I could not do anything else." Another staff member said, "The managers are approachable, accessible

and visible within the home." A third staff member said, "I am supported and have no problems with the managers."

Feedback was sought from people and their relatives through annual questionnaires. The last survey was completed in April 2017 and people had mainly ticked to say they were happy. Comments included, "Mam is very happy and well cared for, clothes and room are lovely and clean," and "Staff have been exceptional in looking after [relatives names]."

The last staff meetings had taken place in February and March 2017 and topics discussed were housekeeping, dignity, training and care plans. One staff member said, "We have not had a staff meeting lately, we are awaiting a new one."

People and relatives we spoke with said they were not aware of meetings taking place. We saw one had taken place in April 2017 and topics discussed were parking, activities and an upcoming raffle. One of the regional managers said they knew work needed to be done with meetings and had arranged for one to take place the week after inspection.

We asked for a variety of records and documents during our inspection. We found these were stored securely. However due to the lack of managerial oversight some were not easily accessible on the day of inspection. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. We saw the provider was displaying their rating from their last inspection.

We asked staff what they thought the culture of the service was. One staff member said, "The culture is everyone is friendly and caring, I love coming to work. I am happy." One person who used the service said, "It is alright here, a good bunch of people and it is comfy."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always completed with plans to manage the risks. Falls were not analysed monthly to prevent or minimise reoccurrence. We were not provided with an electrical safety certificate to evidence the electrics were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to ensure the effective operations of the service. There were limited checks to assess, monitor and improve the quality of the service or ensure the safety of people living in the service. Risks were not always adequately assesses or action take to mitigate them. Records were not always well maintained or contemporaneous.