Barchester Healthcare Homes Limited

Alice Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Alice Grange is a modern purpose-built service over three floors, that provides accommodation for older people, some of whom may have nursing needs or be living with dementia. The service can accommodate up to 80 people. On the day of our inspection visit there were 70 people living at the service.

People's experience of using this service:
People who lived at Alice Grange and their relatives told us that the staff were kind but that there had been a lot of changes recently, which had disrupted the quality of service they received. Nor did they feel there were enough staff, particularly at weekends. One person told us, they had to wait an hour for help then after they had asked to get up.
Another person commented that they did not think there were enough staff because, "I miss out, when I want to go to other floors for activities they don't always come to take me."

Personal risks were assessed, and steps had been put in place to mitigate risks, around falls for example. However, they did not always contain enough information and detail so that staff knew how people should be supported during an epileptic seizure.

Staffing levels were not always enough to keep people safe, replacement staff were not always brought in if staff went sick at short notice or if they were on leave. Often staff were taken off their substantive role to cover a different role, carers were asked to cover the hostess post for example. Safe recruitment processes were followed.

Health and safety risks within the home were not always properly addressed. The food serving trollies were unattended while switched on, meaning that people were at risk of burning themselves.

Medicines were not managed in a way that ensured that people received them safely.

Staff were trained to recognise abusive situations and knew how to report any incidents they witnessed or suspected. Staff had access to equipment that protected them and the people they supported against cross infection.

People's needs were assessed prior to them moving into the service, but the information was not always detailed and was not always reflected in their care plan. People did not always receive care that was personalised and responsive to their needs. The care plans did not always contain detailed explanations for staff on recognising people's disabilities or how they could be supported with the difficulties associated with their illness.

Staff received training appropriated to their role, however it was not evident that staff were always given a proper induction.

People were supported to eat and drink enough to maintain a healthy weight for them and have a balanced diet, but people told us that the food quality was poor, and they did not always get their first choice. The staff worked to ensure that people received the care they needed when they used and were supported by different services.

Because there was not always enough staff to support people, the people were not always supported to have maximum choice and control of their lives. However, staff supported people in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People were asked for their consent by staff before supporting them in line with legislation and guidance.

Staff who spoke with us talked about the people who used the service in a caring and positive way. People told us that staff were very busy and did not always have time to stop and spend time with them, but that they were kind, caring and protected their privacy. We saw evidence in records that people were able to express their views and staff listened to what they said.

The service had listened to people's experiences, concerns and complaints. However, people and their relatives told us that in the past complaints were not always dealt with properly but hoped things would improve now there was a new manager in place.

There has been a quick succession of managers recently that has added to a fall in the quality of care people have received. The provider has taken steps to get a manager in place and a new manager started work on the same day as the first day of our inspection.

The service was not well led, paperwork was disorganised, and information and records asked for were not always available or just could not be found. Quality assurance systems were in place but have not always been robust, as reflected in the comments made by people who used the service and their relatives, and the concerns and omissions we have identified during this inspection.

Rating at last inspection: After the last comprehensive inspection, the service was rated Requires Improvement in the Safe key question and Good in the other four areas, meaning that the service was rated Good overall. (published on 15 June 2017).

On 21 March 2019 we carried out a focused inspection over two key questions, Safe and Well-led because we had received concerns raised by people's relatives and the adult social care professionals. As a result, Safe was rated Good and Well-led was rated Requires Improvement, the overall rate remained Good (published 5 June 2019).

This inspection was prompted in part due to concerns received about the management of the service, medicines and staffing. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective, Responsive and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Alice Grange on our website at www.cqc.org.uk.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Alice Grange

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors, a pharmacy inspector, a specialist dementia nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Alice Grange is a 'care home' with nursing. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A new manager had taken up their post on the first day of our inspection, but they were not yet registered with the Care Quality Commission. This means that, when they had completed their registration, they and the provider would be legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make.

We reviewed any notifications we had received from the service. A notification is information about

important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from members of the public and external agencies.

Before this inspection we had received several concerns voiced by the local authority, the contracts management team, people's social workers, the Clinical Commissioning Group (CCG), Healthwatch and relatives of people who use the service. Therefore, the next planned inspection was brought forward.

We reviewed an action plan the service shared us in response to concerns raised by the local authority safeguarding team after it had carried out an inspection of the service.

We used all this information to plan our inspection.

During the inspection
We spoke with 21 people who used the service and nine people's relatives about people's experience of the care provided. We spoke with the management team; the new manager, the deputy manager, the operations manager (peripatetic manager), the divisional clinical lead and the regional director. We also spoke with three nurses, two team leaders, 17 care staff, one of the activity team and a housekeeper.

We also looked at records relating to nine people's care, eight staff recruitment records, training records and complaints. We also looked at audits and systems in place to check on the quality of service provided.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at additional quality assurance records that were sent to us by request.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question had now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● Staffing levels were not always enough to keep people safe. All the people who used the service, their relatives and some of the staff we spoke with told us that they did not feel that the staffing levels met people's needs and gave us many examples of how it affected them. One person told us, "There's not enough staff, they really struggle. They try not to show it, but after tea time it takes them a long time to come, I waited 1hr 35 minutes last week, I was desperate for the loo and was quite stressed as I thought I might wet the bed." The person explained that staff would come to their room when they called, would turn off the call bell and say they would come back soon, but it was often a long wait.

● Another person told us that one staff member, "…. comes in like a dose of salts, does what [they] have to but doesn't wait to see if you are okay. My [relative] came once and saw how upset I was and [they were] furious." Another person said, "When I set the buzzer off, I tell [the staff] not to turn it off until they have seen to me, if they turn it off you don't see them for 20 or 30 minutes."

● A member of the housekeeping team said, "I enjoy my job, they allow me to be flexible with my time, but we need an extra pair of hands. At weekends we are often short."

● Replacement staff were not always brought in if staff went sick at short notice or if they were on leave.

● We were told that the service used an assessment tool to determine the number of staff needed to meet people's needs. However, the tool had not been used correctly, not all staff had been trained to use it. The regional manager told us the tool was now being used as intended, but we were not assured there were always enough staff on duty because during our inspection we found that there were not.

● Often staff were taken off their substantive role to cover a different role, carers were asked to cover the hostess post for example. On the day of our inspection there was only one hostess on duty, meaning that two care staff were diverted to cover that post on the other two floors. Extra care staff had not been brought in to cover that loss in their number.

● The deputy manager was expected to carry out some care duties as well as complete their office duties. It became apparent that the deputy manager was expected to sacrifice their supernumerary hours (office hours) to cover for care staff/nursing absences. This led to them not being able to keep up to date with their office work, including quality assurance tasks and rotas.

● The daytime staffing level for the whole of the middle floor, which was the dementia unit was two nurses and six care staff during the morning and five in the evening. The dementia floor was made up of two adjacent units and the doors between them were kept closed and locked using a keypad. This meant that staff were not always in the right place to be able to safely monitor people at the proposed staffing levels.

● There was not enough staff at each end of the unit to supervise people. For example, we saw people were left to walk around on one side of the floor without staff being available to support them. On two occasions we observed people who were not using their mobility aids and were in danger of falling, we needed to find

staff to alert them, so they were assisted as needed.
● On the dementia floor, during the first day of our inspection, there were two bank nurses and five care staff on the morning and evening shift. That was one less than the planned staff members for the morning shift. One care staff member said, "It's difficult as we are short staffed, but I try and talk to the residents as much as I can, but as you can see I have to move between two the two sides today to help with personal care as we are short." Another member of staff told us, "Even when we are classed as fully staffed we struggle. There are too many people who need doubles [two staff to assist them], we struggle to get people up by lunchtime. We don't always manage to." This was confirmed by people's visitors who told us that their relatives were often left in bed until the afternoon because staff did not manage to get them up before lunchtime.
● The planned number of waking night staff was two nurses and six care staff to cover all three floors. During the morning handover we spoke with an agency nurse who was sitting in the corridor supervising the whole floor, the central door was closed and locked. When asked who was supervising the other side of the unit, we were told they were. During that time there were four people awake, dressed and walking about in the part of the unit not being monitored. With the doors closed the agency staff would not have been able to hear if anyone had called for help. The agency staff told us that it had been a busy night because they had been one staff down, and that it had got particularly busy around 5am when people had started wanting to get up and there were several people who needed two staff to help them in getting up.
● A staff member told us that the laundry hours were 90 hours a week, but this had been reduced to 60 hours a week, with the possibility of those hours being reduced further. The laundry was not used at night so as not to disturb people sleeping in nearby bedrooms.
● People and their relatives told us that it took a long time for their laundry to be returned. Three relatives told us that they had got into the habit of collecting their relative's laundry to save the delay. A staff member commented, "The laundry ladies really struggle, they could do with an extra pair of hands, the laundry does not go back to residents every day, it's every other day."
● Permanent and bank staff had been recruited safely to ensure they were suitable to work with people who may be vulnerable. However, the service used a high level of agency staff. Information was obtained from the agencies to enable the manager to satisfy themselves that the agency staff had been recruited safely to ensure they were suitable to work at the service. The information relating to the nurses gave all the required information, but those relating to agency care staff gave an introduction to the staff but did not show whether they had received relevant training or had undergone a Disclosure and Barring Service check.

These examples show that there were not enough staff to support people and to keep them safe which is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Observations of staff giving people their medicines showed that they did so following safe procedures. Staff had received training and their competence had been regularly checked.
● Oral medicines were stored securely. However, medicines prescribed for external application such as creams and emollients stored in people's rooms were not secured so they could be accessed by people who could have caused themselves harm by using the medicines inappropriately.
● There was a system in place for ordering and giving people their medicines as prescribed. Medicines given by staff were recorded on Medicine Administration Record (MAR) charts. However, we noted there were some gaps on the MAR charts for oral medicines which could have meant people were not always receiving their medicines as prescribed and safe recording procedures were not always followed. There were also gaps on charts relating to medicines prescribed for external application such as creams and emollients.
● Records showed that some medicines had not been given because they had not been obtained and made available for use. When medicines had been reviewed by prescribers and changes had been made, some

discontinued medicines still remained in the medicine trolley and so could have been given in error.
● There was some guidance to show staff how people preferred to have their medicines given to them. However, for people who were given their medicines prepared in food or drink, written information about this was inconsistent and advice had not always been taken from a pharmacist to ensure it was safe to do so.
●There was guidance to help staff give people their medicines prescribed on a when required basis for some but not for all medicines prescribed in this way. For one person the written information available about a medicine was inaccurate and inconsistent with the prescribed instructions for the medicine leading to more of the medicine being given to the person than intended by the prescriber. In addition, there were not always clear records showing why the use of the medicines was justified on each occasion.
● When people had known allergies and medicine sensitivities, information about this was sometimes written inconsistently which could have led to error and people being given medicines they may be allergic to.
● For people who were prescribed medicated skin patches there were additional records in place to show the sites the patches had been applied to had varied to reduce the potential for side effects, however, these had not always been completed by staff.
● There was sometimes a lack of information to show staff the areas on people's bodies creams and emollients were to be applied to.
● Daily MAR chart checks and monthly checks of people's medicines and their records were in place, however, we noted that these examined only a small proportion of people's medicines each month leading to the potential for inadequate oversight of medicines by the manager.

The poor management of medicines demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Personal risks were assessed and some risks had been mitigated. However, risk assessments did not always contain enough information or detail so that staff knew how people should be supported. One person assessed as being at a high risk of falls, did not have a specific falls care plan to mitigate risks.
● Another person's Parkinson's care plan was not detailed or specific enough. The risk assessment did not include information that would inform the care staff about their support needs, including muscle feeding, stiffness, slow movements, muscle pain or tiredness for example.
● Health and safety risks within the home were not always properly addressed. A food serving trolley in the dementia unit was unattended while switched on, meaning that people were at risk of burning themselves.

Risks to people not being properly assessed or addressed demonstrates a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● It was not apparent that lessons had been learnt when things had gone wrong.
● Systems were in place to log incidents that occurred in the service.
● We were told that accidents and incidents were reviewed monthly to identify themes or increased risks.
● As part of continual improvement of the service, the care of people was reviewed to learn any lessons of how the service could develop.
● These systems that had been put in place should have supported the registered manager to review and identify whether the service was offering a good quality of care. However, due to the quick turnover of managers the system was not properly followed through, which indicated that lessons were not always being learnt when things went wrong, as shown by the concerns we have identified during our inspection.

Systems and processes to safeguard people from the risk of abuse

● The provider had safeguarding adult's policy and procedures and staff were aware of this.

● The staff understood the different types of abuse, how to recognise these and what to do should they witness any poor practice.

● Safeguarding concerns had been reported to the safeguarding teams by some people's relatives and other healthcare professional involved with the service. The service worked with the safeguarding team in their investigation but some of the safeguardings were substantiated. The senior managers had developed a leadership and management plan which they were working through to help them better safeguard people.

Preventing and controlling infection

● The building was clean and fresh smelling throughout.

● Staff were trained in infection control and food hygiene, those we spoke with understood their roles and responsibilities in relation to infection control and good hygiene.

● There were systems in place to reduce the risks of cross infection. This included hand sanitisers provided throughout the building and the use of gloves and aprons to limit the risks of cross contamination.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question had now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed prior to them moving into the service, but the information was not always detailed and was not always accurately reflected in their care plan.
- Information in some people's care plans was ambiguous because of the quality of the assessment. For example, whether one person required a 'soft' diet because of a medical need or by preference. There was no explanation on why the person needed a soft diet or what level of softness recorded in the assessment, only 'Soft diet' was written which was then added to the care plan in that format.

Staff support: induction, training, skills and experience

- A staff member who had raised concerns about staffing levels went on to tell us, "Training is not an issue." Another staff member commented, "We get really good training here."
- The training matrix showed that staff had received the training they needed to carry out their roles.
- However, it was not evident that new staff completed a detailed induction and did not work unsupervised until they were confident to do so. We had been told by two staff members they had not received an induction to ensure they knew the building and how to use the tools they needed to do their work. We asked to see staff induction files to be able to assess their effectiveness, but they could not be found.

Supporting people to eat and drink enough to maintain a balanced diet

- The majority of people we asked told us that the quality of food was poor. One person told us, "The food is very variable, sometimes the meal isn't even edible, one curry was revolting. I could only manage one mouthful. Another person told us, "I have to have moist food for my throat now, but the homemade burger was like leather, I couldn't even cut it!" A third person commented, "The food's edible but lacks taste, it is a bit boring."
- The management team were aware of this concern and told us that they had replaced the head chef to improve people's future mealtime experiences. The new chef would be taking up their post the week after our inspection.
- We observed lunch time in the home and saw that staff made sure people who required assistance with their meals were supported.

Ensuring consent to care and treatment in line with law and guidance

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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Although staff sought people's consent and they were supportive and respectful of people's right to make decisions about their care, the service not always being properly staffed, which restricted people's ability in having those decisions implemented.
● Where there were concerns about people's ability to make decisions the service had assessed this and acted in accordance with the MCA.
● The service had submitted DoLS applications where necessary.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to access health professionals when needed. One person told us, "If I'm not well I only need to say, and the doctor is called." Another person told us that the service made sure they saw the chiropodist, dentist and optician when they needed to.
● Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. One staff member said, "We work with other professionals: doctors, the speech and language and tissue viability teams, and others to care best for the people that live here."
● People's records included information about treatment received from health professionals and any recommendations made to improve their health.

Adapting service, design, decoration to meet people's needs
● The premises and environment were designed and adapted to meet people's needs. The corridors were wide enough for wheelchair access and there were rails to assist people when walking round the home.
● There was clear signage for people to help them navigate around the home, which included pictorial signs.
● The community areas were pleasantly decorated, and people's bedrooms were personalised with items they had brought with them and pictures they had chosen.
● There were hairdressing facilities and an area for people to use where they could offer their visitors refreshment.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People told us that staff were kind, caring, and that the staff were respectful and protected their dignity and independence. However, making people wait for support getting to the toilet because staff were rushed due to staff shortages did not reflect a respectful ethos.
- One person told us, "The staff are very kind. They do rush about, but they stop and chat when they can." Another person told us, "Staff are very friendly."
- Staff communication with people was warm and friendly, showing caring attitudes whether conversations were outwardly meaningful or not.
- A relative commented, "[The staff] are so caring, they look out for [my relative] and give [them] what [they] need."
- However, they systems in place did not reflect a caring provider. The provider had not ensured that there were always sufficient staff on duty to be able to support people in a timely manner, we could not be confident that the organisation's staffing expectations supported a caring ethos.
- Staff having to leave people being worried and upset that they may be incontinent because there were not enough staff to help them get to the toilet is not an example of a caring attitude.
- One person told us, "There's not going to be enough people on in the afternoon, so today they didn't get me up to sit in my chair this morning. I like to get up in the mornings then go back to bed in the afternoon." Another person said, "No one comes and sits and talks to me, they barely have time to do the personal care, sometimes you wait until the afternoon."
- People's records and personal details were kept safe and confidential.

Supporting people to express their views and be involved in making decisions about their care

- People told us staff listened to them and they were free to make decisions about their day to day care. Although people told us they could not always get up or go to bed when they wanted to because staff were not always available to help them.
- There were residents' meetings, they were advertised in advance and the minutes of the last meeting were made available for people to read.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive care that was personalised and responsive to their needs. People told us that they were given the opportunity to plan their care but, because of the lack of staff, care was often rushed and was not always responsive to their needs. People talked about being left in bed when they wanted to get up and not being able to get to the toilet in time for example.
- People's care was not always personalised, this was because the care plans did not always contain detailed explanations for staff on recognising people's disabilities or how they could be supported with the difficulties associated with their condition to enable staff to fully understand how to meet their individual needs. For example, staff were not given guidance to ensure that they could better understand one person's mental health needs or how to reassure them when they were anxious.
- At our last inspection on 21 March 2019, we were informed that a dedicated manager had been appointed to oversee the dementia unit, Memory Lane. It was planned that they would arrange care reviews with the people living on Memory Lane and their families. However, during this inspection we were told that most of these reviews had not been done and the dedicated manager had been reassigned to another unit within the service. The deputy manager informed us that a new dedicated manager to Memory Lane had been appointed and the plan was for the care reviews to be planned and take place before Christmas 2019. The care reviews would then be planned at six monthly intervals. This meant that since our last inspection many of the people living on Memory Lane still had not had their care plans reviewed with their families.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service had assessed people's individual communication needs; however care plans were not always detailed enough to enable staff to meet these needs.
- One person had a sensory impairment; their care plan did not contain sufficient information on how staff could meet their specific communication needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The service had four activity coordinator posts, but during our inspection there were two vacancies and one of the remaining activity coordinators was on leave and their absence had not been covered. That meant that there was only one activity staff member working with 72 people over three floors. Both activity

coordinators' contracted hours were 30 hours over four days. This meant that, with only one coordinator on duty, not all of the 70 people living at the service were able to take part in regular activities that were socially and culturally relevant to them. There were limited dementia friendly activities while we were at the service.

● The activities coordinator notes showed that they did activity sessions with small groups of people. For example, seven people meet in the activity room to play on a giant scrabble board. The service had a mini bus and we were told they try and take people out once a month. Sometimes people took part in a trip to a local cafe. Other activities were planned; entertainers and speakers were invited into the service to entertain and people told us they enjoyed the Pets as Therapy dog visits.

● People told us that they did not feel that there were enough activities on offer. One person told us that, "There's nothing in the evening, the only thing to do is read the paper or watch TV." And, "There is a mini bus, but it can only get a few in if there are wheelchairs. We don't go out, we should go out more." Another person said, "We have activities every day, scrabble, dominoes, a walk in the garden and sometimes we go to a café for coffee in the mini bus. We haven't had any outings lately, we did go to Felixstowe." Another comment was, "There are no activities on this floor, they suddenly finished. Two of the team have gone. Sometimes they have things on other floors, but I need a wheelchair. They sometimes forget to come and get me."

Improving care quality in response to complaints or concerns

● A complaints policy and procedures were in place.

● People knew how to raise concerns and complaints. People who were unable to voice complaints due to cognitive impairment were supported by staff to be heard.

● In the past we had been told that the service did not deal with complaints effectively, but the people we talked with and their relatives told us that this had improved recently.

● Records showed that when people raised concerns, they were managed in line with the provider's complaints procedure.

● Those who said they had made a complaint told us it had been investigated and dealt with to their satisfaction.

End of life care and support

● Staff received training on how to support people as they reached the end of their life.

● People's care records included information about the choices that people had made regarding their end of life care. This included whether they wished to be resuscitated and where they wanted to be cared for at the end of their life.

● People's families were supported to stay with their loved ones at the end of their lives.

● We saw cards and thank you letters from relatives thanking the staff for the care and love shown to their family members at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people and how the provider understands and acts on their duty of candour responsibility

- During our inspection we found the service did not have a clear and creditable strategy to deliver high-quality care and support.
- The atmosphere in the service was friendly. However, staff told us that there had been a lot of change in the last year and this had been disruptive with different people managing the service, staff leaving, and a high level of agency staff being used.
- One staff member told us, "We haven't known what was going on from one day to another, two managers have left in quick succession, the area manager has run us, then a trouble shooter [peripatetic manager] came in, they were making all sorts of changes. Now, within weeks, a new manager has started. We've all got our fingers crossed that we can get down to doing our jobs." Another staff commented, "Morale is terrible, I'm not sure the managers get proper support from above."
- People and their relatives we spoke with commented on changes over the last year, saying it had a detrimental effect on the care that people received. One person's relative told us, "The home is going through changes, I've been to two relative meetings, they don't run them as a meeting should be run, it's a moan fest, has no structure, you come away wondering what their plan is?" Another said, "[The service] has not been well managed, the previous two managers didn't have their finger on the pulse. Their doors were always open, and they would say yes, but no changes happened."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The regional manager and the peripatetic manager were open and transparent about how they quick succession of managers had caused disruption in the smooth running of the service.
- People told us they had acted on their responsibilities on the duty of candour. One person told us, "They called [a person], who I had said not to call, when I was ill. I was very upset and complained. [The peripatetic manager] was apologetic and made sure my contact sheet was put right and showed it to me, so I knew it wouldn't happen again." A relative said, "They have admitted they have made mistakes in the running of this place, I hope they've got it right now."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a programme of quality assurance checks in place. However, they had not remained robust

during the disruptive staff changes. They had not all been completed and were not sufficiently robust to have identified the shortfalls that were found during our inspection in relation to the quality of governance of the service.

● During this inspection we found that people's care plans were not always detailed enough to reflect the person's needs or properly address risks to people.

● Actions we were assured would be done after our last inspection had not been completed. This included reviewing and updating people's care plans with their families.

● Some senior staff had not been properly inducted so that they were clear what their role entailed. There was a lack of clarity regarding the use of the assessment tool used called DICE to determine how many staff were required to be on duty to support people to meet their needs. The tool had not always been used correctly because not all staff using the tool had been trained to do so.

● Although senior staff were provided with hours to complete management tasks they were frequently required to cover shifts providing direct care to the people living at the service. Hence not all of the scheduled clinical governance monitoring had been carried out.

● One member of staff informed us they found it difficult to complete their work when a colleague's shifts had not been covered. "I just cannot cover for both of us", they informed us.

● Staff considered that the management team had allowed too much annual leave to be taken during the same time period. Not managing annual leave effectively had resulted in some shifts not being covered and high numbers of agency staff, who would not always be familiar with the people's needs, being used to cover the staffing rota. On the first day of our inspection two of the four nurses on duty were agency nurses.

● The service had a leadership and management plan in place and we saw the copy dated 27 June 2019. The regional director told us that the actions had been completed. Nonetheless, the concerns we identified during this inspection, indicates that further work was needed.

● We also found that the leadership and management plan, mentioned above had not been shared with all the senior managers for them to assist with implementing the plan.

These examples demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● At our last inspection we found the staff were not always supporting people living on Memory Lane to enjoy their hobbies and interests. At this inspection we were told that there had been new staff appointed with experience in supporting people living with dementia. However, two of the activity team had since left and the other team member was on leave and had not been replaced, leaving only one activity coordinator on duty to cover the whole service. This meant we were not assured that any of the people living in the service were supported to pursue their interests and hobbies.

● The senior staff of the service had arranged and recorded meetings with staff and further meetings were planned. They had also arranged relatives' meetings, including one to explain changes in personnel at the service.

Continuous learning and improving care

● The operational manager and deputy manager, although both new to the service, had worked hard to support the staff and organise the care to meet people's needs. A key to effectively overseeing the care, learning and improving was a daily meeting called a stand-up meeting. Under the leadership of the operational and deputy manager, we saw staff from the various parts of the service attend this meeting to discuss and resolve issues and be informed of important events.

● Although there had been many changes in staff since our last inspection, the deputy manager had worked

to provide consistency with the key worker system and introduce new staff to the people they would support. This included arranging time for staff to read care plans and be introduced to the people living at the service.

● A new night manager had been appointed to provide consistency and build relationships with the day staff to provide a seamless service between day and night shifts.

Working in partnership with others

● The deputy manager had meet with other organisations such as the local authority and clinical commissioning groups to build relationships and discuss issues regarding the care of people living at the service.

● The operational and deputy manager had further developed working relationships with the local GP practice so that GPs attended the service when people needed 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 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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed in a safe way, we could not be confident people would receive their medicine safely. Neither were we confident that risks to people had been properly assessed or managed.

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 The service was not well led, quality assurance systems were not always being completed and did not identify the concerns we identified during our inspection.

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 The service did not ensure that there was sufficient staff to support people in a timely manner, to keep people safe or to meet their needs.