Kingsley Care Homes Limited

Downham Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 12 July 2018 and was unannounced. We last inspected this service on 23 and 30 January 2017 and gave the service an overall rating of good, with a requires improvement for the key question Effective. Since that inspection there have been a number of significant changes to the service which have included both the registered manager and the clinical lead leaving. One of the operational managers with oversight of the service had also left. In the midst of so much change we had concerns raised about the stability and safety of the service from the local authority, health care professionals and from whistle blowers. Our response had been to meet and seek assurances from the service about what they are doing to secure good outcomes for people using the service. We also received a detailed and up to date action plan the service is working towards. However, despite these assurances we were still concerned that planned improvements were not happening quickly enough and we needed to satisfy ourselves that people were safe. For this reason, we brought forward an inspection called a focused inspection where we looked at two key questions Safe and Well-Led because no concerns had been raised about the other key questions. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection which is now rated requires improvement.

Downham Grange is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate people without a nursing need or people living with dementia. It is registered for 62 people. On the day of inspection there were 53 people using the service.

A condition of the home's registration is there should be a registered manager in post. A manager was in post but not yet registered with CQC. 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.

In summary we found concerns about the service but recognized the service was on an upward trend having already made some improvements to the service. There was confidence about the manager and their ability to bring about positive change and there was a full complement of nursing staff but some vacant hours for care staff. However there had been a significant reduction in agency usage which helped reduce cost and improved continuity for people using the service. There was also a new clinical lead who had been in post three weeks. This helped strengthen the management team. The level of skill and experience of the staff team was a concern given that not all staff had a good knowledge of people's needs.

We had concerns about staffing. We were not assured there was an adequate skill mix across the three separate units, the dementia unit, residential unit and nursing unit. The shifts were poorly organized without effective leadership and staff were not deployed sufficiently across the day. This meant people were not provided with the necessary support taking into account their wishes and preferences. We found lunch time

on two of three units were poorly organised and did not help ensure people had enough to eat and drink. We also found the provision of activities did not effectively demonstrate how they met individual's needs. We had concerns that people were not adequately monitored for their safety in communal areas and the risks of this had not considered.

The management of individual risks were adequately documented in people's care plans and known by staff. However, information was hard to track through and we could not always see what actions had been taken. We found some concerns regarding risks posed by the immediate environment which is discussed in the main body of the report.

We had received concerns about the electronic medicines system introduced to the service about a year ago. Medicines errors had meant people did not always get their medicines as intended. We carried out some observations and looked at the system in place and found this to be well managed with minimal errors. We saw that staff received sufficient training to help ensure they were sufficiently skilled and competent to administer medicines as intended.

Staff recruitment processes were not adequate and helped ensure only staff suitable for employment were appointed. Some gaps in records were identified which meant the processes were not always robustly recorded.

Staff had a reasonable understanding of safeguarding people in their care and what actions to take if they though a person was at risk of harm or actual abuse. They were able to recognize what constituted a safeguarding and who to report it to both internally and externally.

The service was adequately cleaned and there were sufficient measures to promote the control and spread of infection. However shared manual handling slings posed a significant risk.

The service was not yet well-led. Not all staff had received recent supervision or support around their working practices. Communication across shifts were not always effectively disseminated and the whole service did not work as a team to ensure people's needs were met.

The service was slowly introducing positive changes but these were not yet fully embedded. The culture of the service did not reflect the needs of individuals or adequately show how people's environment was respected and care was planned around their individual needs.

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.

Staffing levels had improved but the deployment of staff across the service was not effective and we were not assured that people always had their needs met in a timely way according to their preferences.

Not all risks to people posed by the environment or associated with the delivery of care were managed well putting people at increased risk of harm.

The recruitment processes for new staff required improvement because records were not as robust as they should be.

People had not always had their medicines as intended but we were satisfied that improvements in this area had been made to help ensure the safe delivery of care.

Infection control procedures in place were effective and the service was sufficiently clean. However, the sharing of manual handling slings between people was not acceptable practice and exposed people to an increased risk of infection.

Staff had sufficient understanding of what constituted abuse and how they should support people and help them feel safe. Some people did not always feel safe in the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

Recent changes to the service meant we could not be assured that people were receiving high quality of care or that it was consistently provided by staff who knew people well. Changes in the management team meant that the oversight and leadership of the service had changed ownership and we were not yet confident in the service, given recent concerns received.

The service was improving but systems and processes were not fully developed. We were not confident in the work force to

deliver the care required until they had all received the necessary support and training required.

The service was not sufficiently consultative and was not able to demonstrate how it listens to people and took into account their feedback and experiences.

Staffing did not enable everyone to receive personalised, timely care and people's experiences were limited in scope.

Downham Grange

Detailed findings

Background to this inspection

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

We carried out our inspection to check how the service was progressing against its action plan and as part of this focussed inspection only inspected key questions safe and well-led. We wanted to satisfy ourselves that there was effective leadership and enough staff to deliver safe care after recent concerns were raised with us. We were also aware of changes both to staffing and the management team, which could potentially affect the safety and stability of the service.

We carried out our inspection on one day, the 12 July 2018. It was unannounced.

As part of the inspection team there were two inspectors, a specialist advisor who was a qualified nurse and an expert by experience who is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we already knew about this service including the last inspection report and statutory notifications which are important events the service is required to tell us about. We also used the information sent to us including feedback from professionals.

On the day of our inspection visit we spoke with 10 people using the service, six relatives/friends and 10 staff including activity, care, domestic, catering and nursing staff. We also spoke with the service manager, the clinical lead and two operational directors. We spoke with visiting professionals at the service and before the inspection.

Requires Improvement

Is the service safe?

Our findings

At a previous inspection in 2016 the service was in breach of regulations relating to safe care and treatment and good governance. The CQC took enforcement action against the service which the service complied with. At the last inspection to the service on 23 and 27 January 2017 we rated this key question good.

At this inspection on 12 July 2018 we had concerns about staffing levels and the safety of people who used the service.

We were not confident that the service always had the number of staff it said it needed or that there was effective deployment of staff and sufficient organisation across the day. We could not be assured people received timely care or adequate supervision for their safety.

We spoke with people about staffing levels and people's feedback was variable. People referred to a lot of staff leaving and being short at times.

One family member told us their relative was treated as if they had dementia, they had not. They went on to say, "Recently, staff continuity has improved so we're hopeful with the new manager that things will get better." A person using the service said, "They usually respond promptly if I push the bell but they're only human so don't always come quick. I think that they don't have enough staff really. I suppose I'm quite lucky because I'm still pretty independent." Another person said "I'm totally dependent on them, hoisted every time I need something. They often make me wait even if I'm desperate 'we need to find a hoist' is the usual excuse it's very demoralising." Another person said, "It's not too bad living here, I've got used to it but I don't feel close to the staff, they talk at you, but really carrying on conversations with others, football a lot recently which I'm not interested in. They are friendly but very rarely do they sit and have a proper conversation. They bring you to the lounge, sit you down and that's it until the next meal."

This was supported throughout our observations across the day when we saw minimal staff interaction with people they were supporting. Staff told us this was because they were, "Too busy, and could do with an extra pair of hands." They said this was particularly true on the residential and dementia unit. One staff member told us in the residential unit most people needed two staff to assist them with their personal care which sometimes left only one member of staff free to spend time with other people. They said call bells rang all the time and they were not able to answer the bells quickly enough.

We carried out observations on each unit and spoke with staff. On the nursing unit, there were two nurses as one was new and on induction. This unit was running well. People got their needs met in a timely way and the lunch time meal was well organised. The operational manager reported after lunch staff were less busy as had completed their work. On the other two units the residential and dementia unit staff were very busy. The rotas showed and this was confirmed that the service had the number of staff it said it needed and had no vacancies on the day. One member of staff had called in sick and their hours had been covered by an experienced agency staff. Despite this we found the organisation at lunch time very poor on both these units and were not assured people's nutritional and hydration needs were met. This was because people did not

get the support they needed and there was a lot of food waste, because people had not eaten their food. Staff did not to have time to sit with people and encourage them to eat their meals. We noted on one unit the activity staff assisted the care staff during the lunch time service, but when we asked the cook if the kitchen assistants supported staff they said, "No they usually go on their break." This is not good staff deployment because meant there were not enough staff available to assist at lunch time. They also said care staff took around the drink trolleys which was another time-consuming task which could be done by staff additionally employed to support the care staff. We noted some staff had differential shift patterns causing some fragmentation across the service.

We were not assured people had sufficient opportunity to join in meaningful activity which met their specific needs. A regular visitor to the service expressed concern about how much actually went on and what constituted an activity particularly regarding the least able people using the service.

The activities co-ordinator had been working three days a week since December 2017. They were developing their role and supporting people as best they could. They worked 18 hours and there was a second activity staff member who worked 15 hours with some overlap. Staff were not observed supporting the activities coordinator to help people take part in activity. Given there were three units, people needed support to attend. The activity staff felt they could do with more support as they could not leave people unattended and could not start an activity if people wanting to join in had not yet arrived. They had a lot of people to support and could not always provide individualised activities based on people's assessed needs and wishes. The service had not engaged with volunteers to assist care and activity staff apart from one volunteer which for a service of this size was not enough.

On the inspection we observed the chef and the activity staff working with two groups of people making savoury and sweet scones, mixing, shaping and cutting out. The activity engaged people well. One person told us they were disappointed as the staff had not told them the activity was on so had not attended. We did not observe anything else through the day and saw lots of people unoccupied. The television was on for most of day without people taking any interest in it.

We noted communal areas were often occupied by people using the service, and in some cases relatives, but there were no staff in the vicinity to make sure people were safe. We noted people had access to kitchenettes and it was pleasing to see they could make themselves hot drinks but we could not see how the service ensured people's safety. We spoke with relatives who told us it was sometimes the case that communal areas were left unattended. They said continuity of staffing had improved of late. However, some health care professionals told us not all staff knew people well or were able to provide them with the information they needed.

We noted staff being concerned about a person's reduced mobility and risk of a fall. They asked for a wheelchair and staff said it was already in use. Other staff were slow to respond to assist the person and staff member asking for help. We also noted call bells at times went on to emergency mode and some staff ignored these. One person told us that call bell response times could be slow at times of day when staff were busier. They said they would often turn off the alarm and stick their heads round the door and say, "We will be back." The person said they did come back, "Eventually." We asked the service manager if they carried out audits of call bell response times or if they could gain a print out to see how quickly call bells were answered. The call alarm system did not have the capacity to print out this information, which meant that the call bell response times could not effectively be monitored.

We asked the service manager if the manager did a daily walk about to observe and monitor the responsiveness of staff in meeting people's assessed needs. They confirmed the manager did walk round

but could not confirm if this was recorded although there was a template for them to do so. The service manager told us they were at the service most days so we did not know why they were unaware of recorded walk around This would be helpful in determining immediately any risks to the service. One of the operational managers did a visual walk around and when we gave feedback they confirmed their finding matched ours in terms of staffing.

This constitutes a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities 2014.)

The service manager assured us staff recruitment was ongoing and they were over recruiting by 10%. This would help to plan the service more efficiently and ensure planned leave and unplanned sickness could be covered more effectively. They told us they had currently nine resident vacancies. They said they tried to maintain staffing levels and used a dependency tool to determine what staff hours were needed to meet people's assessed needs. They had recently recruited to all nursing posts but had 144 care staff hours per week to recruit to (two days and two nights). Due to recent recruitment the service assured us agency staff would not continue to be necessary to cover hours regularly. This had previously been the case particularly in regard to using agency nurses. The service did not have a maintenance person currently which was a concern given the size of the service but their role was being covered by the organisation who had other maintenance staff.

Risks to people's safety were not always well managed. We identified potential risks due to the lack of supervision of people to help promote their safety. We also observed staff slow to respond to people's needs. We did not feel there was sufficient oversight on shift to ensure staff were sufficiently deployed and additional staff to assist as busier times of the day. This placed people at increased risk of harm.

When speaking with people we received a mixed response about their safety. Most people spoken with felt safe. However, several people did not. One person said, "A fire alarm went off the other night. Someone had asked for a baked potato which the staff wrapped in foil and put it in a microwave. No one came to check on me, I can't walk very far and I was quite frightened. I didn't know what to do." Another person who needed two staff to assist them told us, "I hate night time. I feel very nervous at night, I wanted to go to the toilet the other night and when they eventually came to see what I wanted they told me 'just do it on the bed'. They insist on getting me ready for bed at 6pm because they say I need two staff to hoist me."

We were really concerned that some people were observed by us as having long toe nails which could increase risks to people and affect their mobility. A relative did not know when their family member had last had their nails cut. We spoke with a person who told us, "I'm diabetic and have told staff, and even the new manager, about cutting my toenails. It's been months since they were last seen to. A member of staff used to do it but they left. I can't seem to get anyone to take action and I getting really worried now because one nail is growing across another toe." When we fed this back, we were assured that the chiropodist who had left, had since been replaced and was booked to come soon.

When speaking to catering staff they were aware of anyone with unintentional weight loss and how they should respond to this. They told us about people's specific dietary needs and special diets. They said nurses updated them when there was a new person at the service or a change to an existing person's needs. When asked how often the nurses did this they said every two to three weeks, this is insufficient and increases the risk of errors being made. We noted that heads of department did not meet daily to share essential information to enable risks to be known and effectively managed across the service. Instead the service had handovers between nurses after each shift and then verbal handovers with care staff following that. We felt there was a risk of information being missed or miscommunicated. The service manager told us the electronic care planning system they had included a dash board which would highlight any risk in terms

of people's needs, such as anyone with unintentional weight loss, recent falls or pressure ulcers. They said they expected the manager to log on to the system throughout the day to help them know any immediate risks. The electronic system should not replace the visual observations and there was no written evidence this happened.

We reviewed people's records which were all electronic. These were difficult to track through and find how a person's needs had changed over a period. The service manager said it was possible to do this but we felt it took too much time to collate the information needed. Our frustration was shared with other health care professionals who were not familiar with the new system and some staff said they were not confident with the system. Health care professionals were reviewing people's needs to consider whether current funding matched the person's assessed needs. It was not easy to evidence how people's needs had changed. Some staff did not know people well and were not able to immediately tell us what their needs/risks were.

We saw people had individual fluid targets based on what they would usually drink within a set period. These were reasonable but we could not see what actions staff took if people did not reach their documented fluid target over a few days. For example, one person's fluid target was set as 800mls a day which is low and below the recommended NICE guidance. We saw over three days they had 595, 625 and 420mls recorded which is very low and not taking into account the exceptional weather this summer. This significantly increased their risk of dehydration and infection. We could not be assured if this was a practice issue or if records were not being completed as they should.

Other risks to people's safety were well documented and included how to maintain a safe environment, prevention of falls, maintaining skin integrity, food/fluid intake and guidance around any long-term conditions. There was some input/recording around promoting people's mental health and well-being but this was sometimes poorly described. For example, describing people as agitated rather than exploring possible reasons for a person's distress.

We reviewed environmental risks and found the service was mostly well maintained and purpose built. We looked at equipment and how often it was serviced. This was initially difficult to find as service labels were not on equipment. However, servicing was in date. We looked at electrical installation, checks on water temperature, legionnaires disease and generic risk assessments for carrying out the regulated activities safely. Fire alarm checks and fire equipment was carried out with regularity. A fire visit was carried out by the fire prevention service and they reviewed the risk assessment and fire plan. They recommended this was updated annually but there was no evidence it had been reviewed since the last review in March 2017. We were concerned that the last fire drill was dated October 2017 and stated staff response was slow and the drill had failed. There was no evidence this had been done again to ensure staff response improved. We saw there were individual fire risk assessment stating what assistance people might need in the event of a fire and grab bags and torches for emergency use.

Electronic care records showed, at a glance, anyone who had been weighed and any wound care due. It highlighted anyone in hospital. A do not attempt cardiopulmonary resuscitation DNACPR was indicated by a symbol in the corner of the person's photograph. The system alerted the manager when care reviews were due. Butterflies signified when people were receiving palliative care. Individual care records were updated at the point of care taking place. Staff carried mobile tablets and recorded any personal care given, fluid intake and nutrition. We did not have complete confidence in the system as we found gaps in recording and were told it was because the information might not have not synched properly. Staff told us the system was backed up on the 'cloud.' If the system was down then care provided could be recorded on paper and subsequently uploaded when the system was up and running. This meant that information was not always accurate and could increase risk to the person. For example, if a person had not had sufficient to drink and

the system did not update the person's fluid intake in a timely way, the risk of dehydration could increase.

We reviewed recorded accidents/incidents for the service which were collated and analysed, although we could not always see a clear record of action taken. For example, for a person sleeping in a chair and for another who would strike out when receiving personal care and therefore was in some distress. For other incidents such as the wrong dose of medicines being administered we saw evidence of reflective practice as to why a mistake occurred and actions taken to reduce the likelihood of another occurrence.

The above evidence constitutes a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities 2014.)

Staff spoken with had received training to help them recognise abuse and what actions they should take if they suspected a person to be at risk from harm or abuse. Staff received training which was updated on adult protection and had polices and guidance to follow. Safeguarding records showed concerns were reported to the local authority as required and the service cooperated in any investigation.

We had received some concerns prior to our inspection about people not receiving their prescribed medicines as required. A missed medication round had resulted in an investigation from the local safeguarding team. They raised concern about the use of agency staff who may not be familiar with the medicines system. Although training was provided to all staff administering medication it was thought to be insufficient and did not adequately support staff to use the electronic medication system which they might not be used to. The service had since improved upon this by ensuring a longer handover period between regular staff and agency staff. There was clear recording of training and support received during this initial induction and familiarity with the medication system. A few recent issues had been identified regarding medicines but the service had responded to these appropriately.

On the day of our inspection we saw medicines were given as intended but noted medicines being left unattended and unlocked at one point during the day. A staff member was not wearing a tabard when administering medicines which is an expected practice of the service, when challenged they said it was because the tabard was dirty. This raises the risk of cross infection. The inspector also identified two sets of records for insulin (which controls blood glucose levels) which could cause confusion.

The clinical lead was taking over the responsibility of staff support and training. They had been in post three weeks. They showed us the medicines induction pack. The operational manager provided induction to the' Well-Pad' electronic medicines system. There was some e-learning supplemented by one-one discussion. This was followed by observation of nurses on the floor and nurses observing the compliance manager on the floor to ensure staff were confident in medicines administration.

The electronic system checked and throw up an alert if a bar code was not correctly scanned or if there was an attempt to overdose, for example to give paracetamol more than four hourly. This enabled effective monitoring.

There were two clinical rooms one upstairs and one down. Each unit had a set of keys and nurses collected the medicines trolley plus any fridge items. Staff were aware of time sensitive medicines and these were issued as required. There was a different box inside the trolley for each person. Staff scanned bar codes with Well-Pad which picked up any errors. The drugs trolley stayed with staff and were mostly safe except the incident when left unlocked.

There was a photograph identification of people on the Well-Pad. Photographs were updated at least six

monthly to ensure people were recognisable. Staff were familiar with what people were taking and provided information and assurances to people when they asked. Staff asked people if they needed their medicines as required, such as pain relief and ensured people took it. Nurses confirmed they did not have anyone who regularly refused medicines but did have a protocol for this and would report to the GP anyone who persistently refused. They told us they had support from three GP surgeries.

We checked storage and saw medicines were stored safely and kept at correct temperatures. Daily checks were in place but in one part of the service the checks had gone missing and could not be located. There was a fridge to store medicines which required a lower temperature. One included a pack of diabetic medicine (Glucose) which had expired February 2018, so was out of date. This meant it might be less effective in treating low blood sugar. This item did not have a bar code on it as not from usual supplier and so was dependent on staff visually checking it and recording the best before date. There were suitable arrangements for the disposal of unwanted and unused medicines. Individual audits were in place to ensure people had medicines as required.

Improvements were needed in the staff recruitment processes to standardise the level of information in each file and to ensure any risk of employment were explored at interview. Staff were subject to pre-employment checks to ensure they were suitable to work in care and did not have a criminal record which might make them unsuitable for employment. A job interview tested the candidate's suitability and attributes to work in care. This was supported by references, application form including employment history and confirmation of identification and address. However, we could not always see interview notes on file or how issues flagged up from previous employment, such as the reasons for leaving had been fully explored. For one applicant a previously declared conviction was on their record but we could not see any notes/risk assessment around this to ensure the provider had considered if this staff member could be employed or if any additional safeguards needed to be put in to place.

Once in post staff were supported to develop the skills necessary for their role. For temporary staff there was confirmation of their recruitment process and qualifications, if any, and training completed. However, the standard of training in some instances were poor with all training being signed off as complete in one day and we were not able to see clear induction for agency staff within the service. This meant we could not be assured if they had experience of the client group and sufficient competencies to support staff and people using the service. There was induction in regard to agency nurses and the introduction of the electronic medicines system.

We did not have concerns about infection control apart from the practice of sharing manual handling slings without cleaning them in between and dirty medication tabards. This increased risk of infection spreading from one person to another and had not been adequately considered. The service provider said most people had their own slings and new slings had been ordered and were due to arrive the day after the inspection.

There was a large domestic team in place with a head house keeper overseeing the team. They told us there had been improvements recently and the team now worked across the weekend so there was cover seven days a week. They had cleaning schedules to follow and audits were in place. They confirmed they had sufficient training and adequate supplies of personal protective clothing, such as disposable gloves and aprons. Any hazardous chemical was locked away to ensure the safety of people using the service. The only thing they raised concern about was the lack of storage space.

Requires Improvement

Is the service well-led?

Our findings

This service was last inspected 23 and 30 January 2017 and was rated good overall with a requires improvement in the key question, responsive. Since this inspection there had been a change in the management team, the registered manager and other key staff such as operations manager and clinical lead had left. This had the potential to destabilise the service and we were not assured people continued to receive a good service. This was supported by several whistle blowers who raised concerns with us about the quality and safety of the service and shared concerns about staffing levels. Other agencies had also raised concern and evidence suggested this was no longer a good service.

At this inspection on 12 July 2018 we were encouraged to see a new manager, clinical lead, operational manager and full complement of nurses were in place. Some had only just arrived at the service. The new management team were working hard to improve the service. However, we had yet to see how the changes being made would be sustained and embedded within the service. Our confidence in the service had been affected by assurances from the provider at a recent meeting in March 2018 that everything was in order when in fact we found this not to be the case. We were also concerned that Downham Grange has had recent changes of managers three in the space of two years. The previous manager was appointed in May 2017 and there were concerns about the stability of the service at this time. However, some of the issues which have come to light were not identified by Kingsley Health Care which meant there was not sufficient provider oversight. Relatives told us they had raised concerns which were not fully addressed and some staff had left without the reasons for this being fully explored.

A former operations manager within the Kingsley group went to Downham Grange to support staff after the previous manager left and they have subsequently been appointed as manager for the service and have been in post about three to four weeks at the time of our inspection. They are currently applying for registration.

The task ahead of the service was to embed a new culture which recognised clearly the needs of individuals and to provide personalised care based on their choices. However, we were immediately concerned when arriving at the service to find that staff training was taking place in one of the communal lounges usually used by people living in the service, and staff not having their own space to take breaks away from the communal areas. When we arrived, staff told us the manager was off duty, and said they would ring them before showing us into one of the communal lounges. They did not introduce us to people already in the lounge and it was not appropriate for us to be using people's private space. Shortly after both the operational directors and service manager arrived and preceded to try and talk to us in communal areas before we asked if we could go to the privacy of the office. They too did not explain to people who we were or why we were there. This showed a lack of respect for people's home. This was flagged up at the time of the inspection.

We were also concerned when walking round that in some areas of the service the television was on where people either could not see it or were paying no interest to it. Popular chat shows were on which were possibly not in keeping with people's choices. Later, we found music had been put on by staff and this was

pop music which again might not have been in keeping with people's preferred music choice and had been put on without first asking people's choice. This does not support a person led culture.

Experience of relatives over time had been poor and had reduced their confidence in the service particularly as they said they had raised issues in the past which had not been addressed. They commented they were encouraged by the new manager and said they were aware the service manager was also there regularly. However, in discussion with relatives we remained concerned about what they told us. This included concerns about people's health care specifically poor management of people's nails. One relative told us about a fall their family member had which in turn had reduced their mobility and confidence. The relative felt they were declining and not taking part in any activity and a wheelchair was not available for them, neither were they aware if this had been taken up with the relevant health professional. They also mentioned a shower chair on order was the wrong one resulting in the person not being able to have a shower. They had not been kept up to date with their family member's changing needs and there had been no recent review that they were aware of.

Staff were also not confident about the stability and continuity of the service. They reported seeing staff come and go including managers. They said this had affected the level of support they received and at times staffing levels had fluctuated and could not be relied upon particularly at weekend when management presence was much less. Staff said in recent months training opportunities and support had increased and some staff who had previously left had come back. New staff were expected to be shadowed by existing staff but staff told us they had not been given any guidance about this or how they were expected to support new staff.

The service needed to ensure all staff training was up to date to ensure staff had adequate skills and support to develop themselves to meet their own personal and professional development. Further training around the specific needs of individuals needed to be developed. The service manager was not able to give us a break down of the skills set of their current workforce and how many staff already had or were working towards professional qualifications. Neither were they able to break down the specific skills the nursing staff had and how this matched the needs of people they were supporting. The service had no staff champions which provided the opportunity for staff to take a lead on an area of specific interest or where they have a specific skill. Their role would be to have oversight of this area of interest and provide support to others. An example might be an infection control champion or a dignity champion.

The clinical manager told us they were meeting all staff to discuss their training and development needs and arrange regular supervision of the staff and support for nurses around their clinical skills. The renewed management approach was in its infancy but it was felt by staff in a position of management that the service was heading in the right direction. Management staff told us they had moved on from their position several months earlier when the service was poor by comparison.

The service manager said they were developing a supervision tree showing which staff did whose supervisions. They said in theory they were about 10 weeks behind with supervision since the previous clinical lead left but were getting back on track. They said changes had been made to induction packs and they were creating a buddy scheme.

For people using the service their experiences were mixed across the service. Some felt staffing were not adequate and others felt staff did not have enough time to spend with them or to provide timely care. One relative felt their family member was not getting the attention they needed, but had subsequently moved room and had an improved experience. We found the deployment of staff was poor and there was not effective leadership across the shift with some staff working hard and others less so, but units did not work

together to ensure people received timely care. There were not additional staff at busier times of days resulting in people having to wait for their care. Staffing was a concern in terms of continuity as not all staff were familiar with people's needs given the recent changes within the staffing team and the ongoing use of agency staff in recent months.

Observation of lunch on two of the units showed a high level of disorganisation with people being served their meals at different times, not enough adequate seating with some people left in their wheelchairs all day. We saw people being brought their meal before being given knives and forks and condiments not already being on the table. This meant one person started to eat with their hands. People were not adequately supervised and supported resulting in some people not eating. We could not see people being offered alternatives to their main meal where they were not eating and staff could not tell us if finger foods were available. A relative told us how much their family members appetite had diminished and said they rarely ate a main meal. There were snack stations but these were not accessible to some people and they relied on staff to make snacks and drinks available.

Activities were not clearly established and were not always meaningful to the individual. The range of activities were not fully inclusive and without adequate support some people would not be able to access them. Monthly activities were displayed around the service and included some 1-1 hours but there was insufficient deployment of staff to help ensure people had opportunity to take part in an activity.

Engagement with people using the service was poor. Given all the recent changes it was not clear how this had been communicated. Relatives spoken with had not attended recent reviews. This was being addressed by the service. There was no evidence of regular meetings between people who used the service, their relatives and the management. One person told us they thought that their relative had attended a meeting, "A long time ago." Another relative told us there used to be evening meetings which they could not get to but nothing more recently. They told us there were no newsletters and due to their visual impairment were unable to see information around the service. They relied on other relatives and staff to tell them what was going on. We found consequently, there was little opportunity for people to make suggestions or find out about what was happening in the community. There was limited engagement with the community and only one volunteer. However, we found things were changing, the knit and natter group was a new initiative and there was a further initiative which involved the roll out of a regular exercise programme which aimed to increase physical movement and promote people's well-being.

We raised concerns about how the service was complying with changes to the general data protection act as relatives made us aware that photographs of their family members had appeared on the service's social media site and used for marketing purposes. Valid consent for this had not been sought as far as relatives were aware. This was raised with the service manager who said their communication and marketing team were dealing with this.
The above issues with regards to staffing and poor experiences for some people using the service constitutes a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities 2014.)

In terms of staff engagement, we recognised as part of this inspection some staff worked in a functional way meeting people's physical care needs and not paying attention to people's emotional needs or making time to sit with people. The service manager told us they were rolling out the 'golden ticket scheme' which was an initiative which recognised and rewarded good staff practice and for staff that went the extra mile. It could be that staff helped a person achieve a wish or did something which enhanced the person's day. The scheme provided an incentive for staff which could be exchanged for a reward and was a way of trying to change a task led culture to a more personalised culture.

There was a system of audits in place to help ensure everything was reviewed and any improvement and progress towards improvement was clearly identified and documented. For example, sampling of 10% of care plans each month, infection control audits and health and safety audits were in place. We looked at a sample of audits completed by the manager and the service manager and these identified issues as relevant. We found the manager's daily walk rounds were not documented and there was an over reliance of the manager constantly checking the computerised dash board on the electronic systems to see what the risks were to people's needs. This was a risk as we saw the records did not always synchronise properly.

An action plan had been created and areas of concern had been identified, for example the service had transferred to a new electronic care plan and records system in the past two months and their aim was to get all records on the new system by the end of July 2018 which they had achieved. Each staff member had their own log in and had been trained to use the system. The next target was to ensure all care plans were reviewed, up to date and more accurately reflected people's individual needs. These reviews were being done in conjunction with people and their families to ensure the information collated was relevant, consent was sought and recorded and individual needs were recognised in the planning of the care.

For people moving into the service their initial assessment would be recorded on a paper copy and the information then entered on the system before the person arrived. This would comprise of a basic care plan covering area including dietary intake, and the need to use a hoist.

The electronic medicines system had been in place a year. Recent errors had been cause for concern and had resulted in a safeguarding investigation. It would appear that not all staff using the system were fully confident and the training completed before using the system was not adequate. Systems had been put in place to help ensure training was more robust and staff were adequately supported to have the necessary skills and competencies to administer medicines as intended. We reviewed recent incidents and there were a couple of medicines issues, one was because the pharmacist had run out of stock and the care home had chased this every day, the other involved a person getting the wrong dose of medicine without ill effect but the service had taken the right actions.

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 Individual risks were not always well managed and records did not always demonstrate how risks were managed effectively.

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 did not have sufficient oversight of the service to ensure it was well managed and run in the interest of people using the service. Staff were not sufficiently deployed and people did not receive timely care.

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 Staffing levels did not always ensure peoples needs could be met and there was insufficient management oversight of this.