Kingsley Care Homes Limited

Downham Grange

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 11 July 2016. Four breaches of the legal requirements were found and two Warning Notices were issued in respect of these breaches. After the comprehensive inspection, we gave the provider until 31 August 2016 to meet the legal requirements in relation to this warning notice. We undertook this focused inspection on 7 November 2016 to check that they had undertaken changes to meet these requirements. This report only covers the findings in relation to that notice.

We have not changed the overall rating for this service as a result of this inspection, which was only to follow up our enforcement action. The service remains rated as requires improvement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Downham Grange on our website at www.cqc.org.uk

Downham Grange provides accommodation and support to a maximum of 62 older people, some of whom are living with dementia. The home provides a mixture of nursing and residential care.

At the time of this inspection, the homes registered manager had recently resigned and was no longer working at the home. The provider had recently recruited a new manager for the home, who had been employed for three weeks. They told us that they were applying to become the registered manager for the home. 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 and associated Regulations about how the service is run.

At the previous comprehensive inspection, effective monitoring systems were not in place to ensure quality and safe care. This had resulted in people receiving poor care and being at risk of harm. We found that medicines had not been managed safely and people did not receive them as the prescriber intended.

Since our last inspection, the provider had deployed a number of staff to focus on improving the quality and safety of care provided to people. This included a regional operations manager to oversee the improvements required and take responsibility for the implementation of these. At this inspection we saw that there were effective systems in place that had been developed since our last visit. These were to monitor the quality and safety of people living at the home, and to reduce the risk of harm and poor care. The regional operations manager had identified where improvements had been needed and actions had been undertaken to achieve this. The regional operations manager had, as a result of this also identified where they would like to make future improvements and a plan was in place for this.

The Warning Notices we issued were complied with.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

We found that action had been taken to improve the management of people's medicines.

People received their medicines as intended by the prescriber.

Systems had been developed that identified any errors made in a timely way.

We could not improve the rating for the leadership of the service from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Inspected but not rated

We found that action had been taken to improve leadership within the service.

Systems for monitoring the quality and safety of the service people received had been developed. These had been implemented and were in the process of becoming embedded into regular practice.

We could not improve the rating for the leadership of the service from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Downham Grange

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection of Downham Grange on 7 November 2016. This was carried out to check that requirements of a Warning Notice, issued after our inspection in July 2016, had been met. We inspected the service against one of the five key questions we ask about services: is the service well led. This was because the warning notices were served in these areas.

Three inspectors, one of whom is a pharmacy inspector, undertook the inspection.

During our visit we spoke to the regional operations manager, manager, deputy manager and one member of the nursing team. We focussed this inspection on how medicines were managed, and the systems to monitor and improve the quality and safety of the service. We looked at a number of systems and audits in regard to monitoring quality and safe care and reviewed several people's care records and medicines records.

Inspected but not rated

Is the service safe?

Our findings

At our previous inspection in July 2016, we found that people were at risk of unsafe care and treatment because their medicines were not managed safely. People did not always receive their medicines as the prescriber intended. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We subsequently warned the provider about this and told them that they had to meet this regulation by 31 August 2016. At this inspection, we found that the necessary improvements had been made and the provider was no longer in breach of this regulation.

A member of CQC medicines team looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Medicines were being stored safely for the protection of people who used the service and at the correct temperatures. Records showed that people were receiving their medicines as prescribed. There were frequent internal audits in place to enable staff to monitor and account for medicines. Errors that had been identified were reported to the manager and actions taken. There were improvements in the availability of prescribed medicines by the home promptly obtaining people's medicines, however, we noted that for one person, their pain-relief medicine had not been obtained in time and so not given to them for over 24 hours.

We noted supporting information was available when medicines were given to people to enable staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies/medicine sensitivities and written information on people's preferences about having their medicines given to them. When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to give people these medicines. For people prescribed pain-relief medicines on this basis but who were unable to tell staff they were in pain there were pain assessment tools in place. However, there was a lack of information for members of staff to refer to about when it was appropriate to give them their pain-relief medicines. Charts were in place to record the application and removal of prescribed skin patches and these had been completed by staff. When people were regularly refusing their medicines the home had taken action to review their medicines with their doctor.

Inspected but not rated

Is the service well-led?

Our findings

At our previous inspection in July 2016, we found that adequate governance systems were not in place. There was not an effective monitoring system to look at the quality and safety of the care being provided, or to limit risks to people's safety. This had resulted in people receiving poor care and being at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We subsequently warned the provider about this and told them that they had to meet this regulation by 31 August 2016. At this inspection, we found that the necessary improvements had been made and the provider was no longer in breach of this regulation.

We saw that effective systems were in place to monitor the care and treatment people received. The provider had implemented a number of audits since our last inspection and undertook them regularly. These assessed areas such as the monitoring of nutrition and hydration needs of people at the home, falls, incidents and the accuracy of care plans, medication preferences and the competency of staff. We saw that where shortfalls were noted, these had been identified and action had been taken

The deputy manager told us that since the last inspection they had placed in each person's room a number of charts for staff to complete. These included care, contact, fluid, and food intakes. These charts travelled around the home with the person, so that they could be recorded in or reviewed at all times. At the end of the day, this information was then entered on to the homes electronic care records system.

Each night these charts were collected at midnight and a new one issued for the next 24 hours. The clinical lead and the residential lead undertook audits daily. Each morning the deputy manager and senior staff met for a meeting to discuss the audit from the previous day and the impact on the people living at the home. This meant that managers and leads could discuss and review where, for example, people had received enough to drink, and if they had not, the reasons for this. This supported the deputy manager to identify concerns for people and ensure relevant referrals were made to improve the person's wellbeing. This could be referrals to the person's GP or to specific teams, for example the dietician team to ensure they were receiving the correct care.

We viewed these records alongside care records to see if they were consistent with the person's main record. We saw that they were. People living at the service benefitted from having these charts with them at all times. It meant staff were able to identify if people were receiving the correct levels of care on a daily basis. For example, staff used these charts to see if people were receiving the correct levels of fluids they needed, and to prompt them to have more drinks if they were not.

When we viewed care records it was evident that additional new changes had been made since the last audit. This showed us that the manager and staff were continually reviewing care records so that they were relevant to the people living at the home. Staff told us that they were informed of changes as and when they occurred. One staff member we spoke to said that this was a positive change since the last inspection. We noted that although auditing of peoples care records was now in place, only a small number had been completed each month. We spoke with the manager about this, and they agreed that this number would be

increased to ensure all records were audited at least yearly.

We saw evidence that senior staff reviewed incidents that people living at the home experienced. We saw that these corresponded with individual care records, citing an incident had taken place and the appropriate form was complete. We noted that the homes manager did not analyse this information for any trends that may be occurring, some as for times of the day when a person may be more prone to falling. We discussed this with them and they agreed that they would implement this.

The deputy manager and a senior nurse spoke with us, they felt there had been a positive change since our last inspection. They confirmed that they had daily meetings and that audits had become an integral part of the role which supported them to effectively monitor the care provided. They told us that they had been given protected time to complete pieces of work, where they were not expected to be providing direct support to people. For example, when conducting checks on a new cycle of medicines to be started, additional nursing cover had been deployed. This meant that the senior nurse could carry out these checks more safely as they would be undisturbed. They added as well that they thought staff had better morale as a result of these changes.

The deputy manager and senior nurse we spoke to told us that they had reviewed and changed how daily staff handovers were conducted since our last inspection. They told us that each person's welfare was discussed, and that information taken from the new monitoring records was used to inform this discussion. Any actions needed or taken as a result of this handover was recorded. We saw evidence that these were then reviewed by the deputy manager, or manager, to ensure that they took place. This meant that any changes in people's welfare were monitored, and any action needed was taken in a timely way.

At our previous inspection in July 2016, we found that newly recruited staff, agency staff, and staff visitors were living in unoccupied resident accommodation. Staff had allowed visitors to stay in this accommodation without permission. The registered manager of the home at this time had not assessed the risks to people living in the home from these arrangements. We asked the registered manager to take immediate action regarding this, which they did.

At this inspection we spoke to the providers regional operations manager about security of the home. They told us that since our last inspection, staff have not been permitted to stay in vacant resident accommodation. They told us that there is now only one entry point to the building, which is past the reception area. Previously there was another entrance point which was unchecked. They also told us that the home had recently procured a CCTV system which would provide coverage to external access points and the homes gardens and car park. This was due to be installed in the near future. The deputy manager told us that they had spoken with all staff and emphasised the importance of politely challenging anyone that was not recognised in the building.