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Allingham House Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Allingham House Care Centre is a residential care home providing personal and nursing care for up to 86 people. The home is registered to care for both older and younger adults, some with a diagnosis of dementia. One of the units specialises in providing nursing care to people with complex clinical needs and two others cater for people with nursing and residential needs living with varying degrees of dementia. The service supported 76 people on three floors at the time of this inspection, each floor being a separate unit with adapted facilities.

People's experience of using this service and what we found
The systems and governance procedures to report, monitor and respond internally were not in place and deadlines for information from the home were repeatedly relaxed month after month. The new regional manager had no access to historical information relating to the service as none had been recorded on the system. The provider had failed to respond in a timely manner to early warning signs that this service was failing.
People did not receive safe care. People's medicines were not safely managed. We found multiple failings in relation to medicines.
Care plans and risk assessments were not always updated to reflect changes in people's care needs. We found recording gaps in relation to pressure care, weights, observation and food and fluid charts.
Risks to people were not always identified and risk management plans were not in place to manage risks safely.
There was a high use of agency staff in the home, including agency nurses. Staff were not effectively deployed and were not always aware of their responsibilities or peoples current clinical support needs.
Elements of staff training were out of date and staff were not always supported through supervisions to ensure they carried out their roles effectively.
People living at Allingham House Care Centre had complex needs. The service could not always assure themselves that agency staff were competent or had the appropriate skills to meet those needs, as employment profiles supplied to the home were very basic.
Pre-admission assessments were not always thorough. Prior to this inspection six people had been admitted to the service during May and June. We saw one pre-admission assessment which had not fully explored the person's complex needs. Meeting these needs and how this might detrimentally impact on the care of others living at Allingham Care Centre, had not been taken into consideration.
The provider's quality monitoring systems were ineffective. The provider was not operating an effective system for handling and responding to complaints and proportionate action in response to concerns raised was not taken.
The registered manager was no longer at the service when we inspected. They had submitted an application to CQC to deregister the week prior to the inspection. The previous registered manager had satisfied their regulatory responsibilities as they had reported incidents to the local authority safeguarding team or CQC where required. However, we saw on inspection, these had not always been communicated via the providers internal reporting mechanisms that were in place. Relatives and staff considered that the previous

registered manager had not been visible and had not provided adequate leadership and support.
Whilst there were policies and systems in the service these were not reflected in staff practice.
People were protected from the risk of infection because staff followed appropriate infection control protocols.
People had access to healthcare professionals when required to maintain good health.
Following this inspection, the provider worked in partnership with the local authority and the clinical commission group to ensure people were kept safe.
The extensive nature of the breaches of the Regulations we have identified and the impact of these on people living at Allingham House Care Centre demonstrated a failure of leadership and governance at the home at provider level.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good published in December 2016.
This inspection was prompted in part due to concerns received about the safety of people living at Allingham House Care Centre. The concerns reported to us focused on the inappropriate use of restraint when undertaking personal care, unexplained bruising, poor moving and handling and numerous medicine errors due to insufficient numbers of staff and a high usage of agency staff. A decision was made to bring the inspection forward and for us to inspect and examine those risks.
We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well led sections of this full report.

Enforcement
We have identified breaches of Regulations in relation to safe care and treatment, person centred care, complaints, staffing, fit and proper persons employed and good governance at this inspection. We placed immediate conditions on the provider's registration in relation to the management of medicines. In response to urgent enforcement action the provider appointed a person to have oversight and management of all medicines. Additional clinical and care support has been supplied by the provider from other areas of the business. The peripatetic manager is receiving support in order to mitigate the risks we identified on this inspection.

For requirement actions of enforcement which we are able to publish at the time of the report being published please see the action we have told the provider to take at the end of this report.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Allingham House Care Centre

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team: Due to the concerns raised to us the inspection team consisted of the following. On the first day of inspection there were four inspectors and an inspection manager. On the second day of inspection there were two inspectors, an assistant inspector, a pharmacy inspector, and two experts by experience. The experts by experience had personal experience of caring for an older person living with dementia. On the third day of inspection one inspector returned to the service with an inspection manager.

Service and service type: Allingham House Care Centre is a care home and is registered to provide nursing and personal care and support for up to 86 older people. 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.

The service did have a manager registered with the Care Quality Commission. A registered manager, along with the provider, are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager had left the service the week before our inspection. We received an application from the registered manager to deregister from the service.

Notice of inspection: This inspection site visit took place on 4, 6 and 12 June 2019. All days of inspection were unannounced. We returned for a third day of inspection to check that the provider had taken the required remedial action for those areas identified to them as being urgent and that people were safe from harm.

What we did: Before the inspection we reviewed information, we had received about the service in the time since our last inspection. This included details about incidents the provider must notify us about, such as allegations of abuse, and serious accidents and incidents. We sought feedback from the local authorities who commission services from the provider. Usually the provider is asked to complete a provider information return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, on this occasion the provider was not asked to complete a return as we brought the inspection forward due to the concerns we had identified in our monitoring of the service.

During the inspection: We spoke with 9 people using the service and 17 of their relatives to ask their views about the service. We spoke at length with nine members of staff and consulted with eight others during the inspection. We were unable to speak with the registered manager as they had left the service. Instead we spoke with a peripatetic manager, the deputy manager and the area manager. We reviewed records, including the care records of 11 people using the service and the medicine records for 28 people on the nursing unit. We looked at recruitment files and training records for permanent members of staff and employment profiles for eight agency members of staff, the providers governance arrangements and internal assurance systems. Records relating to the management of the service such as quality audits, safeguarding referrals, accident and incident records, and policies and procedures were also considered during this inspection.

Inadequate

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 has now deteriorated to Inadequate.
This meant people were not safe and were at risk of avoidable harm.

Using medicines safely.
• Medicines were not safely managed. We found multiple failings in relation to medicines. People had run out of prescribed medicines needed to help reduce pain or relieve symptoms associated with diagnosed health conditions. No action had been taken to either re-order or follow up any out of stock medicines. We identified that people's health and wellbeing were at significant risk
People did not receive medicines in a timely manner. The service relied heavily on agency nurses, some of whom were familiar with the service but others who were not. We saw agency nurses undertaking morning medicine rounds, starting at 8.15am and these were still being administered at 11.50am. This meant there were insufficient gaps between the administration of pain relief medicines which placed people at risk. One relative we spoke with told us, "I've spoken to the new manager about [person] not getting their medication at the right time. It's happened several times and it's like you have to battle all the time to get it done right. Hopefully the matter will now be resolved."
• People did not receive medicines as prescribed. We saw unsafe practices in relation to the administration and recording of medicines on medicine administration records (MARs). We identified two people who had been prescribed a thickening agent to be added to their fluids to prevent them from choking. Neither had their own supply of thickener available to them We saw an unlabelled thickener was in use which meant staff were not guided as to the correct quantities of the thickening agent to use. This meant that people with dysphagia were at increased risk of not having their food and fluids appropriately thickened and were at greater risk of aspirating and choking.

Medicines were not safely managed. People were at risk of significant harm from not receiving medicines as prescribed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management.
• We found risks relating to people's care and support were not always managed safely. Risks to people had been assessed in areas including medicines, mobility, the environment and nutrition. However, there were not always updated risk assessments and risk management plans in place for staff to follow to safely minimise identified risks to people. Information relating to risks were recorded on electronic care plans and were not readily accessible for staff.
• One person's eating and drinking care plan identified and recorded they were at risk from choking, but declined to eat the recommended diet consistency, as they preferred to eat normal food. We saw no information available to staff responsible for the serving of meals about the risk of choking posed to the person, as their dietary requirements and risks had not been shared with hospitality staff in the dining area.

Staff were not aware that the person was at risk of choking. Information on the electronic care plan indicated that the person should be supervised whilst eating. During our visit we witnessed the person eating breakfast whilst alone in their bedroom. We also saw that the nurse call alarm was placed out of the person's reach and the suction machine was not readily available and not working. In the event of a choking episode they would not have been able to summon help. These shortfalls demonstrated the provider was not doing all that was reasonably practicable to mitigate identified risks to prevent the person from choking.

• We identified people who were at high risk of developing pressure ulcers. Whilst prescribed regimes and treatments to reduce the risk were in place, including the need for positional changes to be undertaken on a frequent basis, for example every 2-4 hours, these were not always followed. We looked at the electronic care planning system for a person and saw that according to their monitoring charts they received no re-positional changes between 23 and 27 May 2019. We were not assured that people who required regular pressure relief, for example people confined to bed and people who spent prolonged periods of time in a wheelchair, were in receipt of this care. This meant people were at increased risk of their skin integrity being compromised and of developing pressure wounds. The provider was unable to demonstrate that people received regular repositioning to help ensure their safety and well-being.

People's safety and well-being were at risk of harm as appropriate measures were not in place to protect them. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment.
• Rotas indicated the names of the staff on duty on a daily basis to meet people's needs, but rotas were not accurate. We saw one person was included on the rota for Wednesday 5 June who was not available for work. Changes in staffing due to annual leave, sickness or other reasons were not always reflected on rotas. Records kept in relation to the persons employed in the carrying on of the regulated activity were inaccurate and incomplete.
• Staff were not effectively deployed in a way which meant people were consistently supported in a timely manner to keep them safe. There was no management oversight of the deployment of staff to ensure they were carrying out tasks as required and meeting people's needs effectively. We saw that there were not enough staff to manage the high dependency needs of the people currently living in the home.
• Staff also told us they did not always have time to complete monitoring charts as they had too much to do. For example, we saw no thickened fluid charts had been completed on Thursday 6 June 2019 by 2pm. A member of the hospitality team told us they had been too busy to do this. It was unclear if people had had their drinks thickened, which placed them at an increased risk of choking.
• The home employed hospitality staff to serve meals and drinks during meal times. This worked well as hospitality staff knew people's preferences and care staff were then free to support people who required assistance with their meal. However, we still saw activity coordinators and relatives assisting people to eat during mealtimes which indicated there were not enough care staff to meet the high dependency levels of people living at Allingham House Care Centre.
• The peripatetic manager, appointed to the home on 20 May 2019, told us that staffing levels were based on an assessment of people's needs. However, when asked, they were unable to provide us with any details of the way in which people's needs had been assessed, as a dependency tool had not been completed since March 2019. We viewed the dependency tool that the provider used and saw that it did not include consideration of the environment or the clinical needs of its residents.
• There was no clinical lead or oversight by management at the time of this inspection. The clinical lead was absent during this inspection and then later left the service. The registered manager was not present as they had left the week before this inspection. An application to deregister from the service was received and processed.

There were insufficient numbers of competent staff and staff were not effectively deployed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong.
• The peripatetic manager had identified that 'flash' meetings had not taken place. 'Flash' meetings are mechanisms implemented by the service in which the registered manager communicates important and relevant information to all heads of departments in a short, daily meeting, for example information about new admissions to the service.
• Heads of departments had not been formally or regularly updated about what was happening in the home since October 2018, and therefore were not supported in directing and delegating to their staff teams.
• We saw that 'flash' meetings had been reinstated by the peripatetic manager so that the quality and safety of the service being provided could be improved.

Systems and processes to safeguard people from the risk of abuse.
• There were systems in place to safeguard people from the risk of abuse. Staff had received appropriate training and knew of the types of abuse and what to look out for and whom to report their concerns to. The previous management team had reported safeguarding concerns to CQC and other agencies as required.

Preventing and controlling infection
• People were protected against the risk of infection. There were policies and procedures in place and staff were provided with appropriate guidance.
• Care, hospitality, housekeeping and kitchen staff all had access to personal protective equipment (PPE). We observed staff using PPE appropriately during our inspection.
• People, relatives and visitors we spoke with were complimentary about the cleanliness of the home and we detected no malodours during our inspection. Housekeeping staff we spoke with were aware of their responsibilities and worked as a team to keep the home clean.

Inadequate

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 has now deteriorated to Inadequate.
This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• Assessments of people's needs were carried out prior to them joining the home to ensure the home would be able to meet people's care and support needs. Prior to this inspection six people had been admitted to the service during May and June. We saw one pre-admission assessment which had not fully explored the person's complex needs. Meeting these needs, and how this might detrimentally impact on the care of others living at Allingham Care Centre, had not been taken into consideration.
• We saw one assessment undertaken on a person recently admitted to the home. Whilst specific risks had been identified not all staff were aware of those risks, nor were measures in place to manage the risks and keep the person safe.
• We identified omissions in electronic records and inconsistencies in the information provided to staff. This meant people were at risk of receiving care that did not meet their needs or not receiving the care they needed at all. We saw inaccuracies with regards to diet, pressure care, continence care and supporting people with dementia. For example, one person had a percutaneous endoscopic gastrostomy (PEG) tube fitted to provide a means of feeding. The current PEG feeding regime was incorrect on the electronic care planning system as the information was out of date.

People were at risk of receiving inappropriate care that did not meet their needs and was not person-centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Not all staff training was up to date and staff were not always supported through regular supervisions. This meant the provider could not be assured that staff had the knowledge and skills to carry out their roles competently.

Systems were not in place or were not robust enough to demonstrate that staff had the relevant training, skills and experience. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• The service relied heavily on the use of a recruitment agency to keep the service operational Staff we spoke with told us how the lack of permanent staff impacted on the quality of care provided for people. On our second day of inspection one person had waited a long time for staff to attend to their personal care needs. A member of staff told us, "[Person's name] waited for a while; at least over an hour. We do have full staff on today [and] [person] did ring at lunch when it got busy. If there was permanent staff on they would have

known what to do and seen to [person's name] a lot sooner. I feel like the agencies get confused."
• The service was made aware of agency staffs' experience and skills in relation to providing clinical and personal care and support by way of employment profiles for individual members of agency staff. We looked at the profiles of the agency workers employed at the Allingham House Care Centre and saw these were not always fit for purpose. Two agency profiles did not outline what experience either staff member had in relation to the provision of care and contained no details of mandatory training they had undertaken.
• On the second day of inspection an agency worker reported late for shift, replacing an agency worker who had not turned up for duty. The new agency worker was not known to the service, was not asked for identification and the service had not received an employee profile. A member of agency staff told us, "The units are understaffed; different people comes here every day, not trained, so you can imagine how they [people] are supported. They don't know how to handle people"

The provider could not always provide assurances that all agency workers were competently trained for the caring role and people were potentially at risk from receiving inappropriate care. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• Menus were on the dining tables which were attractively laid, with a small vase of flowers on each table. People were offered water and two types of juice. There were always two choices of meals available but if people wanted something else they could choose an alternative. One relative said, "My {relative] won't eat mince or sausages or butter, so they make something different for them."
• People considered the food to be good, varied and well presented. One person we spoke with told us, "I have no complaints about the food."
• People chose to take their meals in their own rooms. We saw people who liked to spend time in their rooms were given hot or cold drinks at regular intervals during the day. However, we saw these were not always left within people's reach.
• There was enough food and drink on offer for people to maintain a balanced diet however, records relating to the monitoring of people's food and fluid intake were incomplete. Steps to manage and monitor people at nutritional risk were not being recorded.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

• The service could demonstrate a good understanding of the MCA and DoLS. People were involved and made decisions about their daily life. When people did not have the ability to make specific decisions about their care, the service involved relatives, where appropriate, and other relevant health care professionals. We were not always assured that decisions about care had been made in people's 'best interests' in line with the Mental Capacity Act 2005. There was no evidence to support the service had raised concerns with the local authority or questioned decisions about care further.

Supporting people to live healthier lives, access healthcare services and support.
Staff working with other agencies to provide consistent, effective, timely care.
• Staff worked in partnership with health and social care professionals to meet people's needs. This included working with GPs, consultants, speech and language therapists and tissue viability nurses.
• People's healthcare appointments were kept in their care files and their health was monitored. If staff had any concerns about people's conditions records showed that the home referred them to health and social care professionals when required.

Adapting service, design, decoration to meet people's needs.
• The majority of people at the home were living with a diagnosis of dementia and as such the provider had sought to make areas of the environment dementia friendly, to help people orientate around the home. However, the dementia residential unit was on the top floor of the home. People living on the residential unit had no immediate access to the outside space and relied on staff or family members to escort them into the garden area. We saw memory boxes in use outside people's bedrooms, containing photographs and small items that were meaningful to each individual.

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.

Respecting and promoting people's privacy, dignity and independence.
• People's privacy, dignity and independence was not always respected and not all staff were caring in their approach.
• We identified omissions in electronic records and inconsistencies in the information provided to staff. This meant people were at risk of receiving care that was not person-centred and did not meet their needs. We saw inconsistencies with regards to diet, continence care and supporting people with dementia.
• One person's personal hygiene care plan indicated a preference for male care workers when being assisted with personal hygiene. The care plan stated the person liked to have a shower at least once a week and indicated male staff only to assist. We looked at daily electronic logs entered by staff in relation to personal care and showering from 1 to 30 May 2019. All 24 entries made during these dates stated that the person declined personal care support, including a shower or wash. Each entry had been made by a female care worker. The person was not supported in a person-centred way which meant their choices had been ignored and their dignity had been compromised. Care and support did not meet their needs or reflect their preferences for male only staff.
• We saw occasions when members of staff knocked on people's doors and entered without waiting for a reply. Similarly, we saw some staff did not always knock before delivering a lunch time meal to people who preferred to eat in their rooms.

People's privacy, dignity and independence was not always respected. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Some staff communicated easily with people and their families and were kind and caring in their interactions.
• People's information was stored securely in locked cabinets and electronically stored on the provider's computer system. Only authorised staff had access to people's care files and electronic records which were password protected. Agency staff were given computer access, so they could record relevant information onto the electronic care planning system.
Supporting people to express their views and be involved in making decisions about their care.
• People were involved in making decisions about their daily needs and level of support. For example, what time they wanted to get up or what they wanted to wear. However, the service did not always meet people's needs. One person told us, "I would like a bath sometimes." They also told us how they had enjoyed attending church before living at Allingham House and said, "I have not been since I came here. There are no services." A relative we spoke with told us, "My [family member] would like a bath. They are no facilities in

the whole building to enable them to have a bath." Other relatives we spoke with also told us about occasions when there had been delays in people receiving medicines and meals, due to staffing issues.
• Staff permanently employed at Allingham House Care Centre were able to describe individual needs of people who used the service. Catering staff were aware of people's allergies in relation to food, discussed this with them and provided safe, alternative options.
• Relatives we spoke with felt involved and informed. One relative told us, "Staff communicate well with us and we are always kept well informed. "

Ensuring people are well treated and supported; respecting equality and diversity.
• People and their relatives told us that the 'regular' staff were caring and kind. One relative we spoke with told us, "They are brilliant; they get her and understand her. They want what is best for my [relative]." We observed and heard some friendly interactions between staff and people.
• We observed that some staff were attentive, listened and interacted with people. There was an obvious rapport established between people and staff employed at the home. This was more difficult to evidence with agency staff, some who were relatively new to the service and did not know people's care preferences. One relative we spoke with told us, "There's far too many agency [staff] now who don't know people."
• The service recorded people's religious beliefs, cultural or spiritual needs. This included people's faith and cultural meals they liked, to ensure people's needs were met. Some people followed the Jewish faith and we saw that this was respected. The home provided some people with culturally specific meals. We saw that Kosher meals were served, and staff were knowledgeable about Kosher requirements.

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
• Care files and electronic care records included individual care plans addressing a range of needs such as medicines, communication, moving and handing, nutrition, and physical needs.
• People and their relatives were not always involved in planning their care needs.
• Care plans were not always regularly reviewed and updated to ensure they reflected people's current needs and contained accurate information about their health and wellbeing. We found poor recording in relation to pressure care, weights, observation and food and fluid charts.
• Information regarding people and their current needs was not always adequately shared between each shift to ensure they received safe support.
Care plans did not reflect people's needs and were not reviewed. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns.
• The service had a document called annual complaints summary log however this was blank. There was no monthly log completed for complaints received in April and May to provide an oversight of the outcomes.

• We saw themes for complaints, for example in November 2018 and January 2019 two complaints were made by relatives concerned that family members were left without adequate bedding and were cold. During the unannounced visit undertaken by representatives from Trafford clinical commissioning group on 2 June 2019, one person was found to have one thin sheet and another person was uncovered in bed. One person expressed they were cold.
• Complaints were not responded to consistently and whilst apologies were offered in most cases only one of the four complaints made in January and February 2019 received a documented formal response from the registered manager at the time.
The provider was not operating an effective system for handling and responding to complaints and proportionate action in response to concerns raised was not taken. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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
• There was a team of three activity coordinators employed at Allingham house. During the inspection we noted a number of activities taking place, for example drawing sessions, film shows and a quiz. The atmosphere on some units of the home was lively. A children's playgroup visited on the second day of inspection. This was a regular occurrence and people we spoke with looked forward to this event. A relative

we spoke with told us, "There is plenty going on. There is a trip to Blackpool planned."
• During a gentleman's club activity one activity coordinator introduced a new member of the group by name to others taking part so that the person felt included. This was a good attempt at building relationships within the home whilst helping to prevent social isolation.

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.
• There were a number of people at the home that required support to communicate or had sensory impairments. Information was not always made available in formats that met people's individual needs.

End of life care and support.
• People's end of life wishes were recorded in their care files, if this was their choice. These outlined what was important to people if they were approaching end of life and included people they wanted informed and their preferences and choices about their end of life.

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership.
Leaders and the culture they created did not assure the delivery of high-quality care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• At the last inspection we found the systems in place to monitor the quality of the service were effective. At this inspection the service had gone through several changes of management. The registered manager, in post since 30 November 2018, was not present at the time of this inspection as they had left the service the week before. Their application to deregister was received on 31 May 2019.
• The provider had carried out numerous audits during 2019 and identified similar issues we found during this. However, the provider had not promptly acted to address the issues. The provider did not have oversight of the home and staff morale was low at the time of this inspection. The systems and governance procedures to report, monitor and respond internally were not in place and deadlines for information from the home were repeatedly relaxed month after month. The new regional manager had no access to historical information relating to the service as none had been recorded on the system. The provider had failed to respond in a timely manner to early warning signs that this service was failing. This includes, increased use of agency staff, increased concerns from relatives and the former registered manager and more latterly their own audits. Systems to monitor the quality of the service were ineffective and had failed to identify issues we found at this inspection, for example in relation to medicines.

Systems were either not in place or robust enough to monitor the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The governance of the service was not effective or robust and this was evidenced by the poor standards of care we found.
• We identified the deputy manager had been allocated numerous shifts in May to cover the role of a senior care worker. This meant they had been unable to devote time to manage staff or to work the supernumerary hours which had been allocated to the role to improve the quality of care.
• The extensive nature of the breaches of the Regulations we have identified and the impact of these on people living at Allingham House Care Centre demonstrated a failure of leadership and governance at the home at provider level.
• Standards of care at the home had declined considerably since our last inspection and the service was not safe. The provider was aware of the majority of the concerns we raised during the inspection, having

identified them during internal audits undertaken at the home, but had not acted promptly to mitigate risk and address the issues.

Systems were either not in place or robust enough to demonstrate the service was effectively managed. People were at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
• Records demonstrated that audits were carried out, however, they were not effective as they did not identify the issues we found at this inspection. At a local level where these were carried out by individual people, such as the maintenance man, the previous registered manager had not had oversight of these records. As a result, this information was not reported internally within the company. This also meant that matters were not being addressed to improve the quality of the service.
• There was no evidence to suggest that events and incidents were explored and analysed to identify trends and patterns and to try and prevent similar incidents reoccurring in the future.

Systems were either not in place or robust enough to demonstrate that the quality and safety of the service was effectively managed. This was 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 this inspection we found some staff meetings were held but these were not regular. There were no records to demonstrate learning was disseminated to staff from incidents, accidents and errors in staff meetings. A file set up to store minutes of care worker and senior care worker meetings was empty.
•Staff we spoke with told us staff morale had been low under the previous registered manager. When asked about the previous management of the service one member of staff we spoke with told us, "I felt like there was no positive feedback from the manager and no appreciation."
• Staff we spoke with employed by the provider told us how stressful the caring role had been at the home with the reduced number of permanent staff and the lack of breaks. They said, "It has been quite bad. There are permanent staff around but there isn't really many; we have a lot of agency staff."
• Regular residents' meetings were held and had been attended by members of the provider's senior management team. The previous registered manager had not attended a number of meetings held earlier in the year. Relatives had used these meetings as a forum to raise their concerns about the care and management of the service.
• Relatives and some staff we spoke with considered that the previous registered manager had not been visible and had not provided adequate leadership and support.

Working in partnership with others
• The service worked in partnership with key organisations, including the local authority and health and social care professionals. Following this inspection, we made other stakeholders, including commissioners, aware of our findings.
• We saw the current inspection rating for the service was clearly displayed. The previous registered manager had understood their regulatory responsibilities and had reported accidents and incidents to the Commission, including any potential incidents of abuse referred to the local authority. However, we saw on inspection, these had not always been communicated to the provider via the reporting mechanisms in place.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Significant risks posed to people in relation to medicines were not sufficiently mitigated against. People were at risk of harm.

The enforcement action we took:

Notice of decision