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# Speke Care Home (Residential)

**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? | Inadequate |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

At our last inspection in December 2014, we identified breaches of legal requirements. We issued the provider with four warning notices in relation to these breaches. The breaches related to Regulation 9, Care and welfare; Regulation 10, Quality monitoring. Regulation 11, Safeguarding and Regulation 13, the Management of medicines of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The warning notices advised the provider that further enforcement action would be taken unless they complied with the requirements of the regulations by the 15 February 2015.

# Summary of findings

We undertook this comprehensive inspection on the 20 and 24 April 2015. Our inspection visit was unannounced. During this visit we followed up the breaches identified during the December 2014 inspection. We found that the provider had not taken the appropriate action.

During this inspection we found breaches of Regulations, 9,11,12,13,14,16,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Speke Care Home (Residential) provides accommodation for people who do not require nursing care. It is a privately owned service which provides accommodation for up to 49 adults. The service is located in the Speke area of Merseyside.

There was no registered manager of the home at the time of our inspection. 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.'

We found similar concerns to those we identified at our last visit with regards to the management of medicines at the home. Storage, administration and record keeping were all unsafe. We saw that there were not clear instructions available for staff to give medicines. Where instructions were available these had not been correctly followed. This placed people at significant risk of harm.

People told us they felt safe with staff and this was confirmed by their relatives. The provider and staff had an understanding of safeguarding, however they did not at all times respond appropriately. We found three incidences where the provider had not responded appropriately to allegations of abuse. This meant people were not safeguarded against the risk of abuse.

Accidents and incidents were not properly recorded or monitored to ensure that appropriate action was taken to prevent further incidences.

People and their relatives told us the home was short staffed. Staff confirmed this view. We saw that staff were too busy tending to people's personal care needs to interact socially with them or meet all of their assessed needs. This placed people's health, welfare and safety at significant risk.

We looked at records relating to the safety of the premises and its equipment. We found concerns with the records produced by the manager. The fire risk assessment did not identify significant risks or detail what actions needed to be taken to minimise the risks of a fire.

The provider's staff recruitment practices had improved. During this inspection we found that adequate improvements had been made to comply with the regulation that had been previously breached.

Staff told us they did feel supported by the new manager. They said they had been sufficiently trained. We saw from staff files, that staff had received appropriate appraisals and supervision. Records for staff training were not up to date and staff had not received the Mental Capacity Act (2005) training or understood the reason for its implementation in the home. The manager and deputy manager told us that staff were not fully competent in their roles and understood that the training programme was not up to date.

The provider had not complied with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and its associated codes of practice in the delivery of care. Suitable arrangements were not in place that addressed people's needs and ensured their consent to the care they received was appropriately obtained . Staff we spoke with had a limited understand of what was their role was and their obligations where in order to maintain people's rights.

Care records did not adequately assess people's needs or risks or plan how to meet their needs. Care records were not up to date and people's care had not been updated when reviewed. Care planning for people living with dementia was not up to date and did not take into account that the people were unable to consent.

The service was not well led. The provider did not have effective systems in place to identify the risks to people's health, welfare and safety and failed to seek people's views on the quality of the service they received. The culture at the home was not open or transparent and staff were not supported or responded to appropriately by the provider. We discussed the issues we had identified at this inspection with the provider and expressed our concerns. We found a lack of accountability and responsibility by the provider in the acknowledgement of any of the concerns we raised.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

People were not protected from potential abuse as the provider and their staff had not appropriately monitored people's care. The provider had not updated the safeguarding policy in order to inform staff as to how to protect people living in Speke Care Home (Residential).

People's individual risks in the planning and delivery of care were not adequate to identify, assess or manage peoples care needs. The lack of appropriate assessments and plans placed people at risk of inappropriate and unsafe care.

People, relatives and staff told us the home was short staffed. We saw from the provider's rota arrangements and observation that this was more evident for the people living with dementia.

The medication procedures and practices were not sufficient to maintain the safe administration of medicines. Staff were not competency checked in administering medication.

**Is the service effective?**

Inadequate

The service was not effective.

Records showed that staff had not received adequate and appropriate training for their job role. This meant that they may not have the right skills, knowledge and support to do their job effectively.

The provider had not complied with the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards to ensure people received appropriate support and were enabled to participate in and consent to decisions about their care.

Staff did not understand some people's additional nutritional needs and they were not being met safely putting people at risk from weight loss.

Care plans lacked sufficient up to date information about people's health related illnesses, such as weight loss. Records informed of the deterioration of people's health, however staff had not actioned the findings.

**Is the service caring?**

Inadequate

The service was not always caring.

Staff predominantly caring for the people with dementia had little time to socially interact with the people they supported as they were too busy tending to people's personal care. A lack of social interaction was observed throughout the home.

People's privacy and dignity needs were not always respected. People were not being provided with the care in relation to comfort and continence checks as required in their care plan.

# Summary of findings

**Is the service responsive?**

Inadequate 

The service was not responsive.

Care records were not person centred and did not adequately assess people's needs or risks. Care record reviews were not updated appropriately so staff were not following the correct plan for caring for people. Some people did not receive care that met their needs.

The complaints procedure at the home was ineffective as the provider and the manager did not action complaints raised.

**Is the service well-led?**

Inadequate 

The service was not well led.

There were no effective quality assurance systems in place to identify and manage the risks to people's health, safety and welfare. No audits had been conducted in relation to care plans, health and safety, accident/incidents, infection control and staff training or safety of the premises. Medication audits were ineffective as issues found did not have any actions completed.

People's satisfaction with the service had not been sought through the use of satisfaction questionnaires.

# Speke Care Home (Residential)

**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.

The way in which the inspection was conducted also corresponds to the new Health and Social Care 2008 (Regulated Activities) Regulations 2014 that came into force on the 1 April 2015

This inspection took place on 20 and 24 April 2015 and was unannounced. The inspection on the 20 April 2015 was carried out by two Adult Social Care Inspectors a specialist advisor for medicines and a specialist advisor for dementia care.

Prior to our visit we looked at information we had received about the home and any information sent to us by the provider since the home's last inspection.

During this inspection we spoke with five people who lived at the home, five relatives, four care staff, two senior care staff, the cook, three domestic staff, the activities coordinator, the manager and deputy manager, the provider, the Local Authority and the infection control lead from Liverpool NHS.

We looked at the communal areas that people shared in the home and with their permission visited three people's bedrooms. We also looked at a range of records including ten care records, medication records, recruitment records for three members of staff, training records relating to the staff team, staff rotas, policies and procedures, records relating to health and safety and records relating to the quality checks undertaken by the service.

Inadequate

# Is the service safe?

## Our findings

We asked two people who lived in the home if they felt safe. One person said "I would say so. I don't feel unsafe here". The other person said "I feel safe I suppose". We spoke with five relatives and they told us that they thought that their relative was safe in the home. All of the visitors told us they came to the home frequently.

We looked at the risk assessments for ten people. The risk assessments in the care plan records looked at were ineffective. For example, records for bed rails were undertaken using a tick box, staff were not completing the forms appropriately. We saw records that showed that one person had fallen out of their bed. The risk assessment in place stated 'keep the bed at the lowest height from the floor'. A review was completed two hours after the person had been taken to hospital due to falling out of bed. The risk assessment was unchanged and did not take into account the fall some two hours earlier. As a result there were no updated actions for staff and the person continued to be at risk of injury from falling out of their bed. Another person had an ulcerated foot and was prescribed cream because of the risk of the infection spreading. The risk assessment was not updated and the cream was not being applied as prescribed. A further person who smoked had no risk assessments available to identify the risk of their smoking to themselves or others living in the home.

**These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not provided in a safe way that met people's individual needs.**

We found that since our last inspection very few improvements had been made with regards to medicines and many of our concerns from our previous visit in November 2014 were still outstanding. Medicines were still not administered safely. The system in place to ensure that medicines that should be taken on their own before any other medicines was not being followed by staff and not being monitored effectively.

We saw that some people were still not receiving their medicine in accordance with their prescription because staff were not following the instructions. For example one person had been prescribed steroid cream to be applied twice a day. A review of the person's records showed that there was no evidence that the person's cream was applied twice a day in accordance with the prescription.

Discontinued medication for one person was still on their Medication Administration Record (MAR) sheet to administer. The MAR showed that staff had offered this medication to the person and they had refused this along with all their medication. This person had been placed at risk of receiving medication that was no longer prescribed for them. The person concerned had been reported to the prescriber but no further action had taken place which placed the person at risk of ill health. Another person's medication had been stopped with no recorded reason.

We also had some concerns with the recording of controlled drugs in the home. Some medications were mis-spelt and the pages of the drug register (a legally required recording system for recording the administration of controlled drugs) were loose. This meant that there was a risk that controlled drugs could be mismanaged.

Medicines prescribed as needed known as PRN medication did not have instructions available for staff to inform them when and in what circumstances these medicines were to be given. This meant that people were at risk of not receiving these medicines safely. Additionally the times of medicines such as pain relief that must have a strict gap between doses had not been recorded. As such the staff giving these medicines could not be sure that a sufficient gap between each dose had been maintained. This placed people at risk of receiving these in an unsafe manner.

There was no effective checking of MAR sheets taking place so that the issues identified at this inspection would be noticed and appropriate actions implemented by staff.

In one of the medication storage rooms, a loose unidentifiable tablet was located on the floor. This was concerning as there were no records to indicate that this tablet could not be accounted for.

**These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As care and treatment was not provided in a safe way**

Inadequate

# Is the service safe?

In discussions with staff they showed that they had an understanding of the arrangements for safeguarding vulnerable adults. Staff told us that if they had any concerns about any allegations of abuse or neglect they would report this to the manager or senior staff.

We saw that an incident had occurred where there were considerable risks to the health and well-being of the person who did not have capacity. The person had been taken to hospital due to falling out of bed. There was no updated care plan in place to support this person's behaviour and the incident had not been reported to the local authority safeguarding unit or notified to CQC. Appropriate action had not been taken to ensure that this person received adequate support.

We observed two people's care over the two days inspection. Both people had been diagnosed as having vascular dementia and required full care support. Both people's records stated that they were unable to mobilise independently and required two care staff to transfer them by hoist. They were not provided with the appropriate assistance to meet their continence needs as described in their care plans during the inspection.

**These were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people living in the home were not protected from abuse or improper treatment.**

Two people we spoke with told us the home was short staffed and staff were always very busy. Three relatives told us that at times they felt the home did not have enough staff. They said they had observed that staff were not always available when needed and that staff rushed around and appeared very busy. Staff told us that they did not have enough staff specifically on the unit for people living with dementia. They explained that staff absences were not covered and this caused staff to be very busy.

We saw the rotas and the staff ratios for each shift in the two units of the home. There were two staff caring for the seven people living with dementia. One person was cared for in bed and four people were not mobile without the support of two staff. The two staff told us they were required to contact staff from the other unit of the home to support them in attending to people's personal care needs. We were informed this did not happen when requested, as at times there were not sufficient staff on the residential unit to support them. The manager and deputy told us that they were aware of the staff ratios not being sufficient to meet the needs of the people as the staffing levels had been determined by the provider on budgetary constraints and not on the assessed needs of people living in the home.

We examined the duty rotas for staff and saw that at 2pm every day, one care staff, both cleaners and the laundry assistant went off duty. Care staff were then responsible for the cleaning and laundry as well as the care needs of people living in the home. We spoke with the manager regarding this who told us that they were aware of the arrangements for cleaning and laundry and had been looking into changing the times that cleaning staff were available.

**This a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the staffing ratios did not meet the care and support required for the people as written in their care plans. Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not been deployed in order to meet the needs of people living in the home.**

We looked at the cleanliness of the home and saw that the communal areas of the home appeared fairly clean and tidy. The two medication rooms were seen to be tidy however they were dirty and there were dead insects on the floor of one of the medication storage rooms. The three medication trolleys were not in a good state of repair; they had rust in areas and were not cleaned appropriately. We saw spilt dried liquid medicines in all three. In the trolley labelled number 1 there were three Handihalers (a delivery system for inhaled medicines) prescribed for two people. They were not labelled for the individual people and had dirty mouthpieces that could cause infection for the people using them.

We saw that there was a cleaning schedule for all areas of the home however a kitchen assistant was only available to work up until 2 pm daily. This had an impact on the kitchen as the main meal was provided at five in the afternoon when only the cook was in the kitchen. This was exacerbated by the dishwasher being out of order. We were informed that the dishwasher had not worked for several

Inadequate

# Is the service safe?

weeks and this had been reported to the provider. On the second day of our inspection the provider informed us that a new dishwasher had been ordered. We asked about cleaning audits and were told that none were carried out.

At our last inspection we found that the provider had not initiated an infection control procedure for staff to follow. We contacted the Infection and Prevention Control Nurse from Liverpool Community Health. They had visited the home in January 2015 and implemented an action plan as the home was not meeting infection control standards. Recommendations were set and the provider was given 14 days to meet the action plan and recommendations. The provider did not complete an audit or meet the recommendations set. We requested an infection control audit from the manager; they told us they did not have any audit completed to show how they were monitoring the infection control.

**These examples are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not protected from the risks of infection.**

At our previous inspection we had told the provider to make improvements to their processes with regards to recruiting new staff. At this inspection we found that appropriate checks including criminal checks were carried out prior to staff commencing work within the home. We looked at the recruitment files for three staff members and saw that the files contained all the documentation that was required.

Inadequate

# Is the service effective?

## Our findings

We spent time talking with five people who lived in the home. Comments we received included "It's ok here ok, I'm happy living here" and "The staff are good". We spoke with three relatives who told us that they were happy with the care that their relative received. One relative had contacted us prior to the inspection to express their concerns with the care their relative received. Two other relatives told us the staff were very busy and were always rushing around. Comments included "My relative is better cared for in the dementia unit, staff are good in their roles". And "My relative is better placed in the dementia unit, staff are good".

We asked the staff if they felt supported in their roles. They all spoke highly of the manager and said that they did feel supported. We looked at supervision records for three staff, two of whom had recently been employed. We saw that supervision was being provided on a three monthly basis. We also saw that the third member of staff had received an appraisal in March 2015.

We asked the manager and deputy manager about staff training and they gave us a training matrix which showed what staff training had been completed by staff. That included moving and handling, safeguarding, communication, food hygiene, nutrition, MCA and DoLS and dementia care, fire safety, equality and diversity, first aid and medication training. It informed that not all staff had completed MCA and DoLS training, nutrition awareness training or eating and drinking difficulties training. It was not a comprehensive list as there was no information on induction training.

We looked at how staff were assessed as skilled and competent to undertake their job role. We saw that there were no arrangements as to how learning is monitored. We identified at the inspection gaps in staff's knowledge and understanding especially with regards to mental health as staff did not have a clear understanding about capacity, decision making and best interest decisions. We also had concerns regarding staff competency to safely manage medicines and provide person centred care. The manager informed us that staff were not competent in their roles in relation to these areas.

We spoke with staff regarding the arrangements in place for writing care plans. The provider informed us that a member of staff from another home had come and given staff training in care planning. This training was not recorded in staff records. Staff spoken with informed us that they had not perceived this as training more as set of instructions as to "what we are doing wrong". Staff told us that they had not felt sufficiently supported to develop care plans correctly.

**These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not receive such appropriate training and to enable them to carry out the duties they are employed to perform**

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive options are taken.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the manager, senior carer and staff. Whilst a senior carer demonstrated a better understanding of what was required all other staff spoken with were not clear on what it meant to implement a DoLS assessment or about the best manner to support people with fluctuating capacity.

We were provided with a newly obtained organisational policy on the MCA, which was a copy of information downloaded from a general source. The information was confusing to anyone without extensive training in this area and was not suitable to support the staff in their roles. We saw that the associated codes of practice in relation to the Mental Capacity Act that may provide staff with clearer instructions were not available.

The senior carer had been instrumental in completing and submitting DoLS applications for all seven people on the unit for people living with dementia. At the time of the inspection they had received one authorisation that required monitoring and actions by staff. Records showed

that the applications had been made without first determining if the person required this due to a lack of capacity to make the decision as to whether they wished to live in the home.

Seven applications had been submitted because there is a key lock pad on the door of the unit for people living with dementia. We reviewed the records and talking to staff we were told that one of the seven people was not living with dementia, nor had any cognitive difficulties, and was able to make all their own decisions. It was therefore inappropriate for the service to apply for a Deprivation of Liberty order for this person. We were also informed by the manager that several people living on the other unit were living with dementia. No consideration had been made as to whether an application for a DoLS order was needed.

We reviewed ten people's care files. We saw that where people were noted as living with dementia or having fluctuating capacity, there was no evidence that the provider had followed the required legal processes to ensure people had given appropriate consent or participated in decisions in relation to their care.

We looked specifically at care files regarding consent and how the provider was assessing the capacity of people. Where this was available it only related to photos; lap strap use and outside visits. Each section called for a signature, but there was no signature in place. In one file the consent for photos was signed by a relative, the person's ability to consent to their photograph usage had not been determined. Families cannot give consent to the care and treatment of a relative without statutory authority to do so. We discussed with the manager and staff if they were aware of which relatives had a legal authority to act on behalf of people. They informed us that they were unaware of this. We looked at peoples care records and could find no information that showed if relatives had been granted the legal authority to act on behalf of their relatives or the extent of that authority. There was no policy available that would guide and support staff in making sure that people's individual rights were supported.

We reviewed records regarding DNAR (do not resuscitate) we saw that where these were in place they had not been reviewed in order to determine if they remained appropriate. Additionally where the person lacked capacity to make this decision an assessment of their capacity and a meeting to discuss their best interests had not been held. Without undertaking the proper legal process people were at risk of not having their wishes or rights upheld.

In order to support the appropriate consent for the management of medication we looked at the policy to see if there was any arrangements should it be needed for the giving of medicines without the persons permission known as "covert" administration. The policy contained no guidance or information regarding this. Without clear guidance people are at risk of receiving medicines that they did not wish to receive or of receiving medicines unlawfully.

**These are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care and treatment of people must only be provided with the consent of the relevant person.**

We spent time on the first day of this inspection conducting a SOFI (this is a formal observation of people and how staff interact with them) in the main lounge at lunchtime. Staff were seen to support three people who could not manage to eat by themselves. Staff did talk to the people they were supporting and were dignified about the support; they did not rush the person. The interaction was seen as positive.

We were told that people had a choice to either eat their meals in one of the two dining rooms or their bedrooms. The home operated on set mealtimes during the day and had a four week rolling menu from which people had options to choose from. People had varied opinions about the amount and type of food they were offered and we saw little evidence that people's feedback on the menu options provided was gained to ensure they were happy with the choices.

A light lunch was provided with the main meal served at tea time. The menu of the day was detailed on white boards in the dining rooms. However the writing could not be read by the inspectors who were seated at dining tables during the meal. There were no picture menus available or menus available in suitable formats to meet people's individual needs. We discussed specialist diets with the cook who told us that there were people who required soft diets, fortified diets and diabetic diets. We looked at care plans and nutritional information that identified people's food and drink preferences and specific dietary requirements. When we reviewed care plans for people we saw that two people

required a fortified diet and one person needed a low potassium diet. There was no information available to inform staff how to ensure that the person received a low potassium diet. We spoke with care staff as to how they made sure that people received a fortified diet as an example. They were unaware as to how this was managed stating that the cook gave them the ready plated meal and told them who it was for.

We looked at how people who needed a special diet or who were at risk of poor nutrition were monitored to make sure that they received this diet. We saw that there were food and drinks records available but these were not all fully completed nor did they clearly outline how much of the food the person had eaten. As an example the records would state "ate half a dinner" but there was no description as to how much food a dinner was.

Tea and coffee was served mid-morning and afternoon with hot chocolate and sweet snacks for the people. The deputy manager told us she was, "brought to tears" when she saw the reaction of the people being given chocolate bars to open and enjoy. The manager has also purchased fruit dishes and there was a variety of fruit at hand in the dining rooms.

We reviewed the care plan of one person who was identified as having special dietary requirements in relation to a medical condition. We found a lack of any appropriate nutritional planning and information in relation to the person's dietary requirements and risks. We saw an incorrect calculation of a MUST score (a risk assessment to determine if a person is at risk of malnutrition) where staff failed to recognise or take action with the person's weight monitoring and weight loss. The monitoring of their food/ diet and fluid was inconsistent. Additionally the person frequently refused food and was prescribed a nutritional supplement to be given once a day. Neither the person's diet sheets nor their MAR records indicated that they had received this supplement daily. The risks to this person's nutritional needs had not been recognised and appropriate action taken. We requested that the manager contact the persons doctor that day in order to seek advice.

**This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the nutritional and hydration needs of people was not consistently monitored and their needs were not being met.**

We reviewed the premises during our visit. The service did not provide a dementia friendly environment. For example, signage throughout the building was small and above eye level, all of the bedrooms looked the same and environmental cues which help people living with dementia to orientate themselves to their surroundings were either not available or not clear.

There was also no difference in colour or design between people's personal bedroom doors or bathroom doors to enable people living with dementia to tell the difference and maintain their independence. Bedroom doors were numbered with good sized brass numbers, but this is the only differential, the doors were otherwise identical.

The unit for people living with dementia had corridors and communal areas that were decorated in an array of bold colours, there was an overuse of colour, for example decorated plastic table cloths, and decorated table mats which produced a potentially confusing spectacle. Attempts had been made to make this a more vibrant environment to stimulate people living on the unit.

Inadequate

# Is the service caring?

## Our findings

We asked the people living in the home if the staff were caring. Most people responded positively about the staff. People's comments included, "The staff are nice" and "Staff are very good". Visitors told us, "The staff are fabulous, they really care. My relative has lived here a long time and has not deteriorated. Her appearance is always good" and "They do look after my relative well". Another commented "The staff show my mum so much warmth and love. There are some brilliant staff here".

We observed the staff talking to and supporting the people who lived in the home. The staff were caring in their approach and appeared to have warm, positive relationships with the people that they were supporting. However we did see that when staff did have time to interact with the people they did not use the time to do this and spent time talking to other staff members. This meant that staff missed an opportunity to build relationships and interact in a positive manner with the people they supported. We discussed this with the manager and the deputy manager. They agreed this to be the case as the deputy manager had observed at least one of these instances for herself. Staff in the unit for people living with dementia did not have time to spend interacting with people as all their time was spent predominantly carrying out personal care for people.

We spent time over the two days inspection monitoring the care support in particular for two people who had been placed by staff in the back TV room that was connected to the main lounge/dining room. The seating area was behind a wall where staff could not see the people directly without walking up through the dining room. Records for the two people showed that they were not mobile independently and required full care support to ensure their wellbeing. Care plans informed that they should have had two hourly comfort and continence checks. We observed that these two hourly comfort checks were not provided nor were the two people assisted to the toilet throughout the two days. We looked at daily records; these did not record what care had been provided and when.

We saw during our inspection that there was limited involvement with people who lived in the services about how they wished the service to run.

Care plans did not set out people's preferences for when they reached the end of their life. There were no arrangements for people to make advanced decisons about the care and support that would wish to receive at the end of their lives.

The manager told us that no one who lived in the home currently had an advocate. They also told us they did not have any information to give to people about how they could find one. This meant people may not be aware of advocacy services which are available to them. On reviewing the service we could not find any information available for people about independent advocacy services and how to access them.

We did see staff throughout the inspection attending to the requests of people in a dignified way. When people requested help with going to the toilet, staff would act straight away. However the people with dementia who required comfort position changing and regular attendance to their continence needs was not taking place.

Inadequate

# Is the service responsive?

## Our findings

We asked the people who lived in the home if they did any activities. They told us that there were activities provided. One person said "We play board games and have sing a longs. I get my hair done by the hairdresser every week, I like that" another said, "I go in the garden sometimes and read my newspaper that my daughter brings in for me". Visitors we spoke to told us that there were activities provided including singing, art and watching films. One visitor said" There should be more activities for people with dementia".

Observation records were not being recorded appropriately, this included comfort, nutrition and continence care. Care plans indicated that monitoring and observations should be implemented by staff however they were not happening. The manager told us that the observation and monitoring records required improvement and staff need training to be competent to do this effectively.

**This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the care and treatment people was not appropriate did not met their needs and reflect peoples individual preferences.**

There was a statement by the front door regarding how to make a complaint, people we spoke with told us they would talk to staff if they had a complaint. Visitors told us they would talk to the manager if unhappy about anything.

One person we spoke with told us they had made a complaint that had not been dealt with by the manager or the provider. They told us they had e-mailed numerous times in an attempt to seek clarity from them in relation to their relative. This was ongoing from January 2015 and they had still not had a response. The manager when asked said that she was not sure why they had not responded to the complaint. We requested the complaints records from the manager who confirmed that there were no records regarding the complaint.

We were made aware prior to the inspection that social services had received a safeguarding concern and had undertaken an investigation. We requested these records from the manager and any learning that she had identified following the complaint. The manager confirmed that these records were not in existence.

**This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As there was no effectively, accessible system for identifying, receiving, recording, handling and responding to complaints by people or others.**

We spent time talking to the activity coordinator who worked 30 hours a week. They had an activities programme however we were told this would change if people wanted to do something else. The activity coordinator employed the services of an entertainer who visited the home on the last Friday of the month to sing and entertain the people in the home. We were told there was no budget for activities and the activities coordinator had to raise funds by holding charity events. The activities coordinator did not have any training in providing activities to people living with dementia. The manager told us that she was looking at a suitable training programme for the activity coordinator.

Most people living in the home spent most of their time in the lounge area during the day but were sitting most of the time in silence with the television on in the background. There were staff in the lounge but little interaction took place on the first day. The activity coordinator was on duty on the second day and we observed her interacting with people by talking to them. We did not observe any activities being provided.

On the unit for people living with dementia we observed that most people spent the morning of the first day of our inspection asleep in chairs. There was insufficient stimulation or specialist equipment to enhance their lives or to assist them in maximising their potential for enjoyment.

We asked about how people were supported with their personal care and we were told by staff that they asked people daily about having a bath. Staff told us that people in the home could have a bath whenever they requested one or when it was required in their care plan.

We looked in detail at ten care plan records for people living in the home and we had concerns about all of them. The care and treatment was not designed to meet all their needs. Care plans were not person centred and were not updated to reflect changes. Care records did not reflect the care actually being provided by staff in some instances or reflect people's current needs.

Inadequate

# Is the service responsive?

The care plans available had not incorporated people's personal preferences or choices. Although in some cases these were available in the file. Care plans centred on meeting peoples physical needs and made little or no reference to their emotional or psychological needs. As an example we saw that one person could become very distressed during the day and could shout a lot. There was no information in the care plan as to how to help this person manage their behaviour or how to monitor their behaviour in order to make sure that any changes in their needs were recognised.

We saw that where people's needs changed such as developing an infection as an example this information was not included in their care planning and did not provide up to date instructions to staff as to how to meet the person's individual needs. We saw that some care plans used almost identical wording for one person and another as such this did not reflect the person's individual needs and did not provide a person centred care plan.

One person had continuously refused some food and all their medication. Although this was briefly outlined in the person care plan there were no instructions to staff as to what action to take. This person had complex medical needs that were not being monitored and the lack of an appropriate person centred care plan placed them at risk of harm.

These are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the care and treatment people was not appropriate did not met their needs and reflect peoples individual preferences.

Inadequate

# Is the service well-led?

## Our findings

We spent time talking to the people living at the home about the manager and the provider. People told us that the manager was really nice comments included "The manager is very friendly", "Really nice person" another commented "I'm not sure who the manager is". People were not aware of who the provider was.

All staff spoken with were very positive about the manager who had been in post since February 2015. We were told they were very much a "people's person, friendly, approachable and cared". Staff told us that the manager was supportive and listened to them, comments included "The manager is lovely, she works with us for the people", and another commented "The home is a happier place since she came".

We checked what systems the provider had in place to manage the health, welfare and safety risks posed to people who lived at the home. We found a lack of adequate systems. The systems that were in place were not effective and their operation by the provider was not well managed. For example, we saw that no meaningful audits had been completed. Medication audits lacked information and clarity with no actions implemented when issues were found. We saw that audits that had identified concerns identified the same concerns when the audit was repeated. The accuracy of these audits was questioned by the deputy manager as the initials for one person recorded on the audits do not correspond to any person living in the home.

Care plan audits had been completed on some of the care plans we saw. This had been put into place following our last inspection. We looked at ten peoples care records and found inconsistencies in three and issues in all care plans as a result the audits were not effective. The manager told us that a nurse from another home owned by the provider had come in and instructed the staff on rewriting care plans. No actions or findings were drawn from the audits.

Accident and incident audits had not been undertaken meaning the provider was not able to monitor trends in the types, location and/or times of accident/incidents in order to learn from how the accident and incident occurred so that they could be prevented.

There were no audit procedures in place for infection control, building safety, staff training and development. Regular audits would have identified the issues we identified during our inspection so corrective action could have been taken.

We spent time talking with the manager regarding the infection control audit completed by the Infection and Prevention Control Nurse, Liverpool Community Health in January 2015. The home was found to have not met the requirements and there was an action plan implemented to meet recommendations. The provider was given fourteen days to complete but we were told this was not completed by the provider. We requested these on at least three occasions but they were not made available.

The Environmental Health visited the home in March 2015 and awarded the home a two star out of five rating. This was because the home was not meeting their food hygiene procedures. This was a reduction from a previous 5 star rating. There were no plans in place as to how the service could improve in this area or any determination as to any potential risks in a reduction of three stars in their food hygiene rating.

We have historically raised concerns with the provider over the lack of effective quality management systems in place at the home. We found that the provider failed to show any accountability or responsibility for the lack of effective systems in place. This showed us the home was not well led or well managed in the delivery of care.

We saw no evidence that people who lived at the home and/or their relatives or staff had been asked for their feedback on the care provided by the home since 2014. This meant the provider did not have a system in place to enable people's views to be sought so that they could come to an informed view of the quality of the service provided so that improvements could be made and any suggestions acted upon. The provider had not resolved all of the concerns from the last inspection in November 2014 and had not revisited their action plan.

We asked to see the home's health and safety checks. We saw that there were no checks available regarding the overall safety of the building or the grounds. We saw that the gas and electrical certificates were available and up to date however checks on emergency lighting, fire doors and call bells had not been incorporated in any system to check the safety of the building.

Inadequate

# Is the service well-led?

We were provided with a fire risk assessment that covered two pages and contained no information as to what the fire risks were or how to manage them. This had not been audited or checked that it met the needs of the people living in the home and protected them from harm.

We looked at the policies and procedures available in the service to guide and support staff. We found that these were either out of date, reflective of a care service that incorporated nursing, titled for a different service or lacked up to date best practice. We asked the manager for copies of the latest guidance from NICE (National Institute for Clinical Excellence) for medication management and the codes of practice for the Mental Capacity Act. The manager confirmed that these were not available. Without having up to date guidance the service was unable to reflect upon and take action to work to best practice standards.

**These are breaches of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) regulations 2014. As there were no effective arrangements to assess, monitor and improve the quality and safety of the services provided.**

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

This section is primarily information for the provider

# Enforcement actions

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