Bupa Care Homes Limited

Arncliffe Court Care Home

Inspection report

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28 June 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 22, 23 and 28 June 2017. The visits to the service on 22 and 28 June 2017 were unannounced.

Arncliffe Court is registered to provide care for 150 individuals. The service is situated in Halewood, Merseyside. The service is owned and operated by BUPA Care Homes Ltd. The property is a large purpose built residence that has five separate units for people with varying needs. Woolton, Paisley and Childwall units provide residential and personal care for people. Speke unit provides residential and nursing care to people and Gatacre unit provides residential and nursing care to people with enduring mental health illness.

At the time of this inspection a registered manager was in post. 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.

During this inspection we found breaches in Regulations 10, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The CQC are now considering the appropriate regulatory response to the concerns we found. We will publish the actions we have taken at a later date.

People living on Gatacre Unit were not always treated with dignity and respect. We identified task based care and support during one day of our inspection. People were not always offered choices and there was a lack of communication and social interaction within the unit.

Staffing levels on all units were assessed on a monthly basis. However, visitors and staff told us and we saw that staff were frequently moved around to other units within the service throughout the day. Due to the movement of staff it was difficult to establish where staff were working throughout the day.

The quality assurance systems in place were not effective. We identified a number of issues relating to staff deployment, health and safety, training, care planning documents and supplementary recording charts that had not been identified or addressed by the registered provider. This also included a lack of person centred care delivered to people living on Gatacre Unit.

The registered provider had systems and policies in place in relation to the Mental Capacity Act 2005. Staff practice during one day on Gatacre Unit demonstrated that people were not given choices as part of their daily routine. We identified two applications for Deprivation of Liberty Safeguard authorisations that did not consider all of the current restrictions in place for both people.

People had access to regular drinks and food. Where people's fluid intake was being monitored we saw that no action had been taken when two people had not consumed their recommended daily fluid over a period

of a few days. This put the individuals at risk of dehydration.

Each person had their own personal care plan. However, not all of the care planning documents to support people's needs contained detailed up to date information. This put people at risk of not receiving the care and support they may require.

The registered provider had a comprehensive staff training programme. Records demonstrated that not all staff had received up to date training for their role in line with the registered provider's training schedule.

People's access to communal areas on Gatacre Unit was restricted as the conservatory area was being used to store equipment for the unit. A number of paving stones required attention as they posed a tripping hazard. The risk of tripping around the outside areas that people accessed on a regular basis had not been considered. The registered provider had failed to ensure that the fire risk assessment had considered and mitigated any risks in relation to the main gates of the service being locked through the night.

The majority of people and their family members felt that the service was safe. Staff were aware of the policies and procedures in place to safeguarding people.

People's medicines were managed safely and appropriate storage facilities were in place.

The registered provider had good recruitment procedures in place that ensured that appropriate checks were carried out prior to a new member of staff beginning their role.

A comprehensive complaints procedure and recording system was in place. People and their relatives knew who to speak to if they wanted to raise a concern about the service.

The CQC were notified as required about incidents and events which had occurred within the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six month if they do not improve. This service will continue to be kept under review, and if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating the service. This will lead to cancelling their registration or varying the terms of their registration.

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.

Risks to people were not always considered and planned for. Staff did not always follow best practice when supporting people to move.

Effective systems were not in place to monitor equipment and protect people's skin.

Staff were recruited appropriately and relevant checks were carried out. This helped ensure that only suitable staff were employed.

Systems were in place to help ensure that people received their medicines safely.

Is the service effective?

Requires Improvement

The service was not effective.

Practices failed to demonstrate that people's rights under the Mental Capacity Act were protected.

People did not always receive support from a staff team that had received up to date training for their role.

People had regular access to health care services on a regular basis.

People were happy with the food made available to them within the service.

Is the service caring?

Inadequate

.The service was not caring.

People were exposed to task centred poor practice which impacted on their rights, care and well-being.

People were not always treated with dignity and respect.

Information recorded did not always promote and open and caring culture.

People's confidentiality was protected.

Is the service responsive?

Requires Improvement 

The service was not responsive.

People's care planning documents did not always contain up to date detailed information about their needs.

Monitoring records and assessments relating to people's needs failed to demonstrate that people were in receipt of the care they needed.

People and their relatives had access to the registered provider's complaints procedures.

Is the service well-led?

Inadequate 

The service was not well-led.

The registered provider's quality assurance systems were not effective.

The registered manager and registered provider had failed to identify and challenge restrictive practices within the service.

A registered manager was in post.

CQV were notified as required about incidents that had occurred at the service.

Arncliffe Court Care Home

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 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.

We visited the service on 22, 23 and 28 June 2017. Our visit on 22 June 2017 was carried out by four adult social care inspectors and a specialist advisor and took place at 6am in the morning. On the 23 June 2017 three adult social care inspectors and an expert by experience visited the service. The visit on the 28 June 2017 was unannounced and was carried out by three adults social care inspectors.

We spoke with 37 people who used the service and 15 of their family members. We also spoke with 27 members of staff, the registered manager and the organisation's quality assurance manager for the area. In addition we spoke with a visiting doctor and community nurse who were visiting the service. We looked at care records relating to 15 people, which included, care plans, daily records, supplementary monitoring charts and medication administration records. We observed interactions between people who used the service and the staff supporting them.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in communal areas and staff interaction with people during mealtimes.

Prior to the inspection we reviewed the information we held about the service including notifications of incidents that the registered provider had sent us in addition to safeguarding information we had received. We contacted the local commissioners for the service and the local fire and rescue service as part of this inspection to obtain their views. The local commissioners told us that they had no immediate concerns relating to the service.

Inadequate

Is the service safe?

Our findings

People told us that they generally felt safe living at the service.
Family members told us, "Feel (Name) is safe here" and "I trust the staff".

Risks to people's safety were not always fully considered. We found, and staff confirmed, that for security reasons the entrance gates to the service were locked by a combination lock during the night. Staff working on one particular unit had the responsibility for the locking and unlocking of the gates. We asked if the registered provider's fire risk assessment considered and mitigated, where possible, any risks relating to the use of the type of lock used. Following our visits we contacted the local fire service who visited the service. During their visit it was established that the registered provider's current fire risk assessment did not include mitigation factors detailing the use of the combination lock in use. Following the visit from the fire service the registered provider stated that the fire risk assessment was being updated with management procedures implemented for use of the lock and codes.

Training records supplied by the registered manager demonstrated that not all staff had received up to date training in relation to fire. For example, records demonstrated that 64 staff were overdue training in relation to fire drill, 82 staff were overdue training in relation to fire extinguishers and 33 staff were overdue training in relation to fire safety awareness. Failure to have a staff team with up to date training and awareness in fire safety could result in emergency situations not being managed appropriately and people being put at avoidable risk.

Risks to people's safety were not always considered when planning their care and support. One person who lived on Paisley Unit showed an inspector the fenced outside space that they had access to walk around independently. Whilst walking, the person tripped over an uneven paving stone. This was one of several paving stones that had been marked, to indicate a hazard. Staff told us that the paving stones that were uneven had been identified in around November 2016 as requiring attention as they posed a hazard and that there was a programme of refurbishment with some areas identified as high risk already made safe. The person accessed the paved area several times a day. However, the risk of tripping on the uneven paving stones had not been considered in planning the person's safe care and support.

One person's care plan stated that they were "high risk of falls" but there was no evidence to suggest how this risk was being mitigated or managed. The person had experienced a fall from bed several weeks previously. The falls diary did suggest this situation was going to be discussed to see whether a best interest decision should be considered in relation to the use of bed rails. However, there was no evidence that this had taken place. The care plan was unclear and the risk assessment in place did not identify how the person's care was being effectively managed.

In another record one person's pre-admission assessment completed in March 2017, identified that a "Crash mat and sensor mat" would be needed. The care plan stated that the person was at a high risk of falls and required a senor mat due to fall sustained in June 2017. This demonstrated that the equipment stated as being needed in March 2017 to minimise risk had not been put in place. This was confirmed by staff.

Systems were not in place for the safe management and monitoring of pressure relieving mattresses in use by people. For example, one person's specialist mattress was set at 'active firm'; staff were unsure how this setting had been assessed. In addition there were no effective systems in place to check that the appropriate pressure setting was maintained. Information contained in one person's care plan related to a specific mattress but did not relate the mattress the person was actually using. Failure to review and monitor that people's mattresses were maintained at the correct settings may result in the mattresses being ineffective and put people at risk of not receiving the pressure relieving care they require.

People's records demonstrated risk assessments had been undertaken to establish if individuals were at risk from developing pressure ulcers. However, not all of the people identified as being at risk had a system in place to ensure that they received regular assistance to move or turn whilst they were in bed. For example, one person's records stated, "Position was changed in three different positions"; this information gave no indication as to when the changes of position occurred. We observed that two people on Gatacre Unit were both positioned in a way that their heads were against and touching the bedrail covers. We brought this to the attention of the staff who helped both people re-position within their beds. No system was in place for either person that demonstrated that regular checks were made of their comfort whilst in bed. This demonstrated that monitoring systems in place were not effective.

Equipment was available throughout the service to support safe handling and transfers of people. We observed staff utilising hoists to support people to move safely and training records demonstrated that the majority of staff had received training in safe moving and handling practices. However, we observed two staff on Gatacre Unit and two staff on Speke Unit using an inappropriate lift to support people out of their chairs. Failure to use safe moving practices puts both people using the service and the staff at risk of injury.

The registered provider had a system in place to establish the perceived number of staff needed to be on duty to ensure that people's needs were met. However, rotas in use throughout the service failed to give a definitive number of staff that were available to meet the needs of people on each unit. This was because staff were seen, on two days of this inspection, to be constantly moved around each unit. Rotas available demonstrated how many staff should have been on duty on each unit. For example, Gatacre Unit rotas demonstrated that the unit had been short on their allocated staff for six out of 14 days. The rotas for Speke Unit showed a variance of between four and seven members of staff being on duty during the morning time. However, the rotas did not record where staff from each unit had actually worked whilst on duty. This resulted in there being no means for reviewing what and where staff had worked on particular days. Family members commented about the lack of staff available on Gatacre Unit. Their comments included, "You can have four people shouting and one lady trying to sit on another lady, another person's top was falling off them – no staff available to support people. Very distressing for visitors" and "There is not enough staff to support people. There is only one hostess at present and this means that people are being supported often by staff they don't know or who don't know them". Two further family members told us "There are insufficient staff, we have raised concerns but nothing has changed". Staff also commented about the lack of staff available at times and that units were often short staffed. They told us that working below the expected number of staff wasn't dangerous, but the quality of care suffered. Staff felt that they did not always know people's care and support needs when they were transferred to another unit for a short period of time.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as care and treatment was not provided in a safe way for the people supported.

Observations and checks on Childwall, Speke and Woolton Units showed that people were supported to receive their medicines safely. Appropriate storage facilities were available. Policies, procedures and guidance were available to staff to support the safe administration of medicines. Staff involved in the

administration of people's medicines had been assessed as being competent to do so.

Medication Administration records (MARS) were in use for recording when a person had been offered or administered their medicines. Separate recording documents were in use for the recording of when creams had been administered to people. We found that some staff were using the specific creams charts to record information and others were using people's daily notes to record this information.

A system was in place for the ordering and disposal of medicines. A record of all medicines which arrived at the service was maintained and any unused medicines were disposed of appropriately. Monthly audits had to take place on units. Following each audit an action plan for any improvements was devised. For example, actions from the Woolton Unit medicines audits included weekly stock counts of all medicines to be completed and allergies to be listed on all records and MAR sheets.

A handy person was employed to arrange and carry out routine checks around the environment. Records showed that checks and tests of equipment and systems such as fire alarms, emergency lighting, water quality and temperatures were undertaken. Each unit had a book in which all identified repairs were recorded. The maintenance person checked these books each day and where needed repairs took place. At the time of this inspection the service was in the process of updating their hot water management system and due to this the temperature of some hot water had been reduced for a short period of time.

The registered provider had clear recruitment and selection procedures in place. Information contained on staff files demonstrated that appropriate checks had been carried out prior to them starting their employment. For example, all but one staff file contained two written references, a completed application form, evidence that formal identification had been sought and a check with the Disclosure and Barring Service had been carried out. These checks were carried out to help ensure that only staff of a suitable character were employed by the registered provider.

Policies and procedures were available to staff in relation to safeguarding people from abuse. Staff spoken with had a knowledge and understanding of procedures and they knew where they could find the policy, and other guidance for reporting any concerns. Training records demonstrated that 62 staff were identified as being overdue training in safeguarding.

Requires Improvement

Is the service effective?

Our findings

People told us positive things about the service. Their comments included, "I sleep well, the home is nice and quiet", "The girls (Staff) check I am sleeping but I stay in bed late" and "I can have what I want to eat and like sitting at the dining room table with other ladies".
Family members told us that there was a "Nice atmosphere in the home", "(Name) is eating well".

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 a possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make 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 the best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). Senior staff demonstrated an awareness of the Mental Capacity Act; however, not all staff were able to relate to the MCA or DoLS.

We checked whether the service was working within the principles of the MCA and whether the application process on behalf of people protected people's rights under the MCA. The registered provider had submitted applications under DoLS to the local authority for a number of people. These applications were for people they believed could not make a decision due to mental capacity as to where they should reside or the use of other restrictions, such as locked doors. However, we saw that not all of the DoLS applications made on behalf of people had considered all areas of potential restriction on an individual's liberty.

For example, staff told us that one person had a tendency to get agitated and cause harm to themselves when they were up and out of bed and was therefore now spending their days in bed with a bedrail in place. Staff explained that this decision had been made with family members. We looked at the DoLS application and assessment of the person and found that the use of bedrails and remaining in bed had not been considered in the DoLS process. In addition, the person's records contained conflicting information with regards to giving their consent. For example, one record stated, '(Name) is a person who chooses to stay in bed and they becomes very agitated when in a chair due to their dementia', which indicated that this was the person's choice. However, other parts of the care planning document stated, "(Name) lacks capacity over her care and her family are involved in all decisions".

The registered manager told us that one person slept in a particular type of clothing which could restrict the person's access to their body. We looked at the person's DoLS application and other subsequent documents relating to the Mental Capacity Act 2005. No information was recorded to demonstrate that the use of the clothing had been considered in the application and assessment of the DoLS application. Failure to ensure that people's specific situations are considered when applying for Deprivation of Liberty Safeguards could result in a person rights under the Mental Capacity Act 2005 not being adhered to.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as systems in place had failed to identify that all restrictions had not been considered for people in relation to

the Deprivation of Liberty Safeguards.

The registered provider had a clear schedule of training that staff were expected to undertake to maintain up to date good practice. Staff told us that they received on-going training within their role and that they felt the standard of training was good. Training records demonstrated that the majority of staff had completed training that included medicines, pressure ulcers, moving and handling, health and safety and infection control. However, records demonstrated that over 80 staff were recorded as 'overdue' with their up to date training in relation to managing behaviours that may be seen as challenging, 40 staff had been identified as being 'overdue' with their up to date training in relation to caring for a person living with dementia and 43 staff had been identified as being 'overdue' with their up to date training in safeguarding. In addition, as identified earlier in this report a large number of staff had been identified as requiring fire safety training. Staff received awareness training in relation to the Mental Capacity Act 2005 as part of their induction training. However, no records were available to demonstrate that any further training in relation to the Mental Capacity Act 2005 was undertaken by the staff team. The registered manager told us that they recognised that improvements were needed in relation to ensuring that staff received appropriate training for their role in line with the registered providers training programme.

This is a breach of Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) 2014 as training records failed to demonstrate that suitably skilled and competent staff delivered care and treatment.

Policies and procedures were in place to offer guidance to staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. During this inspection we observed staff on the majority of units offering people choices. For example, choices in relation to food and drinks and where a person wished to sit within the communal areas. Staff spoken with knew that people should be given a choice within all aspects of their care and support.

We saw that on Speke, Woolton, Paisley and Childwall unit's people's dietary requirements and wishes were met. We spent time with people during several mealtimes and saw that people were given choices in respect of what they wanted to eat and drink. People and their relatives spoke positively about the meals available. Their comments included, "The food is good", "Food is lovely, we get plenty of it, too much sometimes". During one meal people were heard to say, "That was lovely" and "I really enjoyed that". People told us that they had a choice of where they wanted to eat their meals; one person told us, "I usually have my meals in the dining room but if I'm watching something special on my TV I eat in my bedroom". On Speke unit a hostess was on duty. It was their role to support people throughout the day with food and drinks. The hostess demonstrated a good awareness of people's dietary needs and wishes and individuals specific needs in relation to eating and drinking.

The chef visited each unit on a regular basis to speak to people and told us that the kitchen staff were happy to meet people's dietary requests. We saw on occasions throughout this inspection people ordering specific foods that they wanted to eat. For example, fried eggs on toast for one person and macaroni cheese for another person were prepared quickly following their requests.

People had regular access to local health care professionals and GP services. A twice weekly surgery was held at the service by a GP. The GP was available during these visits to see people at their request or who had been referred by staff. Outside of these surgeries staff would contact the local out of hours GP service in the event of a person needing medical support. Information was available to demonstrate that staff had made referrals to healthcare professionals on behalf of people at appropriate times. Three family members told us that they felt their relative's health needs were managed well. One told us that their relative had

gained much needed weight whilst living on Speke Unit.

The registered provider had an induction programme to induct all newly recruited staff into their role. This programme included staff being enrolled on the Care Certificate. The Care Certificate is a set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. Two staff told us that they had recently commenced employment and that they had completed training, along with a period of 'shadowing' other more experienced staff as part of their induction process.

The majority of staff spoken with felt that they received supervision and support from their line manager. Staff meetings were held periodically within the service to provide regular updates to staff teams.

Inadequate

Is the service caring?

Our findings

Although people told us that they felt that the staff team were caring towards them we found that this was not always people's experiences. People commented "The girls (Staff) are very polite and nice", "Staff are lovely and kind", "Very happy", "I get up and go to bed when I like. Not made to get up early" and They (Staff) do their best".

Family members also spoke positively about the care and support their family members received. Their comments included "Care is good. Care staff very good with (Name). Personal Care is also very good. They are good at communicating with me and will always contact if there is any news".

The quality of care delivered to people was inconsistent on the Gatacre Unit. During the first day of the inspection we found that there was a good relaxed atmosphere within the unit and staff were seen to have positive interactions with people. For example, during mealtimes people were shown both meals available to enable to make a choice.

However, during the second day of the inspection we found that people were not in receipt of care that promoted respect and dignity. During one mealtime we observed nine people sat in the dining room on Gatacre Unit. Dining tables were set in three long rows and were not set with any cutlery or condiments. People requiring a soft consistency diet were served a chicken and rice dish. Others were served soup and sandwiches. No choices were given to people living on Gatacre unit as to what they wanted to eat. This demonstrated a lack respect towards individuals.

One person was being supported to eat their meal by a member of staff. Whist supporting this person the member of staff was asked to support another person to use the bathroom. The member of staff left the room returning approximately 20 minutes later to resume supporting the person with their meal. Throughout the person's meal no interaction was promoted or took place by the member of staff. This demonstrated a lack of respect for the person and a failure to provide a dignified mealtime experience.

A second person needed the support of a member of staff to eat their meal. As their meal was served and placed on the table the member of staff was called away to support another person to use the bathroom. After approximately 15 minutes another member of staff sat down next to the person to assist them with their meal. An inspector explained to the member of staff that the meal had been served sometime prior and asked whether the food was still hot. The member of staff felt the bottom of the plate and said it felt warm, then said that they would get another meal to ensure that it was hot. Again, this demonstrated a lack of respect for the person needing support to have their meal. Out of five members of staff around the dining room, only one member of staff was seen to positively engage and communicate with the person they were supporting. All other interactions were seen to be task based, for example, pouring drinks and cleaning tables.

On Gatacre Unit we observed a number of care practices that failed to demonstrate or promote the respect or dignity of people. For example, one of the inspection team was speaking to a person in the lounge area;

the person's nose was running. A member of staff with tissues in their hand went in front of the person and wiped their nose without asking or indicating what they were going to do.

Another person was seen to bend over the side of her chair as if to be sick. A member of the inspection team asked a member of staff to assist the person. The staff member was seen to roll their eyes and said, 'She's spit, that's what it is". Later that morning medical assistance was requested as the person continued to experience difficulty.

A member of the inspection team was speaking to a person who became upset and tearful. A member of staff walked passed and stated, "She does this"; tissues for the person had to be requested by the inspection team.

On Gatacre, Paisley and Woolton Units we observed a lack of interaction between staff and the people they supported. For example, on two occasions no communication or interaction took place with people sitting in the dining area following their meal or in the lounge area. Staff were seen to be engaged in setting tables and carrying out other duties. On one occasion on Woolton Unit, whilst staff were giving people their medicines two large trolleys were left for an hour and a half in front of two people in the lounge area. The trolleys blocked the view of the room and the television for both people. This demonstrated a lack of thought and respect for people.

On Gatacre Unit we found that people's freedom of movement around the communal areas and choice of where they wished to sit was restricted. This was because the conservatory area of the lounge was being used as a storage area for wheelchairs, hoists and other equipment used within the unit. This storage prohibited the use of this area for people.

Records written by staff failed on occasion to demonstrate that an open and caring culture was promoted within the service. For example a diary entry on Woolton Unit stated "Residents not to be put to bed before suppertime". On Childwall Unit a diary record stated "CQC inspection due" and "CQC will possibly call sometime in the near future / archiving needs to be done and they are paying staff to come in and do it if they would not mind

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as people's right to choice, respect and dignity were not respected.

On some units we observed some good practice and examples of care and support offered by the staff team. Staff knew people's needs, their likes and dislikes. It was evident on occasions that strong relationships had been built between people and the staff that supported them. Staff were seen to discuss common interests and generally chatting to people about their welfare. On Woolton and Childwall units we saw lots of laughter and banter between people and staff. People told us that they liked to have a laugh and a joke with staff. Where needed, staff offered comfort and support to people. For example, one person became confused and was crying. Staff were seen to offer compassion and a comforting arm around their shoulder which the person responded positively to.

Dining tables on Speke, Woolton, and Paisley units were set with crockery, table cloths, cutlery and condiments to help promote a pleasant dining experience for people. We joined people for breakfast on Paisley unit one morning. People were seen to be offered cooked and cold breakfast food choices and staff were seen to sit and have breakfast with people which generated lots of conversation. Staff told us that the unit manager encouraged staff to spend time eating and having a drink with people during mealtimes to promote social interaction. In addition staff said that a further benefit of this was that it gave staff the

opportunity to gently encourage people to eat their meals. Staff were observed explaining to people their choice of menu and when required showing the actual meals available to individuals in order for them to make an informed choice.

People told us that they had the opportunity to bring into the service personal effects and items that were important to them. For example, people had decorated their rooms with pictures and photographs, ornaments and small pieces of furniture brought from their previous address. One person told us that bringing their personal effects to the service "Helped me settle in. I love to look at my family photographs so I never feel alone".

When the information was available, the care planning records gave the opportunity to record people's choices in relation to their end of life. In addition, where a decision of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) had been made by or on behalf of an individual under the appropriate legislation, this was recorded and placed in a person's care planning file. In addition, the information also available in the unit office so that staff were aware of the decisions in place around the people they supported.

The registered provider offered support to people who were at the end stages of their life. We spoke with a family member of a person in receipt of end of life care. They told us, "Excellent care. Staff very good. No issues. Always clean and good attention to personal care" and "Amazing, can't fault them, we are so grateful".

A noticeboard was available in each unit that displayed information about the service for people and their family members. This information included how to raise a compliment or concern and what activities were taking place. In addition, people had been provided with information about the registered provider, their aims for the service and the expected level of service that should be expected at Arncliffe Court.

Records containing people's personal information were kept safe in locked cabinets and offices. This helped ensure that the information was only accessible to staff who needed to have access to these records.

Requires Improvement

Is the service responsive?

Our findings

People and their family members made positive comments about the service provided. Their comments included, "Lovely place for mum", "Mum is looked after so well", "No complaints at all" and three family members told us that staff communicated well with them about their relative's needs.

Each person had their own individual care plan that gave the opportunity to record their lifestyle choices and how their assessed needs and planned care needed to be delivered to ensure that their needs were met at all times. Family members told us that they participated in their relative's care planning.

Information contained in people's care plans and other records relating to people's care needs did not always contain accurate up to date information or that people had received their care as planned. One person had been placed on end of life care two days prior; however, the care plan had not been written to demonstrate the person's changes in need. Daily records demonstrated that the person was in receipt of the appropriate care they needed; however, a clear plan of care had not been developed.

Inconsistent information was seen in some people's care plans. One person's care plan stated that they had epilepsy. There was no indication as to what type or frequency of seizures, if any that the person experienced, or of any rescue medication available to keep them safe. The information on action to be taken was in the main to contact 999. Another person's care plan stated that they had atrial fibrillation, an irregular heartbeat. The care plan stated to check for breathlessness or rapid heartbeat. We saw that the care plan had been reviewed but there was no reference to any observations made in relation to the person's condition. Another person's care plan stated that they were type 2 diabetic. There was a care plan in place for diabetic care; however, the clinical information recorded was minimal. There was no guidance to state as to what to do in response to blood glucose readings that were above or below the recommended range.

Fluid monitoring charts for two people at risk from dehydration demonstrated that for three days one person had only achieved between 45% and 51% of their recommended fluid intake. The second person's charts demonstrated that they had taken between 56% and 78% of their daily recommended fluid intake. There was no further information recorded as to how the individuals could be supported to achieve the fluid intake they required. Failure for a person to maintain their appropriate fluid intake may result in a person becoming dehydrated.

One person's care notes stated that the person had sunburn. The notes stated that the sunburn may be from the direct sunlight from their bedroom window. Notes written two and three days later stated the person had been in the garden and again noted sunburn. An entry in the communications diary noted that moisturiser had been requested from the GP following the sunburn. Staff stated that sun cream had been applied, however this was not recorded anywhere.

One person had a Grade 4 pressure ulcer on their sacrum which according to their care plan records was to be photographed on monthly basis. Photographs of the wound were available and the dates of the

photographs were written on small pieces of paper due to the date on the camera not being set correctly. Measurements of the ulcer were not consistently recorded and therefore made analysis of any improvement of or deterioration to the wound difficult.

Supplementary records for the management of an enteral feeding tube were not always recorded. For example, the person's care plan stated a daily rotation of the tube but there was no documentary evidence to demonstrate that this was taking place. A number of people required their drinks thickening to prevent them from choking. Staff responsible for preparing people's drinks had access to the thickeners, however there was no recording system in place for staff to sign that they had used the thickener whilst preparing drinks for people.

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This was a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as care and treatment was not planned or provided in a safe way and accurate records were not held in respect of people.

Prior to a person moving into the service an assessment of their needs took place. The purpose of this assessment was to identify specific needs and wishes of people and to ensure that the service has the facilities to meet these needs. Family members told us that they had been involved in their needs assessment prior to them moving into the service. The assessment considered people's needs and wishes relating to physical and psychological needs. Information gained during this assessment process contributed to the planning of the person's care and support.

Both day and night staff on duty were able describe and the needs, likes and dislikes of the people they supported. For example, one team of night staff were able to explain the needs of a particular person throughout the night and the support they required from staff. Although staff recorded the support they had delivered throughout the night, the person's care plan contained limited information about the actual support needed or delivered by the staff team. We discussed this with the registered manager who made a commitment to make arrangements for the re-assessment of the person's needs.

The opportunity for people to access mental and physically stimulating activities varied within the service. For example, we saw two activities co-ordinators setting out the lounge area on Speke unit for a cinema afternoon. Staff had prepared small theatre style packets of popcorn and sweets for people to have during the film show. The cinema afternoon was well attended by people. A family member visiting Speke unit told us, "There is always something going on activity wise; cinema, bingo or a pub night". Another unit was holding an afternoon tea event in which people from other units had been invited to. Staff on Paisley unit explained that they encouraged people to get involved with baking and also had floor games that people enjoyed playing. No activities were seen to take place on Gatacre unit. Family members told us that there was an occasional outside entertainer visited but generally there was little stimulation available to people.

A complaints procedure was available in all units and the offices of the service. The procedure informed people of how to raise a concern or complaint about the service they received. People and their family members told us that they would speak to particular staff if they had a concern. The registered provider had a system in place to record all complaints and concerns raised regarding the service and copies of all letters and investigations and actions taken were maintained of any complaints made for further analysis.

Inadequate

Is the service well-led?

Our findings

The registered manager had been in post since April 2017.

The registered provider had a system of audits and checks in place to monitor the quality of the service people received. For example, representatives of the Quality team and area managers visited the service on a monthly basis to carry out a monthly review. Following these reviews and action plan was developed which recorded any actions required, who was responsible and the timescales. Daily 'walk around' checks were carried out by senior clinical staff. These checks were carried out on each unit and included checks on people with clinical concerns, hospital admissions, monitoring falls, safeguarding concerns, wound management and assessing the care planning documents for one person's care planning documents each day, a system known as 'resident of the day'.

Daily audits and checks completed by senior staff members and audits carried out by the registered provider's representatives had failed to identify or address the issues that we identified during our inspection. This demonstrated that there was a lack of effective and robust monitoring of the service delivered to people. Checks had failed to establish that people were potentially not receiving sufficient fluids on a daily basis. Insufficient information in people's personal care plans had not been identified which left people vulnerable to not receiving the care and support they required.

Systems were not in place to record, monitor and minimise the risk of pressure sores to people who spent the majority of their time in bed. In addition, no system was in place to ensure that pressure relieving equipment was monitored to ensure if effectiveness for people.

The auditing system had failed to identify issues relating to planning safe effective care by ensuring the people's environment was safe and free from avoidable harm. The fire risk assessment had failed to consider the use of a lock for the main gates to the service. Areas designated safe for people to walk around had raised paving stones that posed a tripping hazard to individuals. In addition, grass cutting had not been removed from pathways which created further risk of slipping to people and create confusion as to where the actual path was. No action had been taken to improve people's freedom of movement around Gatacre Unit by moving equipment that was stored in the conservatory area.

People's care planning documents failed to contain detailed information as to how a person's needs were to be met and when needed care planning documents were not always updated in a timely manner. One person had been placed on end of life care two days prior; however, the end of life care plan had not been written.

Inconsistencies in recording of care needs and health situations had not been identified. One person's care plan stated that they required a high calorie protein fortified diet. Other information within the care plan stated normal diet and fluids. Another person's weight chart recorded weight between 42kg and 46kg. However, the care plan evaluation stated that the person's weight was 64.4kg.

There was a failure to identify and address issues relating to people's supplementary care records. For example, the management of a person's enteral feeding tube was not always recorded. On Gatacre Unit there were no positioning monitoring charts in place for people. Although staff were supporting people throughout the service with thickened fluids there were no records being maintained of when thickened fluids had been given to individuals. This lack of information could result in people not receiving the care and support they required.

The registered provider had failed to identify and act on maintaining an up to date rota system that clearly identified where a member of staff had worked during their working day. In addition checks had failed to identify and address the lack of communication, interaction and dignity showed to people. Gaps in the staff training matrix demonstrated that a large number of staff had not received training in a timely manner or in line with the registered providers programme.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider's quality assurance audit systems were not effective in identifying and addressing areas of improvement needed within the service.

Staff explained that at the beginning and end of each shift a handover took place. These handovers gave staff the opportunity to pass valuable information onto their colleagues about any changes in a person's health or needs. Senior staff also attended a 'take ten' meeting every weekday morning. These meetings were attended by unit managers and heads of departments and gave the registered manager the opportunity update the staff on any event planned for that day.

People and their family members told us positive things about the staff team and the service they delivered. Comments included, "Staff are very good but just don't get the time to be with people", "Happy with the service that staff deliver but just not enough of it", "Can't fault any of the staff", "Staff are marvellous, wonderful" and "Staff are amazing".

The registered provider had a comprehensive set of policies and procedures that were available to all staff within the service. The documents are developed to assist staff in using the correct legislation and best practice when delivering care and support to people. These policies and procedures were regularly reviewed and updated by the registered provider.

The service had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations.