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Prospect House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 21 and 22 July 2016 and was unannounced. At the last inspection in July 2016 the service was rated as good. This inspection was brought forward in response to a number of concerns raised by the local authority.

Prospect House provides accommodation for people who require personal care, and supports older people living with dementia. The service is registered to accommodate up to 24 people, and at the time of the inspection there were 17 people using the service.

The service had not had a registered manager in post since January 2016. At the time of the inspection there was a manager in post who was in the process of applying to CQC to become the registered manager. However following this inspection we were informed that the manager had left the service before their application to become registered manager had been processed. A deputy manager and business manager were in post to support with the running of the service whilst the registered provider was recruiting for a replacement manager. 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 our inspection we identified multiple breaches of the Health and Social care Act 2008 (regulated activities) 2014. We will publish the actions we have taken at a later date. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. As a result of serious concerns found during the inspection we raised two safeguarding referrals to the local authority for investigation.

We identified a number of issues around the safe storage and administration of people's medicines. These issues had also been identified by staff working for St Helens Contracts and Commissioning Group (CCG), during a medicines management audit in April 2016. At our inspection we found that limited action had been taken to complete the action plan outlined by the CCG. This placed people at risk of harm due to medication errors. There were no quality monitoring processes in place by either the manager or the registered provider. This meant that areas of improvement could not be identified and acted upon.

People's safety was not always maintained, and follow up action had not been taken to identify why incidents had occurred, or how they could be prevented from happening again in the future. For example one person had sustained serious bruising, however no action had been taken to identify what had caused this, or to report this to the local authority. The registered provider had failed to carry out checks on the water supply to ensure they were free of dangerous bacteria, and there were parts of the environment which were unclean and dirty, which placed people at risk of infection. This meant that people were at risk of harm and ill health.

People's rights and liberties were not always protected in line with the Mental Capacity Act 2005. Mental capacity assessments had not been completed for people requiring covert medication, and the correct procedure had not been followed with regards to the use of CCTV that was in place. Staff had not completed training in the Mental Capacity Act 2005, and were not aware of their roles and responsibilities in relation to this. For example, one person was having covert medication administered without due regard being given to whether this was in their best interests. This placed people at risk of having their right and liberties undermined.

Staff had not undertaken the training necessary for them to carry out their role effectively. For example a majority of staff had not recently completed training in Dementia awareness, infection control or moving and handling. There was an induction process in place for new members of staff, however this did not work to the current standards required by the Care Certificate.

The registered provider is required to give due regard to the protected characteristics outlined in the Equality Act 2010. We found examples where adequate consideration had not been given to ensuring that people's needs were met with regards to their disabilities, or religious and spiritual needs. This meant that people's rights and dignity were not always maintained.

Care records did not always contain accurate, up-to-date or personalised information. There was a review process in place, however there were multiple examples which showed that this process was not robust where information had not been updated to reflect changes. This meant that adequate information was not always available to ensure that people who used the service received safe care.

The registered provider is required by law to notify us of certain events that occur within the service. We found multiple examples where this had not been done, or had not been done in a timely manner. This meant that the registered provider was not acting in accordance with the law.

The registered provider is required to demonstrate that they have an appropriate understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and understand the consequences of failing to take action on set requirements. However the number of breaches of the Regulations identified showed that the registered provider did not have a sufficient understanding of their roles and responsibilities in relation to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they enjoyed the food that was on offer. People were given a choice of second helpings and staff provided people with the support and assistance they needed at meal time. Menu options were presented in written and photographic format to support those people who had difficulty reading. However the photographic menu was not updated to reflect the choices available during the two days of the inspection. This undermined the dignity of those people who were unable to read the written menu.

People told us that staff were respectful, and we saw examples where staff treated people with kindness. Care records containing people's personal information were stored securely which ensured that their confidentiality was being maintained.

There were activities available for people and they told us that they enjoyed these, and felt that there was "plenty to do". A local volunteer group were visiting people at the time of this inspection, and another volunteer group had previously visited the service, and spent time gardening with people. This ensured that people had the social interaction they needed, and that they remained involved with the community.

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 months 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 this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not supported to take their medicines safely and medicines were not stored in line with manufacturer guidance, which can impact upon their efficiency.

Risks to people were not managed effectively. Parts of the environment were unsafe, placing people at risk of injuring themselves.

Parts of the environment were unclean and there were inadequate infection control measures in place to prevent the risk and spread of infection.

Is the service effective?

Inadequate

The service was not effective.

People rights and liberties were not always protected in line with the Mental Capacity Act 2005. Staff had not completed training in this area and they were unsure of their roles and responsibilities in relation to the Act.

Staff had not completed the training they needed to carry out their role effectively.

People were not always supported to access support from relevant healthcare professionals when required.

People enjoyed the food that was available, and staff provided people with the support they needed with eating and drinking.

Is the service caring?

Requires Improvement

The service was not always caring.

People's personal possessions were not always kept safe, in line with the registered provider's processes.

Staff interacted with people in a caring and respectful way.

People's privacy and confidentiality was maintained.

Is the service responsive?

Inadequate

The service was not responsive.

Due regard was not always given to people's protected characteristics as outlined within the Equality Act 2010 which meant that people's rights and dignity was not always maintained.

People's care records did not always contain personalised information, and the system for reviewing the records was not robust.

Is the service well-led?

Inadequate

The service was not well led.

There had not been a registered manager in place since January 2016.

There were no quality monitoring systems in place to assess and make improvements to the quality of the service people received.

There was no system for gathering feedback from people. Action was not taken to rectify issues identified by other professionals, to ensure improvement within the service.

Prospect House 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 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 inspection was unannounced and took place on the 21 and 22 July 2016, and was scheduled in response to concerns that had been raised by the local authority. It was carried out by one adult social care inspector, and a pharmacy inspector.

During the inspection we spoke with three people who used the service and four people's relatives. We also 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 spoke with six members of staff and looked at three staff recruitment records. We also spoke with one visiting professional. We looked at the care records for six people. We also looked at other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe within the service. Their comments included, "Staff treat me well" and "I like every minute of this place". Family members also commented that they felt their relatives were safe. They commented, "Yes [Name] is safe" and "[Name] is safe and well looked after".

However, we found that people who used the service were not protected against the risks associated with the administration, use and management of medicines. People did not always receive their medicines when they needed them or in a safe way which left them at risk.

We looked at medicines, electronic Medication Administration Records (eMARs) and other associated records for fifteen people living in the service. We spoke with the senior care workers and members of the management team about the systems in place for managing medicines.

Medicines were not always stored safely. The temperature of the medication fridge was above the required temperature for storing medication, sometimes ranging two and a half degrees Celsius over the recommended limit. Medicines can spoil and become unfit for use if they are not kept at the correct temperature. We were told by the deputy manager that a new fridge was due to delivered on the day after our visit, however no action had been taken to ensure the safe storage of medicines needing to be refrigerated, even though the manager had been aware that the fridge had not been working properly. This had been raised with the registered provider in April 2016 following a medicines inspection by St Helens CCG, Controlled Drugs (strong medicines that may be abused) were not stored securely, despite there being a Controlled Drugs cabinet available.

Some of the eMARs we looked at were inaccurate as the quantities of medicine received or brought forward from the previous month had not been accurately recorded. This made it difficult to calculate how much medication should be present and meant there was no guarantee that people had received their prescribed medication. We saw two examples where courses of antibiotics had been given for longer than prescribed and three examples where people had not been given their medicines as no stock was available, including strong pain killers. Failing to make sure adequate supplies of medication were available placed people at unnecessary risk of pain and discomfort.

Records for the application and use of creams and other external preparations were incomplete. We saw two examples where medicines including creams and nutritional supplements were not listed along with instructions for use on the person's eMARs. In addition there were no body maps and/or care plans available for the use of creams and supplements which meant staff did not have access to any guidance or instructions about how to use prescribed medication. This put people at risk of not receiving their medication.

Many people were prescribed medicines, e.g. painkillers and laxatives that could be given at different doses i.e. one or two tablets; or that only needed to be taken or used when required (PRN). We found that there was not enough information available to enable care workers to give these medicines safely, consistently

and with due regard to people's individual needs and preferences. For instance there were no details on people's MARs, and there was no information in care records.

One person's records indicated that they were being given their medication covertly, i.e. hidden in food or drinks without their knowledge or consent. There was no information within care records or MARs to tell staff which medicines were to be given covertly or exactly how and in what circumstances they should be given. Arrangements for giving medicines in this way had not been made in accordance with current guidance set out by the National Institute for Health and Care Excellence (NICE).

A number of people were prescribed nutritional supplements in order to prevent malnutrition and weight loss. Records for these products were poor and in one case we saw that the supplement had not been given as prescribed since March 2016. On checking the person's care plan, we saw that they were still losing weight. We asked that this was raised as a safeguarding concern with the local authority.

Staff told us that they found the electronic system difficult to use and that arrangements had been made to change pharmacy and go back to the non-electronic system they used previously. Whilst it was it good that staff views had been taken on board, it was of concern that the system the manager intended to go back to is no longer recommended in the current NICE guidelines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's medicines were not being stored or administered in a way that was safe.

Care was not always delivered in a way that ensured people's safety. For example one person's care records indicated that they would be at risk of injury if they had bed rails in place, as they may attempt to climb over them at night and fall. We looked in this person's bedroom and found that bed rails were in place. Staff told us that this person was more settled during the night, however this person's records did not indicated any change in their level of night time need. This placed this person at risk of serious injury. We asked that this person's needs were reviewed immediately.

Another person's records indicated that they needed the stair lift when using the stairs due to poor mobility and being at high risk of falls. There was no risk assessment in place around the person using the stair lift, despite this having been raised in a recent visit by the local authority. Staff also told us that they supported this person with walking down the stairs instead of using the stair lift, to support this person with maintaining their mobility. This was not in line with the care plan and placed this person, and staff at risk of injury. During the inspection, a new lift had been installed which staff assured us they would be using to support this person instead of the stairs.

The care records for another person did not contain details around the use of a night-time sensor in their room to ensure their safety during the night. However staff demonstrated that the sensor needed to be plugged in and positioned in a particular way to ensure that any movement during the night was detected. This meant that the person was at risk of falling during the night because information about how to manage the risk was not available for new staff members, or staff who were not familiar with this person's care needs.

An accurate record of accidents and incidents had not been maintained, which meant that it was not possible for an analysis to be carried out to establish how and why the incident occurred and to help prevent a reoccurrence. For example we found one person's record indicated that they had sustained a bruise to their lower leg which was described as "serious" and "raised almost like a blister that could burst". This person had also sustained a "moderate" bruise to their right hand. This was not recorded in accident

records, and this information had not been included in the tissue viability care plan. Staff told us that this bruising had since healed, however no referral had been made the relevant health professionals to assess whether this required further medical attention. No subsequent monitoring of this injury had been made by staff to ensure it was healing appropriately, and no investigation had been completed into how the injury had been sustained. This meant that there was a risk that the person's injuries could have deteriorated, causing them further harm. There was also the risk that this injury could have occurred again in the future, without the appropriate preventative measures being put in place. We asked that this was raised as a safeguarding concern with the local authority.

Parts of the environment were not secure, and placed people at risk of injury. The main access to the stairs required use of a key fob, and we found this door was kept secure. However access to the stairs could be gained via the downstairs shower room which had two access points, both of which were kept unlocked. This meant that there was a potential risk of people injuring themselves on the stairs. We raised this with the business manager and the deputy manager, who told us that access to the stairs would be secured by installing a fob operated lock.

This was a breach of Regulation 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because action was not always taken to ensure people were protected from the risk of harm, and safeguarding concerns had not been adequately investigated or reported to ensure people's safety was maintained.

Measures were not in place to prevent the risk of infection. The registered provider is required to carry out tests to the water system to ensure that water remains free from harmful bacteria. This had not been done, and no risk assessment had been carried out to determine the frequency around how often these tests needed to be completed. The registered provider informed us that action would be taken to remedy this immediately.

Parts of the environment were dirty and unclean, and there was a malodour throughout the service. There were stains on the chairs and carpets in communal areas, and in one person's room we found yellow splash marks on the skirting board. In one person's en-suite there were scratch marks on the floor and radiator and the lino was peeling away in part. In the dining room there was a patch of mould on the ceiling, and some of the plaster was cracked and flaking away. In the linen cupboard we found that linen was being stored on the floor. This placed people at risk of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because action had not been taken to prevent the risk and spread of infection.

During the inspection we observed that there were enough staff on duty to meet people's needs. The deputy manager told us that they normally had additional staff to support people in the morning and evening as these were the busiest periods, however due to a staff shortage, existing staff were starting and ending their shift an hour earlier and an hour later to ensure these hours were covered. The manager told us that they were currently in the process of recruiting new staff.

We looked at the recruitment records for three members of staff. There were measures in place to ensure that staff were of suitable character, for example staff had been subject to a check by the disclosure and barring service (DBS). A DBS check informs employers of any criminal convictions staff may have, and supports them to make a judgement around their suitability. Staff had also been required to provide two references, one of which was from their most recent employer.

A recent safeguarding issue that had occurred within the service had raised concerns around staff knowledge on reporting and responding promptly to protect people from abuse. Since this incident staff had completed safeguarding training. Staff demonstrated a good understanding of how to report concerns and told us that they would report these straight away to the manager, or to the local authority safeguarding team. This meant that people would be protected from the risk of abuse.

Action had been taken to monitor and maintain equipment and some aspects of the environment. Monthly checks were being completed on hoists, and weekly checks had been completed on the stair lifts and nurse call bells to ensure these were in working order. The electrical system had been checked and signed off in May 2016, and a new lift had been fitted and signed off as ready to use. New boilers had also recently been put in place. This ensured that these aspects of the environment were safe.

Inadequate

Is the service effective?

Our findings

People told us that staff were skilled, and did their job well. One person told us, "Staff are very good". One person's relative also commented, "[My relative's] behavioural needs are managed well by staff". However we found that the service provided by staff was not effective and people were placed at risk of not receiving the care they needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met, and found that they were not.

DoLS applications had been made to the local authority for those people who needed them, which meant that some deprivations of people liberty were lawful. However we found other examples where restrictions on people's liberties were not being managed within the law. For example one person's medication had been administered to them covertly. A mental capacity assessment had not been completed to determine this person's ability to consent to this, and a best interests meeting had not been held with other professionals to determine that this was in the person's best interest. We checked whether the covert medication had been authorised within the DoLS authorisation, and found that this made no reference to the use of covert medicine. This meant that their rights had been infringed.

The registered provider had installed CCTV inside the service, which we were informed was due to a previous break in. There is clear guidance around the use of surveillance within adult social care settings, however we found no evidence that this guidance had been followed. There was no record to indicate that a discussion had taken place around the impact this may have had on people's privacy, or whether other, least restrictive options had been considered, for example placing the CCTV outside. A letter had been sent out to people's relatives informing them that CCTV was being installed, however not all relatives had the legal authority to make decisions on behalf of people who used the service. There had been no attempts to assess people's mental capacity to consent to the use of surveillance, and no attempt to determine whether this would be in their best interests. This meant that people's rights had been infringed. Following the inspection we forwarded the relevant guidance to the registered provider for their consideration.

Staff had not received training in the Mental Capacity Act 2005 and not all of them were aware of their roles and responsibilities in relation to this. We observed examples where staff offered people choice, for instance during meal times staff provided people with different options, and asked before giving their support.

However staff did not have any formal knowledge of their responsibilities under the MCA to prevent them from infringing people's rights. Examples, as detailed above demonstrated a lack of knowledge around the MCA. We raised this with the registered provider who told us that they would source appropriate training for staff.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's rights had not been protected in line with the Mental Capacity Act 2005.

Staff had recently accessed training around safeguarding and first aid and they were registered to receive training in the safe administration of medication following the inspection. However training records showed that key areas such as dementia awareness, infection control, equality and diversity, manual handling and the Mental Capacity Act 2005 had not been completed. The business manager told us that they were in the process of organising manual handling training, and would also organise training in the other areas. There was an induction program in place for new staff, which included a period of shadowing experienced members of staff. However, the induction programme was not up-to-date with objectives outlined by the care certificate, which came into force in 2015. This sets out the minimum standards expected of staff working within the care sector. This meant that staff would not have the necessary skills and knowledge in line with current and good practice which they needed to carry out their role effectively.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not taken action to ensure that staff had the necessary skills and knowledge to carry out their role.

One person had a risk assessment showing that they were at high risk of weight-loss and required supplements to help them maintain their weight. This person had not been given their supplements as prescribed since March 2016. We looked at this person's weight monitoring records and saw that between 29 February 2016 and 10 June 2016 they had lost four and a half kilograms in weight. Records did not indicate whether there had been any recent dietician input, and the deputy manager was unable to confirm this. This meant that this person was at risk of deterioration. We asked that this be raised as a safeguarding concern with the local authority.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because action had not been taken to manage this person's risk of weight-loss.

Menus were on display on the walls which outlined the food options available for the day. These included a photographic menu which helped inform people with memory loss such as those living with dementia and people who have difficulty reading. However we saw that options provided on the photo menu had not been updated and did not show the correct meal options which were available that day. This had the potential to confuse people and undermined the dignity of those people who were not able to understand the written menu.

People's care records contained details around their dietary needs. The chef maintained a record of people with special dietary requirements, for example people with diabetes, or those people who required soft food options. During meal times we saw that staff provided support to those people who needed help with their meals, and offered seconds to people where they wanted them. The food looked well presented, and people commented positively on it. One person commented, "The food here is lovely", whilst another person told us, "The food here is nice. They change things if you don't like it".

Requires Improvement

Is the service caring?

Our findings

People told us that they liked staff and felt that they were caring and respectful. Their comments included, "I like the staff. I think they love me", "The staff are nice" and "The staff are respectful. We all get on together". However, whilst there were aspects of the service that were caring, we identified areas where the care being provided had impacted upon people's safety, wellbeing, rights and liberties. We also identified examples where due consideration had not been given to meeting people's religious needs, or ensuring that they received support with meeting their needs in relation to sensory impairments. We have reported further on these examples further under the safe, effective and responsive domains.

People's personal possessions were not always kept safe or treated with dignity. We found a selection of jewellery being stored in the medicines safe, along with some money. We passed these to the deputy manager for appropriate storage. The business manager told us that there was a current investigation into the loss of money. We reviewed the registered provider's policy on handling personal property, which did not contain details around the safe storage of personal items such as jewellery. The business manager told us that the normal process would be that these items would be kept in the safe located in the office, to which access Is limited. These items were subsequently put into appropriate storage.

Do not attempt resuscitation (DNACPR) orders were in place for people who did not want to be resuscitated in the event of their death. These were visible at the front of care records so that they could be easily accessed in the event of an emergency. However people's care records did not always contain details about their future wishes, or whether they had declined to discuss this. This meant that staff would not always have access to the information they needed to support people in the way they wanted at the end of their lives. We have reported further on this under the 'responsive' domain.

People's relatives told us that they were made to feel welcome when they visited, and that they were offered refreshments. Their comments included, "We're made to feel welcome" and "Staff are always welcoming". We observed examples where staff spoke in a friendly manner to people who used the service and their relatives. One person's relative told us, "They really love my mum here. They genuinely care for my mum". This showed that positive relationships had been developed between staff, relatives and people who used the service.

Staff showed concern for people's wellbeing, and acted promptly to offer support where it was needed. We observed staff prioritising one person who was presenting as very sleepy during lunch to ensure that they had some food, before supporting them to go and have a lie down. One person's relative gave us an example where they had seen staff acting quickly to disperse tension between two people, commenting "The staff really managed it well".

Staff involved people on a day to day basis in making decisions about their care. We saw examples where staff asked people whether they wanted their support, for example with going to the toilet, or whether they wanted to wear a napkin during lunch time. Staff told us that they would take the time to explain things to people. At the time of the inspection there was no one receiving support from an advocate, and there was

no information available for people around how to access support from the local advocacy services. However, the deputy manager demonstrated an understanding around when supporting people to access local advocacy services should it be required. An advocate acts as an independent source of support to ensure that people's voices are heard during decision making processes.

People's privacy and confidentiality was respected. Staff ensured that people's doors were closed when attending to their personal care needs, and they were discreet when supporting people from communal areas to access the toilet. One person commented, "Yes staff are respectful".

Inadequate

Is the service responsive?

Our findings

People told us that staff were responsive to their needs. One person commented, "They're there if you need them". People's relatives also told us that they felt the right level of care and support was provided to people. Their comments included, "It really works well here for [name]" and "[My relative] is very happy here. Staff are very good, and seem to be very professional". However we found that the service provided was not always responsive.

Care records did not always contain details around people's religious or cultural needs. For example although some people's records contained information around their faith, we found that one person's care records stated their religion, however no action had been taken to ascertain whether they wanted or required support with celebrating religious festivals. An activities section within the care records had been recently reviewed, however it was recorded as 'under evaluation' despite this person having lived in the service for seven months. Care records did not outline whether this person adhered to any dietary requirements prescribed by their religion, and stated 'N/A' in the section entitled 'meeting religious needs'. We spoke with staff who did not know whether this person practiced their religion, or how they could meet their needs in respect of this. This undermined this person's dignity, and reflected poorly on the regard the registered provider had for their religious and spiritual needs.
The support provided to people did not always ensure their communication needs were met. For example, one person's care record stated that they were deaf, and that staff should use flash cards and write things down when communicating with this person to enable them to understand. One member of staff was familiar with the information outlined in this person's care records, however other staff were not. We did not observe either of these methods being used when staff communicated with this person. We also observed that the photographic menu had not been updated to show what options were available at meal times. This meant that staff did not respond appropriately to the needs of people who were unable to read the written menu.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because action was not always taken to ensure people's needs were met with respect to their religion or disabilities.

Care records did not always contain accurate, up-to-date or personalised information. For example, the 'interests' and preferred 'routine' and 'dislikes' sections of one person's care record had been left blank. Another person's care records indicated that they were willing to discuss their 'last wishes', however there was no further detail around what these wishes may be. In another example, one person's record stated that they had written an advanced statement, however there was no indication around the wishes they had expressed. This meant that accurate and up-to-date information was not available for staff, and placed people at risk of receiving care that did not meet their needs. We raised the inconsistencies within the care records with the deputy manager and business manager who told us that these would be reviewed.

Care records had been reviewed, however inconsistencies within these showed that a thorough review had not been undertaken. Some reviews had been copied and pasted from previous reviews. This is considered

poor practice and did not demonstrate the outcome of the most current review or any changes the person may have had since the last review. Other reviews had been dated with no explanation to outline whether or not there had been any changes to people's needs. In some examples, the reviews indicated that no changes had been made to people's care needs since 2014. This meant that systems were not in place to ensure that information was accurate and up-to-date.

This was a breach of Regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems were not in place to ensure that records were up-to-date, accurate and personalised.

People's relatives told us that there was no system of gathering feedback in place, however they said they would feel comfortable approaching the manager, or another member of the management team with any comments or concerns. People were aware of the complaints process and told us that they would make a complaint if they felt they needed to.

People and their relatives told us that there were activities available, such quizzes, games and gardening. During the inspection staff were playing board games with people, and there was also a quiz. One person commented, "There are enough activities. There's plenty to do". There was a television lounge available for people, however this room only had six chairs and therefore would not have been able to accommodate all the people living in the service. The majority of people spent time in the dining room, which also contained a lounge area. There was no television in this room, and whilst there was a radio, during the two days of the inspection it was not used. We asked the business manager and deputy manager whether it had been people's choice not to have a television in this area, or to have the radio turned off. We were informed that people had not been consulted, however this would be something that would be done.
The service had links with the local community. The prince's trust had recently carried out some voluntary work in the garden, which looked bright and well-tended as a result. During the inspection a group of children who had volunteered also came to spend time with people who used the service. This helped to stimulate people and promoted their involvement in the local community.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place within the service, and the previous registered manager had left in January 2016. A new manager was in post at the time of the inspection and was in the process of applying to the CQC to become the registered manager, however they were not present during the inspection. Following the inspection we were informed that the manager had left work at the service. A deputy manager and business manager were in post to support with running the service whilst a new manager was being recruited.

People we spoke with could not always remember who the manager was, however told us that staff were helpful if they had any issues. One person commented, "They are there if you need them". People's relatives had mixed views around how the service was run. Their comments included, "The staff and manager are always visible", "The manager is ok. They're approachable" and "The manager doesn't seem to have a strong presence here. They say they will do things and never do. For example, no family meetings have been organised as promised and the lift was supposed to be fixed before Christmas. It has only just been done in July".

There were no systems in place to monitor the quality of the service, or to ensure the effective management of risk. Audits had not been completed in areas such as care records, people's weights, the environment, infection control and medication. There was a quarterly health and safety audit, however this had last been completed on the 13 March 2015. As a result of this, failings within the service had not been identified and acted upon by the manager, or the registered provider which impacted upon the quality and safety of the service.

A medicines management review had been carried out by St Helens clinical commissioning group (CCG) in April 2016 and identified numerous concerns and shortfalls in the way medicines were managed. The CCG issued the manager with an action plan clearly showing what improvements were needed to in relation to the management of medicines, to ensure people's safety. We found little evidence to show that that the action plan had been implemented and we evidenced continuous concerns similar to those highlighted almost three months earlier by the CCG. Despite the findings of the CCG, the manager and registered provider failed to carry out a full medication audit. The registered provider's policy stated that medication reviews should be carried out 'regularly'. This lack of checks on medication had resulted in discrepancies being missed, and demonstrated poor leadership within the service.

The registered provider did not have any quality monitoring processes in place to ensure that the standards of the service being delivered were acceptable. The registered provider had recently installed a new lift after the previous one had broken, however it had taken around twelve months for this to be resolved. Improvements were needed throughout the environment to ensure it was clean, and minimise the risk of infection. This meant that the registered provider had been ineffective in maintaining and ensuring care was provided in line with the required standards.

There were no processes in place for gathering feedback from people or their relatives, for example through

the use of questionnaires or relatives and residents meetings. This meant that people and their relatives did not have the opportunity to put forward their views and opinions about the service or participate in development of it.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems were not in place to monitor the quality of the service, or mitigate and manage risks to people.

The registered provider is required by law to notify the CQC of certain incidents and events that have occurred within the service. Whilst we had been notified of some things, we found one example where someone was recorded to have sustained 'serious' bruising to their leg and a moderate bruise to their hand, which we had not been informed of. In another example a safeguarding notification had been sent through to us 22 days after the incident had occurred, which meant that we had not been informed in a timely manner. It also came to light during the inspection that some money had been misplaced. This was found by a member of the inspection team during the inspection, however our records indicated that we had not been notified of this incident. The registered provider had also failed to notify us that the previous registered manager had left in January 2016 as required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the registered provider did not always notify us of incidents as required.

The registered provider is required to demonstrate that they have appropriate knowledge of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and understand the consequences of failing to take action on set requirements. However we found a number of breaches of the Regulations which showed that the registered provider did not have a sufficient understanding of their roles and responsibilities in relation to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was a breach of Regulation 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not demonstrate sufficient knowledge around their roles and responsibilities.

Staff were provided with relevant information around the running of the service, and what was expected of them. Team meetings were held, during which updates were provided to staff, and staff had the opportunity to give feedback. Records indicated that issues covered during team meetings included staff sickness, safeguarding and updates on people who used the service. There were policies and procedures in place, which were up-to-date and staff were aware of where these were located. There was a whistleblowing policy in place for staff and they were aware of what whistleblowing was, and told us that they would raise any concerns if they had any. Whistleblowing is where staff can raise concerns inside or outside the organisation without fear of reprisals.