Hill Care 1 Limited

Lever Edge Care Home

Inspection report

Lever Edge Lane
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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 took place on 4 September 2018 and was unannounced. The last inspection was carried out in August 2016 when the service was rated as good.

Lever Edge (Lever Edge) Care Home is a residential care home located in the Great Lever area of Bolton. Lever Edge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lever Edge, Bolton is a purpose built two storey care home. The home is close to Bolton town centre and close to a bus route and the motorway network. The home provides residential and personal care for 81 people. On the day of the inspection there were 76 people living at the home.
There was a registered manager in place. A registered manager is a person who had registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, medicines, infection control person-centred care good governance.

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.

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.

We found a definite distinction between the ground and first floor with regard to infection prevention and control. The malodour on the first floor was unacceptable.

We found that not all medicines were managed safely and that improvements must be made to ensure people's health was not placed at risk of harm.

Staff recruitment was satisfactory. Staffing levels needed reviewing to ensure that there were enough staff on duty at all times to ensure people's need could be met.

There was an appropriate, up to date safeguarding policy and procedure in place. Safeguarding issues had been suitably logged with responses and actions.

The service was working with the legal requirements of the Mental Health Act 200 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Care files included a range of information relating to health and well-being. However, some specific information and monitoring had not been completed.

There was a staff induction and staff training was ongoing. Staff confirmed they received supervision meetings with senior staff.

People we spoke with had mixed views about the care provided at the home. Some were satisfied with the care they received.

On the day of the inspection there was a lack of activities or stimulation for people living at the home. There was little staff interaction with people. At times, some staff were overheard by visitors speaking in a derogatory manner to people in their care, and to each other. Some people did not look well-presented and well groomed.

Health and safety certificates were in place. The overall maintenance records for the environment were up to date.

People we spoke with were happy with the quality of the food. However the presentation of the pureed diet required attention.

There was an up to date complaints procedure. Details of how to make a complaint were displayed within the home.

Staff had access to a range of policies and procedures to refer to as required.

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.

We found that not all medicines were not managed safety and that improvements must be made to ensure people's health is not placed at risk of harm.

There was an appropriate safeguarding policy in place and staff had undertaken safeguarding training.

The home was not clean and fresh and malodours were extremely noticeable.

Is the service effective?

Requires Improvement

The service was not effective.

Care plans were not always being adhered to in relation to diet and personal care.

We were told the food was plentiful, tasty and varied. However, the presentation of the pureed diet needed to be improved.

The home presents itself as a specialist dementia service. However, staff had only undertaken basic training in dementia care and the premises provided little which was specifically designed for people living with a dementia type condition.

Is the service caring?

Inadequate

The service was not caring.

We received mixed views about the care and the manner of some of the staff.

People's personal care and oral hygiene was not always attended to.

People were not assisted to the bathroom when required.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a lack of activities and stimulation. People had not been assisted to continue with their interest's hobbies.

Systems were in place for reporting and dealing with complaints. However, we were told that verbal concerns raised were not always addressed.

Is the service well-led?

Inadequate

The service was not well led.

Audits were in place. However, it was evident that some of these had not been thoroughly completed. Staff spoken with felt supported by the registered manager.

The registered manager had failed to ensure that people were living in a clean environment and were well presented.

Lever Edge 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.

The inspection took place on 4 September 2018 and was unannounced. The inspection was carried out by two adult social care inspectors, a CQC (pharmacist) medicines inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who use this time of care service. The experts by experience had experience in caring for the elderly and people living with dementia.

Prior to the inspection we looked at information we held on the service. This included the last inspection report and statutory notifications we had received from the service. We also contacted the commissioning team at Bolton council, Bolton safeguarding team and Healthwatch Bolton. Healthwatch is an independent consumer champion for health and social care. This helped us to gain a balanced view of what people were experiencing when accessing the service. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make.

During the inspection we spoke with the area manager, the registered manager and five members of care staff. We also spoke with ten relatives, nine people who used the service and a visiting healthcare professional. We observed the lunch time meal on both floors.

We looked at six care records, six staff personnel files, medication records for 24 people, training records, staff supervisions, meeting minutes and audits.

Inadequate

Is the service safe?

Our findings

On arrival at the home we found that the premises were safely secured and people could only be allowed in and out by the staff. This was to ensure the safety of people who used the service.
Visitors to the home were asked to sign the visitors' book so that staff knew who was in the home in the event of an emergency.

People we spoke with told us they felt safe living at the home. People and their families told us they felt the home was safe, tidy and clean. One relative told us, "I have been struggling to find the right place for [relative] until I came here, I just know [relative] is safe". One person who used the service told us, "For me, the place is neat and tidy and that's very important for me living here". Another person told us, "It's not the same as it used to be, things have gone downhill".

We found a definite distinction between the two floors at the home. On the ground floor we found that infection prevention and control was satisfactory. On the first floor (Turton unit) there were 28 people who were living with dementia and most found it difficult to communicate and express their needs and preferences.

Prior to the inspection we were informed by the local authority safeguarding team that they had received a concern from an advocate about the malodour on the first floor.

On entering the Turton unit the stench of urine was overpowering. We found that one of the bathroom floors was wet around the toilet base and this appeared to be urine. We asked a member of staff to clean this up in case someone slipped. We looked in several bedrooms and found that odour control was extremely poor. Some duvets had no quilt covers on and were very stained with dried brown patches. In another room the bed had been made by staff, the quilt cover was stained with dried urine and on removing the quilt we found that the bottom sheet was dirty with faeces. We also found that bedrooms with laminated flooring were sticky to walk on. In two bedrooms wet shave razors had been left out on the sides of the sinks which could have been potentially dangerous as people move freely around the unit. We asked the regional manager and the registered manager to accompany us in to these rooms to show them our findings. The registered manager informed us that they completed a daily walk round the home. However, they had not identified the issues found by the inspection team.

The Bolton Community Infection Prevention and Control Team inspected Lever Edge on 17 July 2018. The home received an overall score of 81% with an amber rating. The home will be re-inspected by the team within six to nine months. There was an infection control policy in place. However this was not being adhered to.

During this inspection a medicines inspector, looked at records about medicines. This included the stocks, the storage and the administration of medicines to make sure they were managed safely. We found that not all medicines were managed safely and that improvements must be made to ensure people's health was not placed at risk of harm. We looked at medicines for 24 people living in the home and spoke with four

senior carers who had responsibility for managing and administering medicines.

We found the records about medicines were not accurate. There were gaps, missing signatures, on the Medicines Administration Records sheets (MARs) for 12 people. Five of those people had not been given all their medicines as prescribed. For eight of those people it was not possible to tell if they had been given all their medicines. We compared the stock in the home with the MARs for six people and found that signatures did not tally with the stock count. For two other people the MARs showed that not all medicines could be accounted for because there was less medicine in stock than was expected according to the records.

The staff administering medicines used the code "W" indicating the medicine had been withheld but did not write any explanation on the MARs as to why the medicine had not been given as prescribed.

Some people were prescribed patches to relieve the symptoms of Parkinson's Disease or pain. Patch rotation charts in were place to make sure the patches were not applied to the same area of the body too frequently to avoid skin irritation. However, we saw these charts were not always completed properly and that the manufacturers' directions had not been followed about the frequency of rotating the patches. It is important that records about medicines are accurate to ensure people are given all their medicines safely as prescribed.

We saw that medicines and creams were not always given and applied as prescribed. One person was prescribed some antibiotic eyedrops to be used every two hours for the first two days and then to be used four times daily. The MARs showed that the drops were only used three times on the first day and twice on the second day and over the next seven days were only given four times daily on two days. If antibiotics are not given as prescribed the infection may return and resistance may be developed to the antibiotics. The same person was prescribed Warfarin (blood thinning) tablets and the records showed they were not given the correct dose on two days in a 14-day period. If these tablets are not given correctly the person is placed at increased risk of a blood clot. Another person was prescribed pain relief to be taken regularly four times daily after discharge from hospital. However their MARs showed they were not given the painkillers regularly placing them at risk of experiencing unnecessary pain. Two people were prescribed barrier creams to be used after washing and periods of incontinence. However their cream application charts showed that they did not have their barrier cream applied on two days placing them at risk of sore skin.

Some medicines need to be given 30 to 60 minutes before food. We saw that arrangements had been made to give these medicines at the right times. However we saw there were inconsistencies and not all these medicines were given safely.

There were protocols in place for medicines which were prescribed to be given "when required" or with a choice of dose. However, some of these protocols must have more personalised information added to them so that staff have clear guidance as to how each person would express their need for these medicines.

One person needed their medicines given to them covertly by hiding their medicines in food and drink. There was no information from a pharmacist recorded indicating the safest way to hide each of their medicines. There was also no recorded practical guidance, with the MARs, to guide staff as to how that person took each medicine.

When medicines containing Paracetamol are administered there must be a minimum of four hours between doses. We looked at the records for the administration of Paracetamol for one person and saw staff did not record the time of administration which meant that doses may be given too close together. Another person was prescribed Co-Codamol which contains Paracetamol and staff had recorded the time of administration

on the back of the MARs. We found that on one occasion doses had been given too close together placing that person's health at risk of harm.

The storage of medicines was inconsistent throughout the home. On one unit there was an air-conditioning unit in the medicines room ensuring all medicines were kept below the manufacturers' recommended temperature of 25 Celsius . On one unit the senior carer confirmed that temperatures of the room and fridge had not been recorded since May 2018 and on the other unit there were no recorded room temperatures available for August 2018. The records about the fridge temperature for the first three days of September 2018 showed that some medicines which needed to be stored in the fridge at temperatures between 2-8 Celsius had been stored between 2- 26 Celsius. We also saw that some antibiotic eye drops that must be stored in the fridge had been kept at room temperature. If medicines are not stored at the correct temperatures they may not work properly.

Creams were stored in people's rooms without a risk assessment being in place to show it was safe to do so. Some people's creams were kept out of reach on the top self of people's wardrobes. However we saw one person had a tub of cream next to their toothbrush. Creams are not safe to be ingested orally and may be accidentally mistaken for toothpaste if they are stored in this way. We also saw people had creams in their rooms that were not currently prescribed for them or did not have their currently prescribed creams in their rooms. If people do not have the creams they are prescribed available for them then their skin integrity may suffer. According to NICE guidelines waste medicines must be locked away safely. We saw that waste medicines were not locked away and there were no cupboards to lock them in.

One person was prescribed a thickener to be added to their fluids to prevent them from choking and to minimise the risk of them aspirating fluids and getting a chest infection or pneumonia. We saw there was clear guidance from the Speech and Language team as to how to thicken their fluids and that they must be given a pureed diet. The records about the use of thickener were inconsistent and did not always show that thickener had been used or that the fluids had been made to the correct consistency. We saw that the food and drink records showed they had been given soup without it being thickened and had been given two pieces of bread and biscuits without them being pureed. On another occasion they were given ice cream which was not thickened. This placed their health at significant risk of harm.

We found this to be a breach of Regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staffing levels and spoke with the staff on duty. We found that on Rivington (residential unit) there were 25 people living on the unit. Staff told us that eight people required two members of staff to assist them. There was a senior carer who administered medication and three carers in the morning. The number of carers dropped to two in the afternoon. This meant that at times there may be no carers free to oversee the lounges as they could be in rooms assisting people. We discussed this with the regional manager and the registered manager, explaining that people's needs did not change in the afternoon. On Smithills unit there were 21 people living with dementia some of whom also had complex needs. Nine of those people required two staff to assist them. Staffing levels comprised of a unit manager or a senior carer and three care staff. On Turton unit there were 28 people living with dementia of which six of those people needed two staff to assist them. Staff comprised of senior carer and four care staff. Each unit was staffed by two carers at night and one senior member of staff covered the whole of the home.

Information provided by the provider on the PIR stated that the home worked to a ratio of 6.5 people to each member of staff. The home had a dependency tool to assess the care needs of people and the number of staff required to provide safe and effective care. The dependency tool seen in the care files we looked at

had been reviewed and were up to date. We asked the regional manager and the registered manager to review the dependency needs of people and to ensure the home is staffed accordingly.

Staff spoken with told us that at times it was difficult to meet people's needs. One relative told us, "The way I look at it is that I am happy that at least there is someone in here day and night, they may not have enough time to sit down an engage the residents in stimulating activities, but then again that's another matter isn't it". One person who used the service told us, "There is a lack of staffing at certain times, especially when staff are pushed with lots to do". Another relative who visited the home regularly told us that they had witnessed people on Turton unit being left in the lounge area for 45 minutes to an hour without any staff presence. They had also witnessed altercations between people living at the home and had found it difficult to find staff to assist. Another visitor told us, "Lately lots of fights have broken out between people (Turton unit). [Name] is frightened, but can't walk away from it. I have gone to look for staff when people are fighting, even if you can find them the don't come straight away". We checked the notifications sent to us from the home and no records were found of any altercations in 2018.

We asked the regional manager to ensure that staff wore appropriate foot wear as a member of staff was wearing shoes with no back in. This could be dangerous for staff and people who used the service when using moving and handling equipment.

Staff recruitment was satisfactory. We looked at six staff personnel files and found the files included an application form, references, proof of identify, terms and conditions and Disclosure and Barring (DBS) checks. DBS checks help ensure staff are suitable to work with vulnerable people.

The home had personal emergency evacuation procedures (PEEPS) in place, this were updated on a regular basis and where kept in a central place alongside other equipment and a grab bag. A PEEP informs the fire service of where people's rooms are and what equipment will be needed to assist people safely out of the home in the event of an emergency. There was a fire risk assessment in place and fire alarms were tested regularly and records were kept up to date.

We looked at the health and safety records. Certificates were up to date for gas and electrical testing and portable appliance testing (PAT). There had been a thorough examination of the passenger lift and moving and handling equipment had been tested to ensure it was safe to use.

There were up to date records of water checks and room call systems. Window restrictors were in place to help keep people safe and secure.

Accidents and incidents were recorded and monitored for each person. There was an overview of accidents and incidents which looked for any trends and patterns and action required to avoid reoccurrences. However, one visitor told us the communication passed to them from the home when an incident occurred was conflicting with regard to how and where the incident had happened that resulted in a skin tear.

There was an appropriate, up to date safeguarding policy and procedure in place. Safeguarding issues had been suitably logged with responses and actions. Staff had undertaken training and demonstrated a good understanding of the issues and how to report any concerns.

Requires Improvement

Is the service effective?

Our findings

On the ground floor in the Rivington unit when speaking with people living at the home most could not recall being involved in the care planning process. However, family members confirmed being involved in care planning and reviews. One person told us "I am not aware if I signed for the way I am cared for, all I know is that the staff are spot on". Another said, "The carers do ask me how I feel and if I am OK but I don't remember if I signed my file". A relative told us, "I am involved with my [relatives] care reviews". Another person said, "I act on behalf of my [relative] because I know them better than anyone and because of capacity issues, the manager and staff recognise my input". A relative on the Turton unit told us that the registered manager had discussed with them on many occasions about their relative's care, mobility and health generally. They felt they could make suggestions, represent any issues the family felt important and if necessary escalate matters. They felt confident the home had been receptive and felt included in all aspects of their relative's care. However, we were told that this was not always the case and things that had been discussed with management and staff were not always acted upon.

The care files we looked at included a range of information relating to health and well-being and included an assessment of individual needs. The assessments included skin integrity, falls, elimination, eating and drinking and sleep and rest. However, we found that care plans were not always being adhered to in relation to diet. For example, dietary needs were not always followed. We saw in one care file that concerns had been raised regarding this person's weight. A referral had been made to the dietician in June 2018 and in August 2018 this person had still not been seen by the dietician. This had not been followed up by the registered manager. Another person told us they were also concerned about their relative's weight loss. we raised this during our feedback to he registered manager.

Visitors spoken with told at times their relatives personal care needs were not met. For example, finger nails were often dirty and people being left being left in dirty clothes.

The home had received a four-star food hygiene rating which was good. People we spoke with were relatively happy with the food served. We were told the food was plentiful, tasty and varied. However, two people told us the food was never hot enough. The menus were planned on a four-weekly cycle. We observed the lunch time meal and found people were offered a choice of meal. We saw that the dining tables were nicely set and people were offered clothes protectors to protect their clothes from spillages. Staff were seen assisting people with their meal in a discreet and sensitive manner. However, for people who stayed in their rooms for meals, the level of monitoring and prompting at times was problematic due to staffing levels.

We saw that some people required a pureed diet. Attention was required to way the pureed diet was served to people. One person described the pureed food as 'slop' and when this person asked a member of staff what is was they replied, "I don't know". On the day of the inspection we saw photographic evidence that had been taken by a visitor of how the food had been served, it was difficult to say what the meal consisted of. People who require a pureed diet should be offered food that is blended in separate portions so that people experience taste, colour and textures.

We saw for some people food and fluid charts were being used. This monitored people's food and fluids daily where concerns had been identified. We found for one person that the record showed they were asleep and that no fluid had been taken on the 28 August from 13:00 until 10:00 on the 29 August 2018. This meant that this person could have been at risk of severe dehydration due to charts showing 21 hours without fluids. The notes in the care plan clearly state, ' Staff are to push [Name] fluids to keep [name] hydrated and reduce the risk of UTIs (urinary tract infections)'.

We saw that people were served drinks during the day. One visitor commented that there were no occasional tables for people to put their drinks on and people struggled holding hot drinks.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack 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 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 interest and legally authorises under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive people of their liberty were being met. Staff had been given training in MCA and DoLS and those we spoke with demonstrated an understanding to the principles of the MCA. They were aware of who was subject to a DoLS and what this meant in practice.

Five of the care files we looked at contained DoLS authorisations and there was clear information as to the date the review and renewal was due. We saw that consent to issues for example the use of bedrails, taking of photographs and information sharing had been signed by the person using the service or their representative.

Staff we spoke with told us they had undertaken an induction when they started their employment and they were required to complete the Care Certificate. The certificate is a set of standards that health and social care workers are expected to adhere to in their daily work and includes all essential training.

We were provided with a copy of the staff training record. We saw that staff had completed training in safer people handling, fire safety, infection control, MCA and DoLS, health and safety, safeguarding and equality and diversity, medication and dementia awareness. Refresher training was undertaken as required.

The home can provide care for 52 people living with several dementia related conditions. The home refers to itself as a specialist dementia service. However, staff had only undertaken basic training in dementia care. More detailed in-depth training should be provided to staff to enable them to carry out their role more effectively. The home was not working to any recognised dementia model.

Staff supervision meetings and annual appraisals had taken place. Supervision meetings provides staff with the opportunity to discuss their work role, issues of concerns and any further training and development they may wish to undertake.

We looked around the Rivington and Smithills units. These were located on the ground floor. These were found to be well presented, bright and airy. These units had access to the garden areas. Most rooms had been personalised with people's belongings brought with them from home. People spoken with told us they

were comfortable and thought their rooms were nice and well furnished. There were comfortable lounges and dining areas which people could access and meet with relatives. The space on the corridors allowed people to move freely around the home with the use of walking aids or wheelchairs.

We noted that two clocks on Turton unit were either broken or without a battery in the dining area and small lounge. This could be very confusing to people living with dementia. People were observed sitting all day in the lounge with nothing to stimulate or occupy them. Throughout the home there was a lack of dementia aids such as coloured crockery to assist people to recognise the food on their plate, pictorial menus, dates and time aids/clocks. Our concerns regarding Turton unit are documented in the safe domain of this report.

We found this to be a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager to tell us how, in the event of a person being transferred to hospital, information about the person was passed to the receiving service. We were told about the 'Red Bag' that was sent with the person. The Red Bag should contain the person's care and medication records, their medication and their personal items.

The Red Bag Initiative was rolled out to all nursing and care homes across Bolton NHS Foundation Trust. We were told the aim of the initiative was to improve the experience of people when they were admitted to hospital and reduce their length of stay by speeding up the discharge process and improving communication between hospitals and nursing homes.

Inadequate

Is the service caring?

Our findings

We received mixed views about the care provided and the manner of some of the staff. People who used the service who were able to express their views and opinions told us that the staff were caring and compassionate. One person said, "The care is very good". Another person said, "When you are upset, staff do realise it and they are very supportive". Some relatives were also complimentary about the staff. One commented, "They are angels, compared to what they have to put up with". Another relative said, "Everyone is doing a great job, they just know the right way to do it". We did see some kind, interactions between people living at the home and staff on both floors.

In contrast one visitor told us that when a person asked to go the toilet they were told by a member of staff, "She's got a pad on". This was an inappropriate comment and compromised this person's dignity. People should have access to toileting facilities and staff to accompany them as required. We saw that some people looked unkempt, some ladies' hair was unbrushed and greasy. We found two people with extremely dirty finger nails. One relative told us they didn't feel confident to mention this to staff and had done their relative's nails discreetly because they felt embarrassed.

On the day of the inspection we saw photographic evidence of when a visitor arrived late afternoon to see a person who used the service had been left in clothing that was covered in dried food. Staff had failed to assist this person with a change of clothing. On another occasion this person was seen in pyjamas in the afternoon and when staff were asked about this they said this person had a skirt on yesterday. We were told this was incorrect information as this person did not own any skirts. We were informed by a visitor that a member of staff made a very derogatory comment, including swearing at a person living with dementia. The visitor who overheard this comment spoke with the member of staff, who said that they were; 'stressed out'. Although the registered manager had been made aware of this and had carried out a disciplinary meeting resulting in disciplinary action being taken. . There was no further action taken with regard to further training for this person to ensure any reoccurrence of this type of poor practice. The registered manager had not referred this to the local authority safeguarding team as was the company's procedure.

We looked at how people were assisted with oral hygiene. In the care plans we looked at there was an assessment on oral hygiene. However, we found in some of the bedrooms we looked in that there were no denture cleaning products or toothpaste and toothbrushes. We were told by a visitor that their friend's dentures had gone missing in December 2017. The visitor had contacted the community dentist and this had been discussed with the registered manager. However no follow up or appointment had been made for this person. This person was on a pureed diet and the visitor told us that when they asked a member of staff about why this person had been given an ordinary meal, and the fact they had no teeth the member of staff replied, "You will be surprised what they can eat without teeth".

Two visitors told us that clothes went missing from the laundry despite them being labelled. They told us they were constantly having to replace clothes.

We were also informed by two family members that when they went to visit the home with a view to placing

their relative at the home they were shown a very nicely presented room on the ground floor. They thought this would be the room offered to their relative. On accepting a place both people were placed, possibly inappropriately on the Turton unit which cared for people living with dementia.

We were aware that some people had advocates that acted on the person's behalf. We have received information via the local authority safeguarding team that an advocate had contacted them regarding the poor quality of care. Comments were also made about staff being highly inappropriate with each other and verbally abusing each other in front of people living at the home. The advocate had tried to speak with staff about these issues and said the registered manager was also aware of their concerns. The safeguarding team are dealing with these concerns. The registered manager had failed to identify and act on the areas of poor care.

We found this to be a breach of Regulation 10 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a service user guide available to people and their families. However this was not in an easy read format. Information about the service and facilities offered is detailed on the homes website.

Requires Improvement

Is the service responsive?

Our findings

People's care plans showed that an assessment of their needs had been undertaken before admission to the home. People's relatives confirmed they had been involved in this initial assessment and had been able to give their opinion on how care and support was to be provided. Following this assessment, care plans were developed detailing the care, treatment and support required. The care plans contained detailed information, but the information was not always followed. Most of the people who were able to talk to us said they had not continued with their previous interest or hobbies since coming to live at the home. One person told us, "I like gardening but we don't do it very often".

As part of our inspection we observed how people spent their day. We were informed that the home was currently without an activities coordinator. The registered manager told us they were in the process of recruiting a person to the position. There was no plan of activities available. There should be sufficient numbers of staff deployed to ensure that people living at the home are able to participate in a range of meaningful activities.

On the day of the inspection there was little evidence of any stimulation or meaningful activity, either individually or in a group setting other than on the ground floor, where one member of staff was seen doing some armchair activities on the ground floor. Late afternoon on the Turton unit a member of staff put some music on and gave people some musical instruments. This appeared more for the inspectors' benefit rather than the people living at the home. Another member of staff who was also sat in the room looked totally disinterested in the activity and did not interact with people.

One person told us, "We sometimes have singers coming in". A relative told us, "The activities have dwindled, people need some stimulation every day". Another person said, "I just think there's nothing for people to do, some could do with being taken out". One person who chose to stay in their room told us that someone had been in and seen to their hair and nails.

In three of the care files we looked at the social history for people had not been completed. This information informs staff about important information and events that had taken place in people's life's. For example, school days, their wedding day, employment and children. This information helps staff get to know the people they are caring for and can generate topics of conservation.

We found this to be a breach of Regulation 9 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider was not meeting the requirements of the Accessible Information Standard (IAS).They were not identifying, recording and sharing the information and communication needs of people who used the service with carers, staff and relatives, where those needs related to disability, impairment or sensory loss. For example some people could not easily read written information such as menus and care plans and pictures or symbols could help people understand the contents and make decisions.

We asked staff about caring for people who were ill and nearing the end of their life. We saw in some of the care plans we looked at that some people had discussed their wishes and others had preferred not to. The home would be supported by GPs and the community nurses.

Throughout the day we saw that some staff attended promptly and efficiently when people required assistance. Not all staff responded in the same manner and some appeared apathetic when responding to people's needs.

There was a complaints policy and procedure in place. We saw that some complaints had been logged, responded to and lessons learned were recorded. We saw some thank you cards sent by relatives to the home. Comments included "We want to say how grateful we are the care and consideration shown to [name]". Another said "Many thanks for all your care to [name].

Inadequate

Is the service well-led?

Our findings

There was a registered manager in place at the home. There was also a deputy manager and senior staff to support the registered manager. The regional manager attended the home regularly to offer their support to the registered manager.

Most people we spoke with said the registered manager was approachable. One relative told us, "I can't fault the management". Another person said, "You can tell the manager things, but it doesn't always get dealt with". One staff member told us they enjoyed working at the home and had confidence in the registered manager.

We saw evidence of staff supervisions and staff meetings were held. Each morning there was an 11am meeting with the registered manager and the unit managers to discuss any issues or concerns raised. We saw that the unit managers held meetings with senior carers. The last meeting was held on 16 June 2018, this covered care plans and medication. Both of which we identified as areas that still needed to be addressed.

The regional manager and the registered manager had failed to identify the problems we found during the inspection relating to the Turton unit. Both were surprised when we discussed the malodour, the stained bedding, lack of oral hygiene and the lack of toiletries. Both were unaware that there were no occasional tables for people to put hot drinks on and that there were not enough chairs for visitors to sit on resulting in them having to sit on the floor.

We saw minutes of the last resident/relative meeting on 25 January 2018. This was poorly attended. The home had a residents' representative at the meeting. Areas for discussion included activities, food, laundry, suggestions regarding the environment and personal possessions as some had gone missing. At this inspection we found that some actions from the meeting had not been addressed, for or example activities.

There was a customer survey carried out in July 2018, the results were found to be positive. Despite our findings at this inspection. Ten professional visitors had completed a survey which indicated that the majority of them would recommend Lever Edge to people who were looking at moving into a residential care setting.

We found that although a range of audits and checks had been completed by the manager, these had not highlighted certain issues and actions taken. For example, the lack of toiletries, the clear distinction between the two floors, the malodour on the Turton unit, staffing levels and people's dependency levels, the pureed food, personal grooming and care of people who used the service.

We found the quality assurance systems, leadership and monitoring of this service to be ineffective.

We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) regulation 2014.

The service worked in partnership with other agencies for example the local council, safeguarding teams , community nurses and the mental health team. However, we did find that at times some referrals had not been followed up. For example, with the community dentist, dietician and the Speech and Language Therapy team (SALT).

The registered manager told us they now had the Tele meds system in place at the home. This is a system where in the event of person becoming unwell at the home or the staff require guidance on a person's wellbeing they can speak with a nurse or GP who can prescribe medication or advise whether the person needs to go to hospital.

The registered manager had sent to the CQC notifications of deaths, accidents and incidents as required. However there are no notifications around falls or any altercations between people living at the home which we were told about during our inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were given in a safely as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective systems and processes were in place.