

SBS-Services Limited

Shandon House

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

Shandon House is a care home providing personal care. It can accommodate 20 older people. The home is owned by SBS Care Homes Ltd.

This was an unannounced inspection which took place over two days on 8 & 12 October 2015.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the service was not always safe. There were some good monitoring / checking systems in place to ensure the home was maintained safely but we found that people had unnecessarily been exposed to a risk because some environmental hazards had not been effectively monitored. These were with respect to monitoring of infection control and fire safety in the home.

Medicines were administered safely. Medication administration records [MARs] were completed in line with the home's policies and good practice guidance. We recommended some review of the medication policy and development of a medication audit tool.

Summary of findings

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused. People we spoke with told us they felt safe living at Shandon House and they were well supported.

There were enough staff on duty at all times to help ensure people were cared for in a safe manner. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We looked at whether the home was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. We found examples of good practice in supporting people with decisions in their 'best interest'. We discussed the need to extend the use of current good practice to more key decisions for people. The manager said this would be developed with further staff training.

People told us the meals were good and well presented. We observed and spoke with people enjoying lunch. We were told that there was choice available with meals.

We asked people if staff were polite, respectful and protected their privacy and dignity. We received positive responses. Our observations of care supported good practice.

There was some information available in the home for people. We discussed some key information such as the

complaints process. We were sent an updated copy of the homes 'Statement of Purpose' which provided accessible information; for example, regarding the complaints procedure.

We found people and their relatives were involved in planning their care to help ensure it was more personalised and reflected their personal choices, preferences, likes and dislikes. We looked at the care record files for people who lived at the home. We found that care plans and records recorded of this information.

We found people were provided with social activities and were encouraged to participate in the daily life of the home.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw an example of one complaint that had been received and dealt with. This had been responded to appropriately.

The manager was able to evidence a series of quality assurance processes and audits carried out internally. We found some of these were not currently developed to ensure the most effective monitoring.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

We found that people had unnecessarily been exposed to a risk because some environmental hazards had not been effectively monitored.

Medicines were administered safely. Medication administration records [MARs] were completed in line with the home's policies and good practice guidance. We recommended a review of the medication policy and development of a medication audit tool.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

There were enough staff on duty at all times to help ensure people were cared for in a safe manner. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Requires improvement



Is the service effective?

The service was effective.

We found the home was consistent in supporting people to provide effective outcomes for their health and wellbeing.

We saw that the principles of the Mental Capacity Act (2005) had been followed.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Staff said they were supported through induction, appraisal and the home's training programme.

Good



Is the service caring?

The service was caring.

We made observations of the people living at the home and saw they were relaxed and settled. People spoken with said staff were caring when they interacted with them. Our observations confirmed this.

Staff ensured people's privacy and dignity were respected when they carried out care.

People and relatives we spoke with told us they were encouraged to give their views regarding the running of the home.

Good



Is the service responsive?

The service was responsive.

Good



Summary of findings

People's care was planned so it was personalised and reflected their individual preferences and routines.

There were activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

Is the service well-led?

The service was not always well led.

Some of the systems for auditing the quality of the service needed further development.

We found an 'open' and responsive culture in the home and the organisation that helped promote good service development.

We found the manager and staff to be open and caring and they spoke about people as individuals. This was evidenced throughout the interviews conducted and the observations of care and records reviewed.

There was a system in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

Requires improvement



Shandon House

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.

This was an unannounced inspection which took place on 8 & 12 October 2015. The inspection team consisted of two adult social care inspectors.

We were able to access and review the Provider Information Return (PIR) as this has been completed and returned to the Commission before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service.

During the visit we were able to speak with 12 of the people who were staying at the home. We spoke with five visiting family members. As part of the inspection we also spoke with, and received feedback from two visiting health care professionals who worked with the home to support people.

We spoke with seven staff members including care/support staff and the registered manager. We looked at the care records for four of the people staying at the home and other records including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits carried out by the manager.

We undertook general observations and looked round the home, including some people's bedrooms, bathrooms, laundry, outside storage, food stores and the dining/lounge areas.

Is the service safe?

Our findings

Arrangements were in place for checking the environment to ensure it was safe. We were shown a range of daily and weekly and monthly environmental checks carried out by the manager and maintenance person including, safety checks for windows, hot water and fire safety checks such as alarm testing, fire drills and safety checks for equipment. There was a system for staff to report general repairs. We checked safety certificates for electrical safety, gas safety, fire safety, mobility equipment and kitchen hygiene and these were up to date.

Personal emergency evacuation plans [PEEP's] were available for the people resident in the home.

We were concerned that, despite these measures, that some aspects of health and safety and adaptation of the environment still needed attention. For example, we observed a number of doors to bedrooms and also a lounge door 'wedged' open so they were ineffective in the event of a fire. We spoke with the manager who told us that some bedroom doors are fixed with apparatus called fire guards which are activated when the fire alarm is sounded but not all bedroom doors, including the ones we saw wedged open, were fitted with this device. The manager said they would address this. We saw that the fire guards that had been fitted were not subject to any maintenance checks or monitoring. This is important to ensure their effectiveness.

We spoke with the manager regarding one door marked as 'fire exit' leading from a person's bedroom on the ground floor. The door was very stiff and difficult to open effectively. The care home is surrounded by trees with little lighting onto the fire escape from this fire exit. The homes current maintenance checks had not identified this.

We looked at the fire risk assessment for the home. This was dated February 2010. There were additions made to the assessment in terms of update and review up to November 2013. Given the observations made by us we discussed the need for a further review of the fire risk assessment for the home.

These findings are a breach of Regulation 15(1) (c) (d) and (e) of the HSCA 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection the home did not have any domestic staff employed. The manager explained that the previous staff had left and not been replaced due the home experiencing low numbers of residents at the time. The home had now admitted more people and the manager had advertised for a domestic staff and was now going through the recruitment process.

The manager and care staff had therefore been carrying out domestic duties. The manager showed us a series of cleaning rotas and environmental checks that were routinely carried out by the manager and care staff. These covered all areas of the home including bathrooms / toilets and people's bedrooms. We also saw an external infection control audit by Liverpool Community Health [LCH] carried out in January 2014. We saw that areas identified on the audit for improvement had been addressed at the time by the manager. This included, for example, the provision of personal protective clothing in all areas including the laundry as well as the development of some policies and procedures related to infection control.

The general environment of the home, day area and most bedrooms, were clean and hygienic. We made some observations during our inspection, however, of concern which meant that systems in the home needed to be tightened up to ensure better ongoing monitoring.

Some communal bathrooms / toilets had no soap and others had no paper towels. One communal bathroom had a stained water jug in the bathroom which did not appear to be clean and the paper towel dispenser was loose on the wall. Bathroom D had no paper towels. Bathroom E had no paper towels and no soap in the dispenser. Bathroom B had no soap and the toilet pan was in need of cleaning. The cleaning rota on the back of the door had the last date of cleaning as 31st July 2015. The staff toilet also had no soap on the first day of the inspection. Some of the soap dispensers were not working when we tried them.

The communal bathrooms / toilets had personal toiletries in them belonging to people in adjacent rooms. We also saw some laundry on the floor in one of the bathrooms and one bathroom had carpet flooring which, in a communal bathroom, would be difficult to clean. One communal bathroom had a black bin bag with waste in it blocking access to a sink preventing people from accessing the sink to wash their hands after using the toilet.

Is the service safe?

The manager reported that these bathrooms, in some cases, do adjoin individual bedrooms and people tend to use these facilities as 'ensuite'. We discussed the need to designate these facilities for their shared use and ensure standards of hygiene are maintained in line with a communal facility. We also noted that one bathroom / toilet had no lock on the door to ensure privacy. The lack of clarity around the designation of these facilities meant that one person we spoke with was not sure about their use and effectively had limited access to toilet facilities.

There was an outside shed where the vegetables are stored. We observed mops hanging on the back of the door to dry near the stored food. There was a risk of contamination of the food. The manager advised us the vegetables would be moved immediately and stored with other food stuffs.

We observed a visitor/relative entering the staff kitchen without wearing any protective clothing to prevent the risk of infection – the cook attempted to intervene and ask the visitor to let her make him a drink but he declined and carried on as though he has done this on other occasions.

There was as strong smell of urine in one of the bedrooms we saw. Another bedroom had some odour of urine and the carpet was badly stained. The manager showed us the cleaning audits and assessments completed to help reduce the risk of these occurring, including regular cleaning of the carpets. Following discussion the manager said they would review the actions needed for more effective interventions.

Although there were cleaning rotas available and the manager had carried out some environmental risk assessments, the issues we identified had not been picked up or actions had been ineffective. The manager was not able to evidence any overriding infection control audit in use that covered all areas of good infection control management. The manager said they would look at examples of these; develop and carry out a more detailed and thorough audit.

These findings are a breach of Regulation 12(2) (h) HSCA 2008 (Regulated Activities) Regulations 2014.

When asked about medicines, people said they felt they were supported well. All the residents we spoke with said they received their medication on time. Relatives told us as far as they knew people were getting their medication on time; there were no concerns raised about medicines.

We observed the medications being given out on day one of the inspection and these were completed in good time with all the people living in the home getting their medicine on time. This was carried out safely so people got their medicines and they were recorded as per the home's policy; following each individual administration the records were completed by the staff. The medication administration records (MARs) we viewed were clear and easy to read and contained a photograph of the person for identification, details of date of birth and any allergies, in line with best practice guidance. Any medicines received from the pharmacy were recorded on the MAR and it was therefore easy to keep an accurate stock count of medicines from the MAR chart. The manager showed us an additional weekly check made of all medicine stock in the home to ensure MAR's maintained and actual stock seen totalled the same. This helped to ensure any medication errors could be tracked.

All medicine administered were recorded on the MAR. This included the application of external topical medicines [creams]. The current system of recording staff administering did not include the staff actually applying the cream at the time. We discussed the need to record this and the deputy manager said this would be addressed.

Although there were no people in the home who were having medicines given covertly [without their knowledge but in their best interest] we were able to see that the manager and senior staff understood the principals involved in how this would be managed.

We looked at records for people who were prescribed medicines to be taken 'PRN' [when required] and also medicines which could be administered in 'variable' doses, including medicines prescribed for when people may be in pain. We found that information was available to guide staff how to administer medicines prescribed in this way. The importance of a PRN care plan to support administration is that staff had a consistent understanding of why and in what circumstances the medication is given and administration can be consistent and can also be regularly reviewed. There was also an accurate record of when a variable dose had been administered so that staff had an accurate record for any future administration.

The home had a medication policy which we saw. We saw the policy had last been reviewed in June 2013. It did not contain reference to key aspects of medication

Is the service safe?

management; for example, use of PRN, controlled drugs, issues of consent and protocol around covert medicines. The manager advised us they would review and update this in line with current good practice guidance.

Only senior care staff were designated to administer medicines. This followed appropriate training. Staff told us that their practice was monitored by the manager to ensure they remained competent to administer medicines. We saw this was not recorded, however. The manager said this would be addressed.

We looked at how medicines were audited. The current system included a weekly stock check of medicines and an occasional external audit by the supplying pharmacist; the last one was undertaken in November 2013. There was currently no other auditing carried out. The importance of a fully developed audit tool was discussed, covering areas such as ordering, storage, training, staff competency, medication review, medicines reconciliation, self-administration, medication records and disposal of medicines.

We would recommend that an audit tool and the homes medication policy should be updated with reference to current good practice guidance.

We asked the people living at Shandon House and their relatives if they felt safe and were ever concerned about anything. People were positive in their response. We were told that they felt very settled and trusted the staff. Everybody we spoke with said they felt the manager and staff were approachable and would help them if needed. We spoke with a relative who said the manager and staff always discussed any issues and they felt their relative was safe in the home.

The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. We spoke with staff who told us they had undergone specific training in safeguarding and how to report abuse. All of the staff we

spoke with were clear about the need to report through any concerns they had. There had been no safeguarding referrals or investigations at Shandon House since our last inspection.

We checked the staffing in the home. For 18 people being supported in the home there were three care staff [including the senior carer] on duty on the first day of the inspection. There was a cook working 8am -1pm. The manager would normally be in addition to these numbers.

There was no domestic staff employed or cook for the evening. Currently care staff were engaged in these duties. The manager explained that because the home's occupancy had increased the staffing had been reviewed and agreed at a recent staff meeting. We saw that from the following week there would be an extra staff working until 5pm. This would support people over this period, particularly as a staff member was designated to work in the kitchen at tea time. There was also a domestic staff being recruited.

To assist the manager to plan staffing to meet the care needs of people there was a 'dependency' assessment tool which could be used. The current dependency of most people living at Shandon House was assessed as 'low'.

People we spoke with told us there was enough staff to meet care needs. A relative said, "There's enough staff about. They seem to have time to spend with residents."

We spent time in the lounge and dining area. We saw staff present to support people. We saw people receiving support with meals [for example] and staff were not hurried and took their time to ensure people's safety and wellbeing.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files for staff recently recruited and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

Is the service effective?

Our findings

We observed staff provide support and the interactions we saw showed how staff communicated and supported people as individuals. Although we found the overall dependency of people 'low' in that many were able to manage their personal care needs with minimal staff support, we found a range of diverse care needs including people who required full personal care as well as people who had a history of mental health care needs. Staff were able to explain each person's care needs and how they communicated these needs.

We spoke with visiting health professionals who supported people at the home. They told us care staff were 'really caring' and the atmosphere in the home was 'homely' and always welcoming. We were told care staff worked well with professionals to achieve good outcomes for people. One professional told us, "I have no concerns; the staff are very proactive and careful and will report any changes [to people's health]." We were told about one person who had a previous history of a very unstable medical condition. Since they had been at Shandon House they had settled extremely well, enjoyed the home and the support offered and their medical condition was now stable. This was due in the main to staff's close working with the health team and the person concerned.

We looked at the support for one person who was frail and was being cared for in bed. The person's care file included evidence of input by health care professionals. We saw the person, who was in bed and had been attended to by care staff so their personal care had been supported and they were comfortable. We saw the person had appropriate equipment such as a suitable bed and alternating pressure mattress to reduce the risk of pressure ulcers. There were daily notes in the care file from the care staff which detailed how care had been carried out. In addition we saw that staff were completing various charts / observations on a daily basis to monitor the person's diet and fluid intake as well as position changes.

A relative told us about the care of a person who was encouraged to be as independent as possible within their complex medical conditions. The person was encouraged to visit out of the home and the day was managed so that important medication could be administered back at Shandon House. We were told the person had to attend

hospital for regular blood tests and this was well managed by staff who supported the person well. The relative reported, "The staff are very good and keep me well informed. [Person] is well settled here."

People we spoke with, relatives and health care professionals told us that staff had the skills and approach needed to ensure people were receiving the right care. We looked at the training and support in place for staff. The manager supplied a copy of a staff training matrix and we looked at records of staff training for two staff members. We saw training had been carried out for staff in 'mandatory' subjects such as health and safety, medication, safeguarding, infection control and fire awareness. Staff told us the training was all e-learning/computer based and this was not backed up by any external training [apart from Diploma / National Vocational Qualification training]. Some staff said they would prefer a more diverse range of training. The manager explained that occasionally the district nurse team would provide additional training sessions, for example in palliative care, but these were not recorded.

We saw in people's care files that any particular medical condition, such as dementia or diabetes that people lived with had articles and information supporting each of the care plans. The manager explained this additional information gave staff the opportunity to learn more about these conditions.

The manager told us that many staff had a qualification in care such as NVQ [National Vocational Qualification] or Diploma and this was confirmed by records we saw where over 80% of staff had attained a qualification. Staff spoken with said they felt supported by the manager and the training provided. They told us that they had had appraisals and there were support systems in place such as supervision sessions and staff meetings. Staff reported they were asked their opinions and felt the manager acted on feedback they gave and this helped them feel acknowledged and supported.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. Most people being supported at the home had the capacity to make decisions regarding their care. We saw examples where people had been supported and included to make key decisions regarding their care. For example we saw a DNACPR [do not

Is the service effective?

attempt cardio pulmonary resuscitate] decision had been made for one person. This showed the person or person's representative had been consulted and followed good practice guidance in line with the MCA.

We discussed some inconsistencies we found however. For example, one of the care records we reviewed had care plans signed by a relative when the person concerned had the capacity to consent themselves to care. The home had developed an assessment tool [two stage mental capacity assessment] and had started to use this to assess people's mental capacity when making key decisions; for example when people were admitted. We discussed with the manager how the assessments could be used in other key decisions in the home; for example around the use of bedrails for one person. Another example was a person who went out regularly into the community; there was some question over the person's capacity to make this decision which had not been formally assessed. The manager said that the current training plans for senior staff would include further updates on the MCA.

The home did not support anybody who was on a Deprivation of Liberty Safeguards authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the manager and senior staff understood the process involved, however, if a referral was needed.

People we spoke with told us that the meals were good and that there was always plenty to eat. We joined people

at lunch time and made observations. We observed a member of staff supporting a person to eat their meal. There was good communication and support and the person was spoken with in a warm and kind manner. The carer was careful to ask the person if they had finished a mouthful of food before providing more food so as not to rush them. The meal time was relaxed and well-paced for all of the people concerned.

Another carer asked people what they would like to drink providing a choice and also asked each person which sauces they would like. People were not asked what they would like for dessert and it was placed in front of them on the table following their main meal. We noted one resident said they did not like rice pudding and asked a staff member for an alternative. We were told that people are asked for their preferences generally the day before but can change their mind.

The cook told us it was sometimes difficult to complete all of the tasks required in the hours currently worked and had asked for a dishwasher to enable them to focus on the cooking and preparing of food as they currently do all washing up. We saw an environmental health inspection report dated in April 2014 which had also 'highly recommended' a dishwasher but to date this had not been supplied. The manager said they would address this with the provider.

The cook had a diet sheet for people with diabetes and understood who required any special diets such as a liquidised diet.

Is the service caring?

Our findings

Shandon House had a diverse mix of people residing there. We spoke with people with varying degrees of mental capacity, other people with physical care needs disabilities and people with mental health care needs.

We found people were cared for and listened to at Shandon House. One person told us, "The manager listens and will always try and get what you ask for." Another person said, "Staff are very good." We found the staff worked as a team and the main focus is the care of people.

We observed staff speaking in a warm and kind manner at all times with people who lived in the home and relatives. We made observations of care throughout the inspection. We saw staff were always patient and took necessary time with people. For example, we saw one carer spending time with a person who was very dependant and needed full support for most care needs. The carer spoke to the person appropriately throughout to encourage and motivate. The carer smiled consistently which provided reassurance and also used humour and worked hard to maintain the person's engagement with the task. This showed respect whilst maintaining the person's dignity in front of others at all times.

People's bedrooms were personable with personal pictures and personal items in most rooms. The resident's name was detailed on the door of their room in most cases and preferred names were used.

Visitors and relatives were welcomed and we observed five visitors/relatives visiting during the course of the day. The

staff were welcoming of visitors and one relative we spoke with told us they were encouraged to attend the resident's meetings held at Shandon House. Relatives were invited to events and parties at the home.

Communication with relatives was good. We spoke with two relatives who both told us independently they are contacted immediately if their relative is unwell and they were well informed by staff. One person said they no complaints about their relative's care. They said they were always contacted when the person had fallen and staff had arranged for a sensor mat at the side of the bed to help reduce the risk of this. We were present when the relative spoke to the deputy manager who discussed the person's next dental appointment demonstrating a caring approach in all areas of care.

People's preferences were respected. One example of this was staff who respected a person's wish not to join in with activities in the day room and not to eat with others and eat in their room. We also observed people being able to leave the dining table when they wished to have a cigarette in the smoker's area so their individual choice was respected.

Staff were able to answer queries relating to people and were knowledgeable regards the people they cared for. An example of this was noted when we asked the deputy manager if a person's falls had been investigated. The deputy was able to explain the interventions undertaken to date.

People's privacy and dignity were respected with their doors closed when personal care was being undertaken.

Is the service responsive?

Our findings

We asked people and their relatives how staff involved them in planning their care to help ensure it was more personalised and reflected their personal choices, preferences, likes and dislikes. People told us they were asked about their care and felt their individual choice was respected. We spoke with a relative who told us about the way the care had been individualised for one person to include a specific agreement to access the community locally. The routine of the care home had been flexible to accommodate the required health care considerations. The relative said they were involved in the care planning and had seen the care file for their relative.

There was evidence that care plans had been discussed with people. We could see from the care records that staff reviewed each person's care on a regular basis. Staff told us that all of the people receiving care were discussed daily and there was a daily entry recorded in people's care files regarding their care. We saw a staff handover where important information was shared.

We asked about activities for people and how people spent their day. We observed people sitting in the day room for a music session in the afternoon and noted there was a weekly activities sheet pinned up at the reception area [albeit it was dated August 2015]. People told us they

enjoyed the activities at Shandon House and there was a variety of activities. On the second day of the inspection a carer was able to get some people involved in quiz in the lounge.

We were told by staff about outings that occur from time to time and these were discussed at residents' meetings. There had been an outing to a pub recently, a coffee morning and a garden party had also been organised. We were also told about a picnic that had been organised over the summer. There was a garden which was accessible although there was only a small area to walk in. The garden provided a lot of colour and was well established.

Residents' meetings were held on a regular basis. We saw the minutes of the last meeting which had been very well attended. This showed a good level of community participation in the home.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We could not find any obvious display of the complaints procedure in the home. The manager said this would be addressed and following the inspection we were sent a [revised] copy of the complaints procedure and informed this would be displayed in the main entrance. We saw an example of one complaint which had been addressed by the manager.

Is the service well-led?

Our findings

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to evidence a series of quality assurance processes and audits carried out internally.

We found some of these were not currently developed to ensure the most effective monitoring and in some areas there needed to be an audit tool introduced to ensure standards were continually maintained. For example we looked at how accidents and incidents were recorded and monitored. We found the way accidents were recorded was detailed and these were seen by the manager and reviewed individually and any on-going action for the individual concerned was considered. There was currently, however, no overall audit of accidents in the home looking at patterns and lessons be learnt regarding the totality of the accidents occurring. This would help ensure trends or lessons to be learnt were identified.

Although we saw cleaning rotas and a check by the manager in terms of general health and safety of the environment, there was currently no effective audit tool used to monitor infection control. The current system of checks had failed to identify the issues / failings we observed on the inspection. The manager said they would review this urgently and link in with Liverpool Community Health for advice.

We found medication administration to be safe but to ensure safe standards were continued we discussed and recommended the development of an effective medication audit which includes all aspects of medication safety.

These findings are a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The manager of the home was registered with CQC. All the people living at the home and relatives we spoke with knew who the manager was. They all thought the manager was a very visible presence and felt confident and happy to approach them with any concerns they may have. We saw that the manager interacted politely with people who lived at the home and people responded well. The manager was supported by a deputy.

A process was in place to seek the views of people who stayed at the home and their families. This was based around residents' meetings which relatives also attended. The manager had collected feedback via questionnaires in the past but said the response rate had not been good. Nevertheless, and following discussion, the manager said they would develop the use of survey forms for the future. The manager collected 'compliments' and thank you cards and feedback and this was wholly positive.

Staff spoken with expressed a high level of satisfaction in working at the home and said that the manager was very responsive and provided an effective lead. The PIR return from the manager said, 'We have an open door policy within the home that any person can come to the office without appointment and speak to the manager of any concerns, complaints or personal issues'. We found this was exemplified on the inspection.

We found the manager to be open and constructive regarding our feedback. Following the inspection we were sent an email updating us on action already taken with some of the issues we discussed.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home. The PIR stated, 'The manager informs CQC of any notifications'. We discussed one incident that had occurred following persons fall in the home where CQC had not received a notification. Following the inspection the manager submitted the required notification.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not met:

Some environmental hazards regarding infection control had not been effectively monitored.

Regulation 12(2) (h)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

How the regulation was not met:

We found aspects of fire safety management and maintenance of the premises needed to be attended to.

Regulation 15(1) (c) (d) and (e)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not met:

Some of the systems for auditing the quality of the service needed further development.

Regulation 17(1)(2) (b)