Norens Limited

Homecrest Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Homecrest Residential Home 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.

Homecrest Residential Home provides accommodation for up to 29 people who require support with their personal care. The home is located in a residential area of Wallasey, Wirral and has a small car park at the front of the home. There are 29 single bedrooms, most of which have en-suite facilities. The bedrooms are situated across three floors. The home's upper floors are accessible via a passenger lift. On the days we inspected there were 26 people living at the home.

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

Prior to this inspection in December 2017, a new nominated individual was appointed for the service. A nominated individual is responsible for supervising the management of the home.

At our last inspection in August 2016, we identified breaches of regulations 12 (safe and appropriate care), 16 (the handling of complaints) and 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the August 2016 inspection, the provider submitted an action plan to The Commission outlining the action they would take to improve the service.

At this inspection, we found that although some improvements had been made to address the issues identified in the August 2016 inspection, the improvements undertaken were insufficient. This meant that the service continued to be in breach of regulations 12 and 17. We also identified additional breaches of regulations 10, 11, 18, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that service's ratings for safe, caring and responsive were downgraded to inadequate for safe and requires improvement for caring and responsive. The overall rating for the service remained unchanged but means that the service has been rated requires improvement for the second time in a row.

During our visit we found that changes in people's nutritional risks were not always responded to in a timely manner. Staff were recording people's weights on a monthly basis but failed to identify and address a consistent pattern of weight loss for two people.

Parts of the premises were unsafe and on day one of the inspection parts of the home were also unclean. The window restrictors in place on people's windows to prevent a fall were of poor quality. The radiator covers in place were not secure and some areas of the home smelt offensively. On day one of our visit, one of the fire exit doors was open but no alarm had sounded to alert staff and one of the home's fire exits was

partially obstructed with mobility equipment. These obstructions were removed by day two of our inspection.

The administration of medication was not always safe. The systems in place to account for the medicines in the home had improved but during our inspection we observed a member of staff sign a person's medication chart without having observed the person take their medication. One person's 'as and when' required medication plan for anxiety and distress was also not followed.

Staff recruitment procedures were unsafe. New staff employed in 2017 did not have adequate information collated by the manager in respect of their suitability to work in the home prior to their appointment. The information that had been collated had also not been verified. One staff member had been recruited without adequate information and had not received sufficient training to do their job role yet they were promoted to a more senior role within the home a month after their appointment. Concerns were subsequently raised with regard to this staff member's conduct. These concerns were reported to CQC and the local authority but the provider failed to report their concerns to the Disclosure and Barring Service (DBS) so that they consider whether this person needed to be 'barred' from working with vulnerable adults or children.

People's ability to make informed decisions had not always been assessed when their capacity to do so was in question. We saw that one person's liberty was being deprived without the correct legal processes having been followed. Another person's clothing had been removed from their bedroom without a capacity assessment and or any evidence that a best interest decision making process had taken place to ensure this was in the person's best interests. This showed that people's right to consent to their care was not always respected.

People did not always receive the support they needed at mealtimes to promote their dignity and to ensure their nutritional needs were met. Some people's fingernails were dirty which did not demonstrate adequate personal hygiene support and people's confidential personal information was displayed around the home which compromised their right to confidentiality. Some of the language used by staff was not always appropriate. They referred to the communal lounge as 'high risk' which may have given visitors a false impression of the people who sat in there.

Care plans contained person centred information about the person and their likes and dislikes. Communication and cognition plans also gave staff guidance on how to promote people's ability to express themselves. This was good practice. We found however that some of the risk assessments and care plans in place lacked sufficient detail and some of the guidance given to staff when supporting people was contradictory.

People's needs were reviewed monthly but the information in people's reviews about their progress was limited. Care staff we spoke with had an understanding of people's needs and the support they required. The majority of people we spoke with felt staff were kind and caring towards them and the relatives we spoke with spoke positively about staff.

Staff training records showed that long standing members of staff received adequate training to do their job role but new staff had not received adequate training before they worked with vulnerable people. All staff members had received regular supervision.

The number of staff on duty was sufficient to meet people's needs but staff were mainly task orientated in their interactions with people. We saw that staff had little time to sit and chat to people in a meaningful

way.

We found that the layout of the communal lounge impacted on the feel of the home. People were sat around the edges of the room which was not very conducive to social interaction and at various points throughout the day staff sat at the top of the room writing people's notes. This gave the lounge a 'classroom' feel. People's movements around the home were restricted and most people sat for the majority of the day in the communal lounge, without independent access to their bedrooms.

People told us they got enough to eat and drink and they were generally satisfied with the food and drinks on offer. The majority of people told us they were happy at the home and relatives said they felt their loved ones were safe and well looked after.

Care staff had a good knowledge of safeguarding and the action to take should abuse be suspected. Safeguarding incidents were properly investigated and documented by the manager.

People had access to activities each day and there was lots of evidence of people enjoying regular trips out for instance, to the cinema, bowling, local festivals, museum trips etc. On day one of our visit, a poetry reading took place and on day two of our visit people enjoyed a reminiscence session. Activities on both days lasted approximately two hours and for the remainder of the day people were observed to sit in the lounge.

Nobody we spoke with had any concerns or complaints about the service. The complaint records we looked at showed that complaints received had been responded to appropriately by the manager.

People views about the quality of the service were sought through an annual satisfaction questionnaire. We saw that the results of the latest survey were positive.

There were a range of regular audits in place to check the quality of the service. Some of the systems were ineffective as they had failed to identify the concerns we found during our inspection. For instance with regards to people's nutritional support, staff recruitment, new staff training, premises issues, implementation of the Mental Capacity Act, medication administration and the promotion of people's dignity and respect. This meant the way the service was governed required improvement to be effective in mitigating risks to people's health, safety and welfare.

At the end of our inspection, we discussed the concerns we identified during the inspection with the manager, deputy manager and area manager. They were open and receptive to our feedback.

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's health and welfare risks were assessed but changes in some people's nutritional needs had not been addressed in a timely manner.

Staff recruitment was not safe as robust recruitment procedures had not been followed to determine staff suitability.

The systems to account for medications had improved but the practical administration of medication was not always safe.

Parts of the premises and its fixtures and fittings were unsafe or unclean.

Is the service effective?

Requires Improvement

The service was not always effective.

There was some evidence good practice with regards to the Mental Capacity Act and Deprivation of Liberty Safeguards but this was not consistently applied to all of the people who lived at the home. This meant there human rights were not respected.

Long standing members of staff had received sufficient training in their job role but new staff had not. Staff received supervision in their job role and an appraisal.

People were given suitable choices at mealtimes and people were satisfied with the food and drink available.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive the support they needed at mealtimes to maintain their dignity or to ensure their nutritional needs were met.

Confidential personal information was displayed in various public areas within the home. This meant people's right to

privacy was compromised.

A number of people's fingernails were dirty which suggested that they did not receive the support they needed with personal hygiene.

Some of the language used by staff to describe the lounge where most people spent their time was inappropriate.

Most of the people we spoke with felt staff were kind and caring towards them. Relatives we spoke confirmed this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's freedom of movement around the home was restricted but nobody complained about this during our visit.

People's care plans were not always clear about people's risks or care and some of the advice for staff to follow was contradictory.

Where professional advice had been given in respect of people's care, it had been followed.

People's social needs were met by a range of activities and people enjoyed trips out.

No-one we spoke with had any complaints. The manager's complaint records showed complaints were responded to appropriately.

There was no evidence that regular resident or relatives meeting took place to discuss the running of the service.

Is the service well-led?

Requires Improvement

The service was not adequately well led.

There was a range of quality assurance systems in place but some of them were ineffective in identifying and addressing the concerns we identified during our visit.

The culture of the home was relaxed but people spent large parts of their day contained in the communal lounge with limited meaningful interaction with each other or staff. This impacted on the atmosphere of the home.

A satisfaction survey was completed in 2017 with people who

lived at the home, relatives and staff. The results were positive.

This is the second time the service has been rated overall requires improvement.

Homecrest Care Centre

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.

This inspection took place on 12 and 19 January 2017. The first day of the inspection was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also contacted the Local Authority for their feedback on the service.

At this inspection we spoke with seven people who lived at the home, three relatives, a visiting healthcare professional, the manager, the deputy manager, the area manager, a care assistant and the activities co-ordinator.

We examined a range of documentation including six care files, four staff files, staff training records, medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's moving and handling support was unsafe, professional advice had not been followed with regards to one person's diet and the home itself was uncomfortably hot. The system in place to account for the administration of people's medicines was also ineffective. At this inspection we found that some improvements had been made but that further improvements were still required. This meant that the service continued to be in breach of Regulation 12 of the Health and Social Care Act. At this inspection, we also identified serious concerns with the recruitment and employment of staff. This meant the service was also in breach of Regulation 19 of the Health and Social Care Act.

We looked at the recruitment records belonging to four staff. One staff member whose records we looked at, was subject to a safeguarding investigation. The safeguarding investigation was substantiated and the staff member was subsequently dismissed. We saw that the provider had correctly reported the concerns about this staff member's conduct to the Local Authority and CQC but found that they had failed in their duty to refer the staff member to the Disclosure and Barring Service. Referrals should be made to DBS when an employer or organisation believes a person has caused harm or poses a future risk of harm to vulnerable people. We asked the manager to refer this person immediately to the DBS.

We reviewed how this person was recruited to work at the home. We found that robust recruitment procedures had not been followed. There were lengthy gaps in the person's employment history which had not been properly investigated or verified. The person's references did not match the referees on their application form and neither were from the person's last employer. The provider had advised the manager to "Give him a try! Probation period must be monitored" but there was no evidence that any monitoring had been undertaken and a month after their employment, the person was promoted to a senior role without any evidence of adequate training or suitability.

We found similar issues with the recruitment of the three other members of staff. All three staff member's employment histories were unclear and there was no documented evidence to show they had been verified. Two staff members' references were all personal and no references had been gained from previous employers despite these being listed on their application forms. One staff member was employed as a care assistant without any prior experience. It was unclear what criteria had been used to determine their suitability for this post as no rationale was documented and no interview notes had been kept.

These examples were a breach of Regulation 19 of the Health and Social Care Act. This was because robust recruitment procedures were not in place to ensure persons employed were safe and suitable to work with vulnerable people.

People's care files contained evidence that the risks in relation to their health and welfare were assessed and regularly reviewed. For example, moving and handling, nutrition, pressure sores and people's risks of falls. People's care plans and risks assessments were basic and some of the management advice given was

generic. We saw that some people were involved with health and social care professionals in relation to their care and accurate and up to date records were kept in accordance with any professional advice given.

We found that changes in people's needs were not always picked up and responded to in a timely manner to mitigate risks to their health and welfare. For example, two people's care records showed changes in their nutritional needs. Both people had been weighed regularly and their records showed they had both lost weight consistently over the period of a few months. One person had lost 18 pounds in 5 months and the other had lost five and half pounds in three months. There was no evidence that either person's nutritional changes had been responded to. For example by staff monitoring their dietary intake or from seeking advice from a dietician or the person's GP. The deputy manager confirmed this. We asked them to refer both people to dietetic services without further delay.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to some people's nutritional health were responded to.

At our last inspection, we found that improvements to the way medication was accounted for were required. At this inspection we saw that this had been addressed but during our visit we found other improvements were still required. For example, one staff member signed a person's medication administration record (MAR) before they had given the medication to the person. This meant an inaccurate entry was made in the person's MAR. Staff administering medications should always observe the person taking the medication before they sign the person's medication records. We spoke with the manager and deputy manager about this and on day 2 of our inspection, they told us the staff member had been placed on refresher medication training.

The home had a medicines room that contained two medication trolleys. The room was of an adequate size but a lot of space was taken up by a medical examination couch that needed to be removed. We saw that all medication was locked away in a trolley or a cupboard. On day one of our inspection the door to the medication room was unlocked and ajar despite a sign on the door stating that the medication room must be locked at all times.

We saw that people had 'as and when' required (PRN) medication plans for pain relief or anxiety relief medications. People's PRN plans were detailed and gave staff clear guidance on how and when to administer people's PRN medication but we found that one person's PRN plan was not considered when they became agitated.

During the afternoon of day 1, this person was observed to be in an agitated state. We observed the person's agitation escalate over a period of an hour. We saw that staff, the deputy manager and the manager all struggled to settle the person and diffuse their anxiety. We checked the person's care records and saw that they had a PRN medication plan in place for the administration of anxiety reducing medication. We asked the deputy manager if the person had been offered this medication. They told us that they had not offered the person the medication. When we questioned this with the deputy manager, they told us they were hoping a call from the person's social worker would calm the situation as this had worked previously. We did not find it acceptable that no consideration had been given to the administration of this medication whilst waiting for the person's social worker to call. The person had continued to be in an extremely agitated and distressed state for over an hour prior to this call taking place.

These incidences were a breach of Regulation 12 as the provider did not have suitable systems in place to ensure the proper and safe administration of all medicines in the home.

A fire risk assessment had recently been completed and we saw that the provider had a number of improvements to make with regards to the fire safety provision in the laundry and the kitchen. Records showed that improvements to the kitchen had already been made and the laundry improvements were in progress. On day one of our inspection, we found that a fire door had been left open. When we pushed the fire door open, an alert sounded to advise us that the fire door alarm had not been set by staff. This meant that the fire door was not secure. One of the fire exits was obstructed with mobility equipment which was stored there. We drew this to the manager's attention and by day two, the obstructed fire exit had been cleared. The home's gas, electric, fire and moving and handling equipment had all been inspected and certified as safe but as we walked around the building we found that parts the home were unsafe and unclean.

On day one of our visit, one person's bedroom contained a tray of congealed porridge and cold toast. One person's electric toothbrush was dirty and a cushion on their armchair was also dirty and stained. One person's toilet contained faeces. Some bedrooms smelt offensively as did the communal lounge. We saw that the carpet in the communal lounge had been cleaned several times but we found that the lounge still smelt unpleasant. PPE equipment such as latex gloves were also found discarded in parts of the building. It was unclear if these were clean or used. These issues impacted on the quality of the environment in which people lived. We spoke with the manager about this who told us that due to training, domestic staff had started work later on that day. On day two of the inspection, some of the cleanliness issued had been addressed.

Parts of the premises and equipment required repair or replacement. One person's hot water tap in their bathroom continually dripped, the lighting in one person's bedroom was inadequate, one person's mattress did not fit their bed frame and a ceiling tile was missing in one person's bathroom. We saw that the home's radiators had radiator covers on but these were not fully secure and could be easily removed. In one bedroom we found that the radiator cover had been unhooked on one side, we were able to access the radiator. It was very hot. Most radiators and associated pipework operate at temperatures that present a burn risk, especially for people who live with dementia who may be unable to react appropriately, or quickly enough, to prevent injury. We spoke with the manager about this and raised concerns about the ability of people who lived at the home to remove these radiator covers of their own accord. After the inspection, we received information from the provider to advise that all radiator covers were now secure

The window restrictors on people's windows were of a poor safety standard and not fit for purpose. The Health and Safety Executive's 'Health and Safety in Care Home' guidance states that window restricting devices must be sufficiently robust to restrain a fall, should only to be able to be disengaged from use by using a special tool or key and must have tamper proof fittings. None of the window restrictors complied with this guidance. This meant that there was a significant risk of them being ineffective in preventing a fall and potential injury. On the second day of the inspection, the area manager told us that a quote for new window restrictors had been
sourced and the work agreed to take place.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the premises and its equipment was safe and suitable for purpose.

We spoke with seven people who lived at the home. The majority said they felt safe. People's comments included "Yes I think so"; "I think so, can't say"; "Yes I do" and "It's mixed, sometimes". Relatives we spoke with told us they felt their loved ones were safe and well looked after. One relative said "I know she is safe and well cared for".

Staff we spoke with were knowledgeable about the signs of abuse and what action to take if they suspected any abuse had occurred.

Overall we found that staffing levels were sufficient to meet people's needs. The manager had a system in place to determine how many staff needed to be on duty at any given time to ensure people's needs were met. We saw that there was usually a senior care assistant and three care staff on duty between 8am and 10pm with two care assistants on during the night. However the rota's we looked at were difficult to read and understand due to the amount of handwritten changes on them.

We saw that there were limited call bell points in the communal lounge for people to use to call for help. We asked a staff member about this. They told us that there was always a staff member present in the lounge to support people. We observed one occasion during our visit when this was not the case. Two people in the communal lounge had a heated debate that escalated. At the time of this incident, there were no care staff in the lounge to help de-escalate this situation and the maintenance officer had to intervene. Shortly after, a staff member returned to the lounge to provide support.

Accident and incidents were properly documented and the records showed that appropriate action had been taken at the time the accident or incident occurred. For example, by referral to the falls prevention team or the purchase of additional safety equipment.

Requires Improvement

Is the service effective?

Our findings

Some of the people we spoke with found it difficult to talk to us about the support they received. Others were able to indicate that generally they were satisfied. Relatives we spoke with told us they were happy with the support provided. A district nurse we spoke with told us that "Staff appear to know what they are doing, trained".

We looked at staff training records. For staff who had been employed at the home for several years, records showed that they had completed a programme of health and social care training each year. We found that new members of staff employed in 2017 had not. This meant they were working with people who lived at the home without adequate training to provide safe and appropriate care.

For example, we looked at the records relating to two new staff members employed as care assistants. Neither of them had any evidence to show that they had received training in the safeguarding of vulnerable adults, first aid, infection control, mental capacity/DoLs, dementia care or moving and handling training. Despite this one of them had been promoted to a senior role. Another staff member was employed in a catering role but there was no evidence that they had received training in safeguarding vulnerable adults, food hygiene, COSHH or fire safety.

There was no evidence that any of the four new staff members employed had been enrolled on the Care Certificate. The Care Certificate is a key component of a staff member's induction which an employer must provide legally and in order to meet the fundamental standards set out by the Care Quality Commission.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure new staff received appropriate training to do their job.

Records showed that the majority of staff had received appropriate supervision in their job role and an appraisal of their skills and abilities when required.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that 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. We found that improvements were required.

We viewed the care records of six people. Some of the people whose care files we looked at had dementia type conditions or confusion. We saw some evidence of good practice with regards to the Mental Capacity Act but found that this legislation had not always been followed consistently for everyone who lived at the home.

For example, one person had been admitted to the home on a temporary basis due to confusion and concerns about their safety in the community. The manager had applied for an urgent (7 day deprivation) and standard deprivation of liberty safeguard for this person (DoLS) when they had first come to live at the home. Only the urgent DoLs was authorised.

At the time our visit, the urgent DoLS had expired and there was still no standard DoLS in place. This meant that staff had no legal right to prevent the person from leaving the home of their own accord. During our visit, this person became extremely agitated and wanted to leave the home. Their exit was prevented by staff on several occasions throughout the afternoon and the person's agitation and distress escalated. We saw that staff and the manager struggled to diffuse the situation such was the person's distress.

We checked the person's care file and saw that no assessment of this person's capacity to keep themselves safe outside of the home had been undertaken. This meant there was no evidence that they were incapable of doing so. There was no evidence in the person's care file to show that any best interest decision making had been undertaken about preventing them from leaving the home and no evidence that everything practicable had been done to support the person to access the community in the least restrictive way possible. We asked the manager about this. They acknowledged that no assessment had been undertaken and said they were waiting on the person's social worker. We saw from the person's records that they had been waiting for their social worker and the independent mental advocate working on their behalf for over two months. There was little evidence that any consistent follow-up action had been taken by the manager with regards to this. This meant that the prevention of this person's ability to leave the home may have been unlawful. On day two of inspection we saw that the manager had taken steps to assess the person's capacity and progress the situation with the person's social worker and GP.

We visited one person's bedroom and saw that their wardrobe contained little clothing or personal belongings. The expert by experience asked the manager about this and was told that the person's clothes had been removed as they liked to get dressed during the night. They told the expert by experience the person's relative had agreed to this. We checked this person's care file and found no evidence that MCA had been followed in relation to this decision. There was no evidence of any discussions or assessments of the person's capacity in relation to this and no evidence that the person's relative had legal power of attorney to decide this on the person's behalf.

This examples show that the principles of the MCA and DoLS legislation had not always been followed to ensure people's human rights were respected. This was a breach of Regulation 11 of the Health and Social Care Act.

People told us the food was satisfactory. Comments included, "Food is ok"; "Today (food wise) is not bad, I eat it", "I think the food is ok", I'm losing weight though and "I like the food, I get a drink at break time". A relative we spoke with told us "They eat and drinks well". Another relative told us that the person was given "What they liked to eat" and that they always ate well.

We saw that at lunchtime, people's meals were of ample portion size and people were given a choice of what to eat and drink. The activities co-ordinator told us "We had a residents' meeting the other day to discuss menus. We have picture cards (to help people choose). People can have a full cooked breakfast –

whatever they want".

Requires Improvement

Is the service caring?

Our findings

During our visit, we observed the serving of lunch and saw that it was a busy event. Most people ate their meals in the communal lounge or conservatory. The dining room tables were not properly set before people sat down to eat. Tablecloths were in place but there was no cutlery, condiments or cups on the table for people to use. Staff brought people's food already plated to the table with cutlery in their hands. This made the serving of lunch a little chaotic. During lunch, a member of staff started hoovering in the lounge area adjacent to the dining room. The hoover was loud, easily heard in the dining room and did not make for a pleasant dining room experience.

Some people struggled to eat their meals. One person's care file stated that they were unable to use a knife and fork and their ability to eat with a spoon was also impaired. Despite this they had been given this cutlery to eat with. Their care plan stated that they needed assistance from staff to eat their meal and that their food needed to be cut up. They were served fish, chips and mushy peas. Neither, the chips nor fish were cut up. We watched this person struggle to eat their meal using their fingers. The person did not receive any support from staff. This person's meal dropped over their clothes and on the floor and we had to seek staff assistance for them. Two other people also struggled to eat their meals and ate with their fingers. No staff intervened to help these people eat their meals in a more dignified way. One person who was assisted to eat their meal was supported by the staff member standing over them which was not very nice and prevented any meaningful social interaction.

We saw that people's personal information was pinned up on A4 sheets of paper in communal areas. This information identified people by name, bedroom location and mobility needs. One person's medication administration records for the application of topical creams was found taped to the wall of another person's bathroom. This meant that people's right to confidentiality had not been respected. We spoke with the manager about this and asked for all personal information to be removed from public areas.

One person's bedroom contained multiple continence products on display on top of their wardrobe. This did not show that the person's privacy was respected. One person's bedroom window which faced the street had a poster on display advertising for staff to work at the home. This did not show that the person's bedroom was treated as their own personal space.

Staff referred to the communal lounge as "high risk" which was not very respectful. It gave visitors to the home a potentially negative impression of the lounge and the people who sat in there.

Whilst talking to people we noticed that some people's finger nails were dirty. This did not show that people were in receipt of adequate support with their personal hygiene. A district nurse we spoke with told us that people looked clean when they visited but added that people sometimes had dirty fingernails. They also told us "Sometimes staff joke and laugh with people. It is not the way I would speak to people. Choice of language, words I wouldn't use".

We asked three people if they had access to regular baths or showers. One person said "In the morning you

get a wash, that's all". Another person said "I have a wash in my room".

On day one of the inspection, both activities co-ordinators were off work. The deputy manager took over this role in the afternoon but the way in which the activities were delivered was interrupted twice by the deputy manager answering the phone. This left people waiting for the deputy manager to finish the telephone conversation. No regard was given to people who were trying to join in or listen to the poem reading. This was not very respectful. We found the reading of the poem to be disjointed and complex for people to understand. When we checked on people participating we found that most people had disengaged from the activity.

These examples demonstrate a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

We asked people who lived at the home if staff were kind to them. Most of the people we spoke with thought they were. Comments included "They are kind to me, yes", "They are nice", "Lovely people", " Yes they are sort of" and "Its mixed, sometimes"

Relatives we spoke said that when they visited they saw staff treating people kindly and that from their observations, they felt staff knew people who lived at the home well. One relative said "They (the person) are always happy and the staff are angels".

Requires Improvement

Is the service responsive?

Our findings

Relatives we spoke with felt that people's needs were met and that they received the support they needed. People we spoke with told us that they spent most of their day sitting in the lounge and we observed this to be the case. People said "I stay in here most of the day", "Nothing much happens. If I want to get up to go anywhere. I can use that walking frame over there", "I can get about, so don't sit here all day" and "I don't care anymore. I don't want to be here. I am unhappy here".

There were key codes on doors that prevented people from accessing their bedrooms without staff support. We saw that two people who were able to use the passenger lift independently went up and down to their bedrooms on their own but most people sat in the communal lounge for most of the day with no access to their bedrooms or the garden unaccompanied. This was restrictive but during our visit, no one raised any concerns to us this.

People had access to day to day activities which lasted about two hours. Activities were provided by the home's activities co-ordinators. There was a picture timetable on the wall in the communal lounge showing what activities were on offer each day. People also had regular trips out. For example in 2017, people had enjoyed trips out to the House of Memories in Liverpool, Egremont Festival, Juke Box Jive Show, bowling, Spaceport, Birkenhead market, the Floral Pavillion theatre p, New Ferry Butterfly park and the cinema. A garden party had taken place and outside entertainers had entertained people at the home. Both the relatives we spoke with told us how much their loved ones enjoyed the trips out.

We spoke with one of the activity co-ordinators. They were very enthusiastic about their role. They told us "I love coming to work". We saw that people who lived at the home responded positively to the activity co-ordinator. It was clear they were well liked and very popular with people who lived at the home. On day two of the inspection, the activity co-ordinator encouraged people to participate in a reminiscence session and we saw that this session was well received.

People's care records contained information about their life histories which gave staff information on people's backgrounds, family life and what was important to them. This helped staff gain an understanding of the people they supported. People's care plans contained information about their mental health issues and gave staff information on how this impacted on the person's communication and understanding. Staff had guidance on how to help people express their needs and wishes but some aspects of care planning required further details. For instance some people had risk assessments in place stating that they were "At risk of health and safety in the community alone". These risk assessment failed to identify why or what provisions had been put into place to mitigate any potential risks.

The advice given to staff with regards to some people's support was contradictory. For example, one person sometimes experienced behaviours that challenged. The person's risk assessment identified that the person did not respond well to verbal reassurance form staff but the persons' care plan advice advised to "Give them lots of verbal reassurance". This was contradictory and placed staff at risk of increasing the person's agitation.

People's care was reviewed monthly but some people's monthly care reviews failed to provide sufficient information on any changes experienced by the person during the previous month. For example, some people's monthly reviews just repeated the statements made in previous months. One person's monthly nutritional review failed to pick up that they had lost weight and one person's monthly review failed to alert staff to the fact that the person's mental health assessment and advocacy support had not been undertaken in a timely manner.

People's records showed that they were involved with health care and social care professionals, for example, their GP, opticians, chiropody, dieticians, falls prevention team and social services. Advice given by visiting professional had been followed. For example, one person had been placed on food and drink charts following advice from a dietician. We saw that this person's food and drink charts had been completed in full by staff with clear information on what the person had eaten and drank throughout the day. We also saw that these charts were reviewed by the manager to ensure that their intake was satisfactory.

Some people required support to change position during the day and night to prevent the development of pressure sores and people's repositioning records showed that they had received the support they needed.

The relatives we spoke with told us they knew how to make a complaint and said they felt comfortable talking to the manager or other staff about any concerns they may have. Details of who people could contact in the event of a complaint had been added to the provider's complaints policy after our last inspection. This information was displayed in the entrance area of the home but we saw that some of the provider's contact details were out of date. We drew this to the manager's attention.

We looked at the manager's complaint records. They were well-organised and appropriately responded to. Records showed that people's complaints had been investigated and responded to properly.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection, the nominated individual for this service changed. A nominated individual is responsible for supervising the management of the home.
The registered manager and deputy manager remained the same. The registered manager was now supported in post by an area manager and a new nominated individual. The manager told us they were still getting to grips with the change in the management structure but felt that the change was a positive one. They told us they felt supported by the new management team.

The relatives' we spoke with thought the service was well managed and said the manager was approachable. A member of staff told us "They are the best manager and deputy. They are so fair".

The manager undertook a comprehensive range of regular audits to monitor the quality and safety of the service provided. This included an audit of care plans, health and safety, accident and incident audits, infection control and medication audits. There were also regular recorded checks of people's pressure cushions, hoists and slings and people's commodes. A full bedroom audit had been undertaken in January 2018. A weekly report on the service was sent to the provider by the manager. This report contained an update on a range of areas including occupancy, cleanliness, décor, medication, fire safety provisions and staff observations. This enabled the provider to have an overview of the service on a regular basis.

We found however that some of the checks and audits undertaken by the manager were ineffective as they failed to pick up the areas of concern we identified during our visit.

For example, there were a number of inconsistences in people's care records about their needs and care which had not been picked up by the provider's care plan audits. For example, the audits had not identified that some people's support plans and risk assessments were contradictory or that some of their risk assessment lacked adequate information. This indicated that the provider's care plan audits were not always effective in ensuring the information about people's needs and risks was up to date and complete.

The environmental checks in place had not identified that window restrictors were sub-standard, or that radiator covers were not secure. They had not picked up that some people's bedrooms smelt offensively or confidential personal information was displayed in public places around the home.

There were no adequate audits in place for the recruitment and on-going employment of staff. This meant that there were no robust checks that safe recruitment procedures had been followed when staff were employed to work at the home. There was no proper system in place to ensure that new staff received the training they needed to do their job role safely before working with people unsupervised.

These examples demonstrate that some of the systems in place to monitor and address quality and safety issues were ineffective as they failed to mitigate potential risks to people's health, safety and welfare. This meant that the management of the service required improvement. This was a continued breach of Regulation 17 of the Health and Social Care Act.

During our visit, we found the culture of the home to be relaxed. We saw that people were able to get up and go to bed at times that suited them and on day two of our visit we saw that some people had chosen to rise late and were having their breakfast at around 11am. Other aspects of the service however were less flexible. For example, the layout of the lounge created a rather institutional feel to the home as opposed to a homely one. People were sat around the edges of the home and at various points throughout the day staff sat at the top of the room behind a table and chair writing people's daily notes. This created a rather 'classroom' feel to the home.

The lounge was a busy area with some people coming in and out. People were not engaged with each other and most sat for long periods throughout the day without much conversation. Staff were task orientated and seemed to have little time to sit and chat to people socially. People received drinks and snacks at set periods and one person remarked that this was 'break time'. This again suggested that the management of the home was task based as opposed to operating on a person centred model of care. This aspect of service management required improvement.

There was limited evidence that resident meetings took place on a regular basis and the manager told us no relatives' meetings had taken place either. This meant there were limited opportunities for people and their families to be regularly involved in the running of the home. We saw that there was a satisfaction survey sent out in May 2017. The survey generated positive results but was only done once a year and did not give people a regular forum to voice their opinions and suggestions about the service. This aspect of service delivery required improvement.

This is the second time the service has received an overall rating of requires improvement. The ratings given to the domains of 'caring' and responsive at this inspection were assessed as requiring improvement. These domains had previously been rated good.

During the visit and at the feedback session at the end of visit, we discussed the concerns we had identified. These discussions took place with the manager, deputy manager and area manager. We found them to open and receptive to our feedback. Some of the issues we had raised on day one had already been addressed or were in progress. This showed a commitment to ensuring the service improved.

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 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity were not always respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Some aspects of people's decision making where their capacity to give informed consent was in question had not been assessed and obtained in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Where risks or changes to people's nutritional needs had been identified, timely action had not always been taken to mitigate those risks. Parts of the premises and its fixtures and fittings were unsafe and unclean. Medicines were not always administered safely or in accordance with PRN protocols.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems were not

always effective in assessing, monitoring and mitigating the risks to the health, safety and welfare of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff recruitment procedures were not robust and had not been operated effectively to ensure staff were safe and suitable to work with vulnerable people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure new staff received appropriate training to do their job.