Timaru Care TA Cressington Court Limited

Cressington Court Care Home

Inspection report

Beechwood Road
Cressington
Liverpool
L19 0QL

Date of inspection visit:
10 October 2017
11 October 2017
19 October 2017

Date of publication:
29 November 2017

Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

This inspection of Cressington Court took place on 10, 11 and 19 October 2017 and was unannounced.

Cressington Court is situated in a suburb in south Liverpool close to transport routes. The home provides a service for up to 56 people who have a range of care needs. The home was purpose built and all accommodation is provided on two floors. The home is located in a residential area of Liverpool close to public transport routes and local amenities. At the time of our inspection there were 38 people living in the home, 23 of whom received nursing care at the service.

This inspection was prompted following the receipt of information from the Local Authority which raised concerns for the safety, comfort and welfare of people living at Cressington Court. These concerns related primarily to issues around the administration of people's medication and the management structure at the service. The purpose of this inspection was to check if the provider was managing risks to people effectively and to ensure that people were safe.

There was no registered manager within the service. The previous registered manager had recently changed roles to become the clinical lead. 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.

When we carried out an inspection of Cressington Court in May 2017, we identified breaches of legal requirements and the service was rated as, 'Requires improvement.' We found that people were not protected against the risks associated with unsafe administration of medication and that the service did not work in accordance with the principles of the Mental Capacity Act 2005. We also found that there was no effective oversight of the service. We asked the provider to take action to make improvements. On this inspection, we found that sufficient action had not been taken and the provider remained in breach of regulations. The concerns we identified are being followed up and we will report on any action when it is complete.

We found that medicines were not managed safely within the home. People were not always given their medication when they needed them or as directed by their doctor. We identified examples of missed medication and of people being given the incorrect dose of medication. The support plans in place for people who had their medicines administered into a stomach tube lacked detail.

We found that the environment was not always adequately maintained in order to ensure people's safety and wellbeing. We identified issues with infection control at the service and observed poor hygiene practices by staff at the home.

Fire alarm and equipment checks were not completed regularly. This meant that faults were not identified

promptly. We saw that fire exits were blocked with items of furniture which compromised the safety and security of people using the service.

Accidents and incidents were not consistently analysed and reviewed at the service. This meant that audits had failed to identify that appropriate action had not been taken to refer one person to the podiatry service following the identification of pressure ulcers. We found the provider's response to incidents and accidents varied and their reporting procedures to the Local Authority were inconsistent.

The service did not always operate within the principles of the Mental Capacity Act 2005 (MCA). We found that some capacity assessments were generic and not linked to key individual decisions. The service had not applied for Deprivation of Liberty authorisations for everyone who needed them. Some people were at risk of being restricted unlawfully.

At the time of the inspection, there was no registered manager in post. We found the management structure at Cressington Court to be ineffective, in terms of assessing and monitoring the quality and safety of services provided and mitigating risk to the health, safety and welfare of people receiving care.

We found that staff assessed risk to people but information was not always updated or reviewed regularly. This appeared to correlate to periods of absence of the last registered manager. There were no effective contingency arrangements in place to manage this review process in their absence.

There was no evidence that the service had made the necessary changes identified at our last inspection in May 2017. There continued to be a lack of effective audit systems and processes to check the quality and safety of the service.

People's personal information was not stored securely within the home which meant that people's confidentiality was not maintained.

The was a lack of systems in place to seek feedback from people.

The provider had not always notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements. This meant that CQC were unable to monitor risks and information regarding Cressington Court.

There were limited activities available to people living at Cressington Court. People told us they "could do with some more entertainment." We have made a recommendation regarding this.

There were sufficient numbers of staff to meet people's needs however we found there was a recent reliance on agency staff. The provider had taken appropriate steps to address this.

Staff had received training however the registered provider's records showed that this was not always up-to date or consistent. For example over 50% of care staff had not received training in safeguarding vulnerable people or the MCA. Nevertheless, the majority of care staff had achieved NVQ level qualifications and appeared to have the necessary skills and knowledge to support people safely.

The provider had systems and processes in place to ensure that staff who worked at the service were recruited safely.

Staff told us they were assisted in their role through supervisions and appraisals however there was no

documented evidence of this. Staff described the provider as, "supportive and approachable" and felt well supported within their roles.

People told us they were given choice regarding meals. Staff knew, and catered to, people's individual dietary needs and preferences. Specialist diets were catered for including diabetic and liquidised diets and we saw people's preferences being met.

The majority of people we spoke with were complimentary about the staff and the service in general. People told us they liked the staff who supported them.

We observed interactions between staff and people living in the home to be warm and familiar. However, although we found that staff were caring towards people living in the home, the provider had not addressed risks identified during the last inspection and this does not demonstrate a caring approach.

Through discussions with staff, we found that they knew people they were caring for well, including their needs and preferences. Care plans contained good information regarding people's preferences, likes and dislikes. This ensured that staff had access to relevant information on how to support people.

People had access to a complaints procedure which provided relevant contact details should people wish to make a complaint.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Medicines were not managed safely within the home. People did not always receive their medication when they needed it.

Fire safety checks were not completed on a regular basis.

The environment was not sufficiently maintained to prevent the risk of infection.

Accidents and incidents were not analysed or reviewed regularly.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental Capacity Assessments were not always decision specific. DoLS applications had not been made for everyone who needed them.

Staff received training however this was not up to date.

People had support to attend routine appointments with a range of health care professionals to maintain their health and wellbeing.

People were given choice regarding meals and preferences were met. Staff were aware of people's specialist dietary requirements.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had not addressed previously identified risks to people. This did not demonstrate a caring approach.

People living at the home told us staff were kind and caring and treated them with respect.

Staff knew people they were caring for well, including their needs and preferences and people we spoke with agreed.

There were no restrictions in visiting, encouraging relationships to be maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were limited activities available to people.

People's care records contained personalised and detailed information however these were not always reviewed regularly.

There was evidence of people's involvement and consultation with relatives in care planning.

People had access to a complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

There was no clear management structure in place at the home and staff roles and responsibilities were not clearly defined.

Systems in place to monitor the quality and safety of the service were ineffective.

People's personal information was not stored securely within the home in order to maintain people's confidentiality.

The provider had not always notified the Care Quality Commission (CQC) of events and incidents that occurred within the home in accordance with our statutory requirements.

Cressington Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The purpose of this inspection was to check if the provider was managing risks to people effectively following recent concerns regarding unsafe medicine management practices at Cressington Court. Additional concerns were raised around staffing levels and the management structure at the service. We needed to complete a comprehensive inspection to ensure people living at the home were kept safe.

This inspection took place over three days on 10, 11 and 19 October 2017 and was unannounced.

Before our inspection we reviewed the information we held about the service. This included the information we received from the local authority quality monitoring regarding the service. We also considered the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

The inspection was carried out by three adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service; in this case, care of people living with dementia. We returned on the 19 October 2017 with a pharmacist to check the way medicines were managed at the service.

During our inspection we spoke with the provider, operations manager, clinical lead, two registered nurses, five carers, three other members of staff, six people living in the home and sixteen relatives of people living at the home. We looked at the care records for eight people and reviewed the medicine management for 18

people. We spoke to three visiting professionals. We observed the lunchtime service and staff interaction with people who lived at the home. We looked at external audits and reviewed other records relevant to managerial oversight and monitoring of the service.

Inadequate

Is the service safe?

Our findings

When we carried out a comprehensive inspection of Cressington Court in May 2017, we identified breaches of regulation in relation to keeping people safe. This was because people were not fully protected from the risk of unsafe administration of medication. We also found that the analysis of accidents and incidents was not completed consistently. On this inspection, we found that improvements had not been made and the provider continued to be in breach of regulation in relation to keeping people safe.

Prior to our inspection, we received information relating to concerns about medicines safety at Cressington Court. These concerns suggested that people did not always receive their medication when they required it and that the systems and processes for the ordering of medicines were ineffective.

During our inspection, one person told us that they did not always receive their medication in a timely manner. The person said, "Sometimes my night tablets can be late." Another person's relative told us that their loved one did not always receive their medication when they needed it. On our inspection; we saw that morning medication was still being given at 12.50pm and lunchtime medication was still being given at 4.10pm. We identified that some of the lunchtime medicines were time specific, which meant they needed to be given at specific times of the day in order to be effective. These included a tablet to reduce the symptoms of heart failure in one person and a medicine for parkinsons disease for another person.

We found that people did not always receive their medication. For example, one person had not been given their diabetic medication on one day and a second person had not had their cream applied for a skin condition on eight days. Similarly, we found that one person who was prescribed a medicine to thin their blood had been given an incorrect dose on four occasions in a 25-day period. These findings were echoed in a recently completed audit by Liverpool Community Health Medicines Management Team on 7 Oct 2017 which found that people did not always receive their prescribed medication and which identified two occasions where people went without their medication on three days and eight days respectively.

There was no care plans for people who were on 'as required' (PRN) medicines. Support plans are important so that staff can be aware of the indications for administration of the medicine and assists with consistency of administration.

People had a care plan in respect of medication and an evaluation sheet within their care files which reviewed any issues in respect of medication. However, we found that there was insufficient detail in respect of the medication plan for two people who had their medicines administered into a stomach tube. Both people had been seen by a dietician who had recorded a volume of water to be given before and after medicines and throughout the day to keep the person hydrated. Neither person had a record of what volumes of liquid had been given during the day, so it was unclear as to whether they were adequately hydrated.

Controlled drugs (CD's) are prescription medicines that have controls in place under the Misuse of Drugs legislation. We saw controlled drugs were not recorded as per legislation as one CD had not been signed out

of the register when a person had moved to another home. One person who was prescribed a CD had been given doses that had been signed out of the CD register, but not on the Medicines Administration Record sheet (MAR), which may increase the risk of a dose being given too early. These errors in recording were also identified by an external medicines management audit which scored the service 60% in relation to their medication administration records and 86% in relation to their management of controlled drugs in a recent audit.

Some medicines need to be stored under certain conditions, such as in a medicine fridge, to ensure their quality is maintained. We found that the temperature of the medicine fridge was not being monitored or recorded consistently.

At the last inspection in May 2017, we found that incidents and accidents were not being analysed consistently. At this inspection, we found that this had not improved and incidents, such as pressure ulcers or falls had not been recorded or analysed consistently since June 2017. We saw that the provider response to accidents varied and they had not always reported incidents of a safeguarding nature to the local authority. The provider's last audit in June 2017 recognised that only two out of 20 incidents were reported to the local authority even though four of these resulted in injuries due to confrontation between people living in the home and three related to a person having an unexplained injury.

During our inspection visit, the clinical lead identified two people as having serious pressure wounds of grade 3 or above. We asked the provider for urgent information in respect of these two people to examine whether the provider's care plan and response was appropriate to help ensure safe care. We received information that one person's pressure ulcer was originally identified on the 28 August 2017 but staff had not referred the person to the podiatry service in accordance with their protocol. Such incidents are reportable to the local authority in line with agreed safeguarding arrangements. We saw that this incident had not been reported to the Local Authority or the CQC. This meant that the systems and processes in place to monitor and review incidents were not compliant with local reporting procedures. Upon our instruction, the provider made the necessary referral to the Local Authority and at the time of writing, these incidents were being investigated.

We saw that care records contained a range of risk assessments including; falls, nutrition, continence, moving and handling and behaviour. We saw that risk assessments were sufficiently detailed and were reflected in the associated care plan. However, we saw that there were some gaps in the review process, for example, some waterlow risk assessments had not been updated since June 2017.

We identified issues with the safety of the environment at Cressington Court. The provider had a contingency plan in place in case of being unable to use the building. A fire policy was in place, fire procedures in the event of an evacuation were clearly marked out, and people had Personal Emergency Evacuation Plans (PEEPs) within their care files. These were personalised and contained relevant information in relation to people's mobility. However, we found that the provider did not complete regular fire safety checks and that equipment checks on blankets, emergency lighting and doors had not been completed since the 16th August 2017. The last fire risk assessment was completed in 2015. A signing in book was in use at the entrance to the building to help ensure they were aware of all visitors in the building in case of fire. We found two fire doors blocked by mobility equipment and other furniture during our inspection which would have delayed escape through those particular exits if there was a fire. Following our instruction, the provider sought advice from an external fire service that identified faults in respect of 12 zones of the fire alarm system. The local fire safety service subsequently completed a fire safety audit on the 27 October 2017 and issued an enforcement notice against the service.

We noted that several store rooms and the boiler room were unlocked. We also saw rolled carpets stored in hallways and a trailing lead in the hallway during our inspection which posed a trip hazard to those living in the home. We saw that health and safety checks were not always completed on issues such as bed rails and water temps. Domestic staff told us they flushed toilets of unoccupied rooms to prevent risk of legionella. However they did not run taps in the sinks. The operations manager acknowledged staff should also be doing this.

The service had a team of three domestic staff who worked from 7.30am to 2.30pm each day. Each staff member had responsibilities to help ensure peoples rooms, communal areas and bathrooms were cleaned daily. Checklists were used to evidence this. Staff told us that once a month they carried out a 'deep clean' of a number of rooms. The home was generally odour free. We checked the laundry and found it was clean, organised and had a system in place to prevent cross infection from dirty to clean laundered clothes.

We found some wheelchairs and hoisting equipment were dirty, with stale food on the wheels, seats, foot rests and straps. The operations manager informed us that recent changes to responsibility for cleaning the equipment had not been undertaken by the staff concerned. These findings were also identified in a recent infection control audit completed on the 10 October 2017 by Liverpool Community Health's infection control service. The audit scored the home as 81% compliant and identified infection control issues with the communal areas, bathrooms and specific equipment in use at the service. The kitchen at Cressington Court had been awarded a food hygiene rating of 2 in February 2017 which indicated that food hygiene practices at the home required improvement.

During our inspection, we observed poor practice in respect of the use of personal protective equipment. We saw medicines being administered by two members of nursing staff, neither of whom were wearing gloves or aprons to reduce the risk of cross infection between people. We saw that one of the nurses had touched the bin with their hands and did not wash their hands before giving medicines to the next person, which also increased the risk of infection. We saw blood on the floor and wall in the medicines room. Staff confirmed this was blood following a staff injury that had not yet been cleaned. This appeared to have been there for some time as the blood had dried. This meant that people were not always protected from exposure to blood borne pathogens.

These findings constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people told us that people responded to them in a timely manner and that there was enough staff to meet their needs. Comments included, "Yes, there's enough staff" and "It is always very busy, there is always someone around". During our inspection, we observed that people received care on time and were not left for long periods. Staff told us that they had enough time to do tasks but could be stretched when other members were off sick.

During our inspection, there was eight care staff on duty, two nurses, and a senior carer to meet the needs of the 38 people living at the home. We looked at staff rotas and found that the staffing levels were sufficient but often fell below the provider's preferred level. We discussed the benefits of a dependency tool in order to better evidence the staff to client ratio. We found there was a reliance on agency staff which may not help promote consistent standards of care. The provider told us they had experienced difficulty in the recruitment and retention of suitably competent staff. The provider had taken steps to address this by their ongoing efforts to recruit permanent staff to promote continuity as far as possible.

We checked how staff were recruited at Cressington Court and the processes followed to ensure staff were

suitable to work with vulnerable people. We reviewed three personnel files of staff who worked at the service and saw that there were safe recruitment processes in place including; photo identification, references from previous employment and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments. Staff told us that they received an induction and shadowed a senior member of care staff before supporting people.

Staff we spoke with were able to describe how they would identify signs of abuse and knew what course of action they would take if they felt someone at the service was being abused. One staff member told us "I would go straight to the manager or the community matron."

Requires Improvement

Is the service effective?

Our findings

When we carried out a comprehensive inspection of Cressington Court Care Home in May 2017, we identified breaches of regulation in relation to the effective domain and this domain was rated as, 'Requires improvement'. We found that consent was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA) in relation to the covert administration of medicines. During this inspection, we found the provider had put in place the correct procedures regarding covert medicines however; they remained in breach of regulation because they were not fully compliant with the principles of the MCA and the Deprivation of Liberty safeguards (DoLS).

The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw mental capacity assessments which prompted staff to consider whether people had capacity in accordance with the four stage legal test, that is; can the person; understand, retain, and weigh the information and communicate their decision. If the person is unable to do any of these, then the person lacks capacity to make that particular decision. We saw examples of day-to-day decisions taken in people's best interests, for example, to include a photograph of them in their medicine administration record to ensure that staff could identify the person when administering medication. However, we found that mental capacity assessments were not always completed correctly because some were not decision specific in accordance with the principles of the MCA. For example, one care file documented that the 'reason for assessing capacity' was 'routine assessment process'. Another record was left blank in respect of the reason for assessing capacity. These assessments were generic and meant that it was not always clear what aspects of their care people had consented to.

People who lack mental capacity to consent to care or treatment can only be deprived of their liberty when this is in their best interest and legally authorised under the Mental Capacity Act 2005 (MCA). At the time of our inspection, the provider had applied for Deprivation of Liberty Safeguards (DoLS) for 11 people living at Cressington Court. This is part of the MCA and aims to ensure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. We saw evidence of DoLS applications and Lasting Powers of Attorneys recorded within care files. However, the operations manager told us that there were eight other people who required DoLS in respect of whom no application had yet been made. These people had lived at the home for over 12 months. This meant that the provider was not acting promptly to ensure that people were not restricted or deprived of their liberty unlawfully.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported and cared for by staff who were familiar with people's needs and wishes. People told us, "They [carers] are really easy to speak to and explain things to me when I need them to". A relative told us

the staff had the required skill to support their loved one safely explaining, "They use the hoist correctly and I can see that [person] is comfortable."

We saw that 24 out of 25 of the health care assistants working at Cressington Court, had achieved, an NVQ level 2 or above. We reviewed the staff training matrix and saw that staff received training in areas considered mandatory such as moving and handling and health and safety. We saw that when additional training was provided in areas such as dementia care, staff had developed their knowledge as a result. For example, one staff member was able to describe how their dementia awareness training helped them understand why some people's vision is affected by the illness. The staff member had changed their approach to interactions with people as a result.

However, we found the provider approach to training was inconsistent as over 50% of the care staff had not received training updates in topics such as safeguarding or the Mental Capacity Act 2005. We also found that not all staff had received training in respect of pressure ulcer prevention. The clinical lead had identified the need for further training and competencies in respect of pressure area care for some members of care staff following the development of pressure ulcers for two people at the service.

We recommend that the provider review their training provision to ensure that all care staff receive the necessary training as identified by the clinical lead of the service.

A staff supervision policy was in place detailing that staff should receive supervision every three months. We were informed by the provider that supervision meetings were recorded and kept in people's personal files. However we did not find any evidence of this. Staff we spoke with confirmed they received supervision and an annual appraisal from managers and told us they felt well supported.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, chiropodist, optician and dentist. We saw that health advice or appointments were recorded within care files in a 'Collaborative Care' document.

We found that generally, referrals to other agencies such as the dietician and speech and language therapist were made in a timely manner. We identified one example whereby a referral to the podiatrist was not made promptly. The provider has reviewed their response and informed us of their intention to complete an investigation as to why their protocols were not followed on that occasion.

There were mixed reviews regarding the food provided at Cressington Court. People told us, "I like the food, I get plenty." Another person said, "There isn't much choice of meals but it's ok." People's relatives told us; "The food's fantastic." Others felt there had been cut backs and the food wasn't always appropriate, one relative stated, "The portions are always good, but we don't get beef on a Sunday anymore, now it's chicken." Another stated, "It's good, but the other day they gave [relative] a half filled baguette and she wears dentures."

We sampled and observed the lunch time meal of 'soup and sandwiches or sweet chicken chilli pasta'. We saw there was a good selection of sandwiches on both brown and white bread, with options such as cheese, fish paste, ham and corned beef. People had a variety of choices at breakfast, lunch and dinner. There were tea trolleys twice a day and people and their visitors were able to request something to eat or drink whenever they wanted.

We could see that meals were served in a friendly manner and assistance was given to those who required it.

We saw that pureed meals were given where appropriate and staff engaged with people as they helped them. We spoke to the chef who was aware, and catered to people's individual dietary needs and preferences, such as diabetes. Care files contained information on people's likes and dislikes, nutritional risk assessments and dietary plans.

Requires Improvement

Is the service caring?

Our findings

We received positive comments about the caring nature of the staff at Cressington Court. People told us; "The staff are great, everyone is very kind" and "They treat me lovely." People's relatives told us, "I find the carers really good, they look after [relative] really well and take time with them", "They [carers] are so kind and friendly", "They are very patient with [relative] who can be difficult at times" and "No-one can love them like you do, but they do their best." Prior to the inspection, we reviewed positive feedback from a relative regarding their experience of Cressington Court. The person told us, "Everyone is an individual at Cressington Court, they even receive individual, thoughtful Christmas presents, not just a generic one".

Although we found that staff were caring towards people living in the home, the provider had not addressed risks identified during the last inspection and this does not demonstrate a caring approach.

During our inspection we observed staff providing kind and compassionate care to those who were living at Cressington Court. We observed staff hoisting a person in a gentle and compassionate manner providing reassurance throughout.

Staff knew everyone by name and care files contained information such as people's likes, dislikes, routines, personal history and family relationships. This information ensured new staff could familiarise themselves with a person's background and social history which promotes conversation and rapport building.

Staff were observed showing respect for people's privacy by knocking on people's bedroom doors and requesting consent before delivering care. Staff knew how to preserve people's dignity by offering choice in ensuring the person was involved in their day to day decision making such as choosing clothes. We overheard natural dialogue between staff and people they supported which referenced that the person had reached the age of '100' and staff congratulated the person and shared some personal anecdotes. One member of staff told us, "I treat them as I would like to be treated."

Relatives told us there were no restrictions in visiting, encouraging relationships to be maintained. Relatives we spoke with told us they felt welcome and were often invited to stay for mealtimes. One person's relative told us, "I'm here 5 or 6 times a week." Another relative told us they sometimes spend the night with their loved one and there are no restrictions around this. We saw evidence of relatives communication notes recorded in care files.

We found that staff worked with the aim of improving or maintaining people's independence. People we spoke with told us staff encouraged them and allowed them to make decisions regarding their care. People told us they didn't feel there were any unnecessary restrictions imposed on them and any restrictions were only for their safety. One person told us, "I can come and go as I please, as long as someone is with me."

We saw that some care files contained information in respect of people's preference for a male or female carer. One care file documented 'always ensure female staff at night.' The provider spoke of their efforts to maintain a staff profile consisting of both genders at night to ensure that people felt comfortable when

receiving personal care.

Care records contained end of life documents to encourage people to consider their choices for the end of their lives. We saw that some people had anticipatory care plans within their files which included their wishes as they approached the end of their lives. For example, one person's plan recorded that they only wanted to be sent to hospital if absolutely necessary and in the event of physical ailment such as a fracture. We saw that DNAR (Do Not Attempt Resuscitation) forms were contained within some people's care files.

Requires Improvement

Is the service responsive?

Our findings

There was no activities co-ordinator employed at the service because the person previously responsible for activities had taken on a different role in the home and they had not been replaced. People told us that on occasions such as people's birthdays, the provider arranged for a singer come into the home but there was not much else to do. Comments included, "There are no activities at the moment, I sometimes get a bit bored" and "We could do with some more entertainment."

The National Institute for Clinical Excellence (NICE) states that people who provide accommodation to older people should 'offer regular group and/or individual sessions to encourage older people to identify, construct, rehearse and carry out daily routines and activities that help to maintain or improve their health and wellbeing.' People living at Cressington Court spent their time watching TV, listening to the radio or reading the daily newspaper but there was a lack of other activities. The layout of the lounge was very open plan with a range of different styled seating to suit people's individual needs. The carers also appeared to engage with people a lot and this was also reflected by people and relative comments. However, we found that people were not offered regular opportunities to engage in activities of their choice.

We recommend the provider review their activities provision to promote stimulation and people's well-being in accordance with the NICE guidance.

We saw that care files contained a pre-admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from the point of admission. However, we found that some care records contained a number of standardised risk assessments which were not personalised and were not reflective of the care people were receiving, for example, a wheelchair risk assessment for a fully mobile person and a catheter care risk assessment for a person that did not require a catheter. Whilst these assessments were not completed and marked 'non applicable', their inclusion in people's files could cause confusion for new staff. We discussed the need to remove the non-applicable assessments from people's files to avoid confusion.

Staff completed 'pain assessments in advanced dementia' and recorded information in a diary for one person who required it; however, for another person who was being cared for in the end stages of their life, a care plan for medication was basic and lacked detail. We did not find any records relating to pain management for this person.

Reviews of people's care records were being carried out, however we identified some gaps in recording and the review processes. We saw that some risk assessments, weight checks and evaluation sheets were not updated monthly in accordance with the provider's policy. Regular review systems are important so that the provider can be sure they are responsive to people's changing needs.

We found that information recorded in people's care plans was personalised and encompassed the individual needs of each person living at the home. We saw that these covered a variety of areas such as nutrition, breathing, elimination, moving and handling, communication, skin care and personal care safety

and comfort. We saw that people's likes and dislikes for their preferred daily routine, personal care and food preferences were documented.

People told us they generally felt involved in the development of their relatives care plans and there was evidence of family consultation within care files. One relative reported, "It's great we get involved all the time and can make changes whenever we need to." Another relative felt that there sometimes wasn't enough involvement but if they asked for more information, this was provided promptly and things were explained to them.

People had access to a complaint procedure which was clearly displayed at the entrance of the home. People knew how to complain, who to complain to and felt they were listened to. One person told us, "I haven't got any complaints." Of the relatives, we spoke with; some had made complaints but were not always satisfied with the response. One relative commented, "I have no problem in approaching them, but I'm not sure they always understand." Another person told us, "I can speak to any member of staff about the care of [relative] sometimes I don't think they respond to it, but they do appear to listen." We saw that complaints had been recorded and investigated appropriately.

We saw that the service had recently introduced a new handover document which was held by each member of staff outlining the needs of each person living in the home. We saw that some files contained a 'catheter passport' and others a 'client profile' which provided a short summary of relevant information in the event that the person had to be admitted to hospital. This helped ensure continuity of care when people transferred between services.

Inadequate

Is the service well-led?

Our findings

At the last inspection in May 2017, we identified breaches of regulation in relation to the well-led domain and this domain was rated as, 'Requires improvement.' Following the last inspection, the provider sent us an action plan which outlined what they intended to do to make improvements within the service to ensure it met the regulations.

During this inspection we found the provider had not addressed the concerns identified at the last inspection in May 2017 and continued to be in breach of regulation. People's medication was still not being managed appropriately and the service remained non-compliant with the principles of the Mental Capacity Act 2005. We also found that the required improvements had not been made to the audit systems and there was a lack of established and routine audit which meant some areas of the running of the home were not being effectively monitored.

We found there was no clear management structure in place at Cressington Court and a lack of clearly defined roles and responsibilities. The registered manager had been off work for some time and recently stepped down to become the clinical lead at the service. This was because they were required to complete a senior care role alongside their management responsibilities and did not receive the required support to meet the demands of this dual role effectively. The provider had not made robust contingency arrangements for someone to carry out the registered manager's role in their absence.

The provider worked in the home a few days a week and told us they were responsible for recruitment and the provision of out of hours 'on call' support. We spoke to the operations manager who told us they also assisted in recruitment and managed the day to day issues such as staffing. There was nobody identified as being responsible for the quality assurance aspects of the running of the home such as health and safety audits and checks on the environment.

The lack of clearly defined management roles meant that a number of the issues we raised with the provider had not been previously identified by them or the operations manager. This meant that systems in place to monitor the quality and safety of the service were not effective. We discussed the need for a full audit schedule to be implemented so that all areas of the home are being effectively monitored.

Of the few audits which had been completed, the management had not always responded effectively or promptly to the issues identified. For example, we looked at a provider audit completed in September 2017 and an external audit completed by Liverpool Community Health medicines management team on 6 October 2017 which identified a significant number of issues with medication. We found during our inspection on the 19 October 2017 that the issues had still not been rectified, for example, PRN protocols were not in place and fridge temperatures were still not recorded.

We found that the auditing procedures relating to accidents and incidents were insufficient as these had not been recorded or analysed since June 2017. We considered the provider response and reporting procedures to the local authority to be inconsistent as we identified a number of notifications which had not been made

in accordance with local reporting procedures. We found there was no clear rationale as to which incidents were referred to the Local Authority for investigation.

During this inspection, we found that recurring concerns, identified as far back as August 2015 in relation to compliance with the Mental Capacity Act, had still not been rectified. The provider remained in breach of regulation because applications for Deprivation of Liberty Safeguards were not made promptly.

We looked at processes in place to gather feedback from people and listen to their views. At the time of our inspection, there was no evidence of residents meetings taking place for people to voice their opinions or make suggestions. A recent provider action plan stated they intended to introduce 'quarterly meetings' to begin in January 2018. The provider told us that satisfaction surveys were sent out annually, last completed in March 2017, but were unable to provide evidence of this.

We found that aspects of people's confidentiality was compromised due to the provisions in place for storage of information at the service. We observed that people's care files and other confidential material was stored in unlocked rooms at the home.

These concerns have arisen as a result of a lack of overall governance and effective leadership.

These findings are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider is required by law to notify the CQC of specific events that occur within the service without delay. During the inspection visit we identified examples where this had not been done in respect of an unexpected death and incidents of pressures sores. The provider lacked knowledge in relation to their obligations in relation to the reporting procedures.

This constitutes a breach of Regulation 16 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People we spoke with were aware of who the management in the home and found them visible and approachable. We received positive feedback from staff who told us, "They will listen; they've always been there for us." Staff told us they would recommend the service "in a heartbeat" and said, "The staff team are like a little family unit, we work well as a team."

Staff told us they were encouraged to share their views regarding the service. We looked at staff meeting minutes and saw that the last record related to a meeting which took place in November 2016. However, staff assured us they took place regularly and more recently than November 2016.

Staff we spoke with were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Whistleblowing is where staff are able to raise concerns either inside or outside the organisation without fear of reprisals. This helps maintain a culture of transparency, and protects people from the risk of harm.

From April 2015 it became a legal requirement for providers to display their CQC (Care Quality Commission) rating. The rating from the previous inspection for Cressington Court was displayed for people to see in the communal area of the home.