

Ramos Healthcare Limited

Acacia Court

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?	Requires Improvement ●
Is the service effective?	Requires Improvement ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 2 and 3 August, 2017 and was unannounced.

Acacia Court is a care home service, registered to provide accommodation and personal care for people living with dementia. The care home is registered to accommodate up to 27 people and at the time of the inspection there were 25 people living at the home.

The home is a purpose built facility with accommodation located over three floors. The home itself comprises of two large detached houses which are joined together by an extension. There is a large lounge area; a dining area, a spacious garden to the rear of the property and a small car park is available at the front of the property.

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

During the comprehensive inspection which took place in April 2016, we found the registered provider was not meeting legal requirements in relation to safe care and treatment and nutrition and hydration. As well as not meeting the requirements in relation to the registered provider's duty of candour with respect to the information they were providing to the Care Quality Commission (CQC). The home was rated as 'requires improvement' overall and was served with a statutory warning notice in relation to medicines safety.

Following the inspection in April 2016 the registered provider submitted an action plan which outlined how they were improving the standards of care and quality of service. We conducted a focused inspection in December 2016 to ensure that they were meeting all legal requirements.

The provider had made improvement regarding the administration and storage of medicines which meant that the concerns which were highlighted in the statutory warning notice had been met.

At the last focused inspection we found that the provider was not always following best practice in relation to medication management. During this inspection we found that concerns still remained in relation to medication processes and systems which were in place.

The provider remained in breach of this regulation.

We observed the environment of the home and found that improvements were needed in a number of areas. The environment needed to be more stimulating for the people who were living with dementia. There was evidence of some attempt to provide dementia friendly areas but further work needs to be applied.

We have made a recommendation in relation to dementia friendly improvements.

At the last focused inspection we found that the provider was not meeting the requirements needed to support the overall governance of the service. During this inspection we found that the medication audit systems had improved and they were identifying the majority of errors which were occurring, monthly quality assurance audits were taking place by the provider and we saw evidence that health and safety audits, maintenance audits and care plan audits were being completed and responded to in a timely manner.

The provider was no longer in breach of the regulation in relation to good governance. However, we have made a recommendation in relation to quality assurance.

The home operated within the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We were provided with information in relation to mental capacity assessments, processes which needed to be in place to make decisions in a person's best interest and ensuring people were supported to have maximum choice and control of their lives. We were provided with evidence to suggest that people were supported in the least restrictive way possible and staff were aware that all 25 people who were living in the home had mental capacity assessments in place and DoLS applications had been submitted to the local authority.

Accidents and incidents were recorded in an accident and incident record book, which were then reviewed on a monthly basis. A monthly analysis was undertaken to mitigate the risk of such accidents and incidents occurring again in the future.

The day to day support needs of people living in the home were being met. An external healthcare professional we spoke with on the second day of the inspection was positive about the level of care and support which was being provided.

We observed staff providing individual support to people in a compassionate, kind and caring manner. Staff could explain the different levels of support which needed to be provided, specialist dietary needs of some of the people they were caring for, as well as likes, dislikes and preferences.

There was no dedicated activities co-ordinator in post however we were informed that different members of the staff team would ensure that there were different activities arranged for each day of the week. The range of different activities was varied, creative and encouraged people to get involved.

It was evident throughout the inspection that improvements had been made to care plans and risk assessments but further improvements were still needed. Staff were familiar with the most up to date care needs of some of the people we discussed and it was evident that the communication systems which were in place were proving to be an effective and useful source of reliable information. Communication systems ensured that staff were made aware of any significant changes which had occurred to a person's care plan and any risks which needed to be managed.

There was a formal complaints policy in place and people we spoke with were familiar with how to make a complaint. The complaints process was visible throughout the home as well as being available in each of the bedrooms. During the time of the inspection there was one on-going complaint which was being investigated. The complaint was being investigated in accordance with the provider's policy and had been responded to an effective and timely approach.

Staff we spoke with were positive about the support which the manager was providing. The people we spoke with, the relatives and an external healthcare professional felt that the home offered a safe, compassionate and friendly environment.

There was a range of different up to date policies and procedures available for staff. When we discussed policies and processes which were in place, staff were familiar with policies such whistle blowing, safeguarding, equality and diversity and medication policies.

Four staff personnel files were reviewed during the inspection and we saw that recruitment was safely and effectively managed. Processes which were in place demonstrated how effective recruitment practices were carried out. This meant that all staff who were working at the home had suitable and sufficient references and disclosure and barring system checks (DBS) in place.

We received positive comments about the food which was provided throughout the course of the inspection. The home tried to establish preferences, likes and dislikes from the outset in order to provide people with their own choices. People we spoke with as well as relatives expressed how that standard of food was "Brilliant".

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Medication processes for thickened fluids were not being followed in accordance with policy or procedure.

Risks were being reviewed but had not been updated in a timely manner.

Effective recruitment practices were in place which ensured staff had received the appropriate checks prior to working in the home.

Is the service effective?

Requires Improvement ●

The service was not always effective.

The environment wasn't adapted to support the needs of the people who were living there.

Staff were not effectively trained in supporting people who required thickened fluids.

Principles of the Mental Capacity Act, 2005 were being followed accordingly.

Staff were receiving regular supervision and appraisals were being conducted.

Is the service caring?

Good ●

The service was caring.

People told us that staff maintained their privacy and dignity

Observations demonstrated kind and compassionate care was being provided.

People we spoke with told us that staff were kind, polite and caring.

Is the service responsive?

Good ●

The service was responsive.

Staff were familiar with the support needs of people living at the home

Activities were organised, creative and stimulating

There was a complaints process in place at the home which was made visible and available for people to familiarise themselves with.

Is the service well-led?

The service was not always well-led.

Quality Assurance had improved but was still not always robustly managed. We have made a recommendation around this.

Health and safety audits were being completed and actions plans were being carried out.

Staff had a good understanding of whistleblowing and safeguarding processes.

Requires Improvement 

Acacia Court

Detailed findings

Background to this inspection

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

The inspection took place on 2 and 3 August, 2017 and was unannounced.

The inspection team consisted of one adult social care inspector, a pharmacist specialist 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.

Before the inspection visit we reviewed the information which was held on Acacia Court Care Home. This included notifications we had received from the provider such as incidents which had occurred in relation to the people who lived at the home. A notification is information about important events which the service is required to send to us by law.

A Provider Information Return (PIR) was also submitted and reviewed prior to the inspection. This is a form that asks the provider to give some key information in relation to the service, what the service does well and what improvements need to be made. We also contacted commissioners and the local authority prior to the inspection. We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, four support workers, the kitchen assistant, four relatives, three people who lived at the home, one healthcare professional and the hairdresser.

We also spent time reviewing specific records and documents. These included four care records of people who lived at the home, four staff personnel files, recruitment practices, staff training records, medication administration records and audits, complaints, accidents and incidents and other records relating to the management of the service.

In addition, a Short Observational Framework for Inspection tool (SOFI) was conducted on the second day of

the inspection. SOFI tool provides a framework to enhance observations during the inspection; it is a way of observing the care and support which is provided and helps to capture the experiences of people who live at the home who could not express their experiences for themselves.

We undertook general observations over the course of the two days, including the general environment, décor and furnishings, bedrooms and bathrooms of some of those who lived in the home, the dining room and lounge areas.

Is the service safe?

Our findings

A CQC medicines inspector looked at how medicines were handled, ordered and stored in the home. At the last inspection in December 2016, we found that issues had been addressed from our previous visit, but recording when creams had been applied and competency training for the administration of medicines needed to be improved.

Topical medicines such as creams and ointments were managed by care staff. A separate topical medicines administration record (MAR) folder had been created since the last inspection. We looked at five of the 17 records and saw the charts were completed correctly. There was evidence of 'when required' instructions and pictures to indicate where creams should be applied. The senior carer said the process was working well and regular checks ensured that all staff remembered to sign the charts.

We checked the records of a resident that required a powder to thicken their drinks because they had difficulty swallowing. We found that the thickened powder was not being given appropriately to minimise the risk of choking. There was no guidance to state what consistency the resident needed on their MAR or on the container. Staff we spoke with gave conflicting information. There was guidance in the care records from August 2016 but one staff did not think the prescribed consistency was now suitable. Staff were not recording when, or how much thickened powder was being used.

Following the inspection written guidance notices were made available, staff were reminded at handover and instructed to record when thickened drinks were given. An appointment for a new assessment was made with the local hospital and staff training arranged.

Medicines were stored securely in locked cupboards, temperature sensitive medicines were stored in a locked fridge and controlled drugs were stored correctly and stock balances were accurate. Maximum and minimum temperatures were recorded in accordance with national guidance, but there were occasions when a higher than recommended temperature was recorded without any further action being taken. A procedure was in place that did not make clear to staff what to do if the fridge was out of range. We raised this issue with the manager. According to records, there were no medicines in the fridge when it had been out of range so no harm had occurred on this occasion. The management felt there was no need to amend their procedures.

The thermometer in the medicines storeroom read 26oC throughout the inspection. Medicines should be stored below 25oC. Managers agreed to find a way to reduce the temperature in the room. We saw evidence of regular weekly and monthly medicines audits although the issues we identified had not been detected during these audits.

We watched some people being given their morning and lunchtime medicines. Staff gave medicines in a kind and patient way and records were signed after the person had taken their medicines. Staff clearly knew the residents well and knew the best way to give each medicine. The last report had highlighted that the carer who was giving medicines was responsible for answering the phone and we saw this again at this

inspection. If staff are distracted, they are more likely to make errors.

We looked at residents' medication administration records (MARs) and examined seven from the 25 residents' records in detail. All residents' records were well maintained to keep them safe. One resident had missed four consecutive doses of their asthma inhaler over a weekend due to lack of stock. Inhalers help to manage asthma symptoms and should be used consistently as prescribed by a GP. We raised this issue with staff during the inspection and discussed adding the inhaler stock balance to the medicine chart so prevent this happening again. We saw that medicines given 'when required' were managed well and additional information was clear in records to help staff administer medicines safely.

This is a breach of Regulation 12(1)(2)(a)(b)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we looked at the records of two residents receiving medicines disguised in food or drink. We saw documentation showing this had been agreed as being in their best interest. The records were detailed, and contained enough information for staff to manage this properly. The pharmacist had advised the home how to disguise each medicine without reducing its effectiveness.

Throughout the inspection we received positive feedback from people who lived at the home, relatives and external healthcare professionals. Comments we received included "It's excellent here, the staff are very kind and I know [relative] is safe here, [relative] is absolutely cared for and looked after". One person expressed "They're [lovely] they do so much", and one external person commented "I have no concerns whatsoever, they're safe and the staff respond to situations quickly".

Care records and risk assessments we reviewed were largely up to date and did contain relevant information although it was discussed that records needed to be updated in a timely manner. For example, a person had suffered quite a considerable fall in the month of July but this had not been updated in the person's care plan or risk assessment. Another example included guidance which had been provided by a Speech and Language Therapist (SALT) which suggested a 'soft, mashed diet, individual sips of normal fluid and to offer full assistance if required', when we then reviewed nutritional care plans or risk assessments this information had not been transferred across to the relevant documentations. We discussed this with the manager who ensured the relevant paperwork was updated as required.

The home had six designated ground floor fire exit points which had been identified in the event of an emergency. Prior to the inspection there had been concerns raised in relation to one of designated fire exit points being accessible to people living in the home. When we discussed fire exit points with the manager, it was confirmed that there had been an incident whereby a door leading to the fire exit had been left unlocked and person who used the service had absconded and therefore was subject to harm. We discussed the importance of having measures in place in order to maintain the safety of building but to also ensure that fire exits were not accessible to vulnerable people.

Following this incident, the registered provider ensured that a sensor was fitted to the door leading to the fire exit point which meant that if the door was left open the sensor would sound and staff would be alerted.

Accidents and incidents were recorded and analysed by the registered manager on a monthly basis to identify trends and patterns. For example, the manager discussed how the creation of two new shift patterns (6am until 2pm and 2pm until 10pm) had been created after establishing that these were high risk times of the day. We found that accident and incident forms were completed in a timely manner and staff were made aware of any situations which had occurred through one of the three daily handovers which took place.

We saw evidence risks being assessed and plans being put in place to ensure the safety of the people living in the home was paramount. For example, we saw evidence of re-positioning charts in for people who needed extra care and support in relation to skin vulnerability. We saw food and diet charts as well as there being a dedicated member of staff who was committed to monitoring the weight of people living in the home. We also found evidence of up to date and relevant nutrition, waterlow and falls assessments in place.

There was enough staff in post to meet people's needs. Typical staffing levels during the day comprised of registered manager, four care staff, senior member of the care staff, kitchen staff as well as domestic staff. Of an evening there was one member of staff working up until 10pm with two wake-in night care staff. The manager expressed that there had recently been some difficulties covering shifts, particularly night shifts but the staffing teams across the two care homes which the provider owned supported each other.

The provider and manager used a dependency assessment scale to determine whether or not staffing levels were appropriate for the level of support which was required. At the time of the inspection, the provider was appointing a new deputy manager to support the registered manager as well as appointing new care staff to support with the creation of the two new shifts.

There was an effective process in place to attend to any maintenance/emergency repairs which had been reported via on-line application system. The maintenance/emergency repair would be 'uploaded' on to an on-line system; the director would be informed of what needed to be attended to and endeavour to respond to this in a timely manner. For example, we saw evidence of there being issues with the hot water temperatures in a shower room. This was reported immediately by staff and the problem was resolved on the same day. Another example was a toilet door which needed to have signage replaced, this was reported and within two days the signage had been replaced.

We reviewed health and safety records of the home during the inspection and found that all required audits, action plans and certificates were in place. Records confirmed that gas appliances, electrical equipment testing, legionella testing and fire risk assessments all complied with statutory requirements. We reviewed a number of health and safety checks which should be conducted in order to maintain the level of safety standards which are required. Checks which were being routinely completed included window restrictor checks, mattress checks, emergency nurse call system, first aid supplies, water temperatures, wheelchair checks and fire extinguisher checks.

Personal emergency evacuation plans (PEEPs) were in place which outlined how people should be supported in the event of an emergency. There was a main folder containing the PEEP information as well as the information being made available on each of the floors where people were living. PEEPs could also be found in the fire safety book in the manager's office.

We spoke with staff about their knowledge and understanding of safeguarding procedures and they were clearly able to describe how to report any concerns. This helped to ensure people were protected from the risk of abuse. There was also an up to date adult safeguarding policy in place.

We reviewed four staff personal files and there was evidence of safe systems being in place to ensure the staff that were recruited were suitable to work with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Records included completed application forms with full employment histories, interview questions and answers, two suitable references and full pre-employment checks. Confirmation of identification was evidenced in files, and Disclosure and Barring Service (DBS) checks had been suitably carried out. DBS checks ensure that staff who are employed to care and support for vulnerable people are suitable to work within a health and social care setting. This enables

the registered manager to assess level of suitability for working with vulnerable adults.

Is the service effective?

Our findings

People were supported and cared for by trained staff who were familiar with people's needs, wishes and preference. One person said "I'm better off here than at home where there was no one to keep an eye on me" Another person said "It's nice and quiet and they [staff] leave me alone when I tell them to". One relative expressed "[Relatives] health is well managed, [staff] know [relative], I get regular updates, it's excellent". One external healthcare professional commented "The staff are great, they report things quickly, they follow guidance and the communication is efficient".

We observed the environment of the home and found that improvements had been made since the last inspection in a number of areas but further improvements could still be made. Accessibility to the garden area had been raised on previous inspections by family members. There was no available ramp for people to access the garden area. When we discussed this with the registered provider we were informed that they were waiting for the planning permission to be confirmed before they could proceed with the adaptations.

We found that larger pictures and names had been placed on each of the bedroom doors so people could clearly identify themselves and their own room, a large 'Acacia Court' family wall tree had been designed for people and relatives to identify the staff team and to enable people to put 'faces to names' and there was decorative wall art placed up around the home to provide a 'homely' feeling. However, the colour, contrast and lighting scheme throughout the home could be improved in order to support people living with dementia.

People living with dementia perceive their surroundings differently. Environments should be adapted to help people interpret their surroundings and be able to navigate themselves around the home in safety. Identifying different colour, contrast and lighting schemes for people living with dementia will help benefit people living in the home as well as improving their quality and standard of care.

We recommend that the provider seeks guidance from a reputable source in relation to dementia friendly environments and how best to support people who are living with dementia.

A variety of training was provided for all staff in order for them to effectively fulfil their roles. Staff completed specific training such as safeguarding training, fire awareness, medication awareness, first aid and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of their induction. Staff were also required to complete dementia awareness training and the home manager had completed the accredited 'End of life' care training. It was identified that further training and understanding of thickened fluids needed to be arranged. During the inspection we found that staff were not effectively following the guidance which had been provided by the SALT team and therefore were not effectively supporting the needs of the person. This was discussed with the manager at the time of the inspection and they were sourcing the training from the local speech and language therapy team (SALT).

Staff expressed that they felt supported in their role. Staff received regular supervision as well as appraisals throughout the course of the year. Supervision enables management to monitor staff performance and

address any performance related issues. It also enables staff to discuss any development needs or raise any issues they may have. Appraisals are used to identify goals and objectives for the year ahead to ensure staff are supported to develop within their role.

Staff received an induction and new staff were enrolled on to the Care Certificate. The Care Certificate which was introduced by the Government in 2015 is a set of standards that social care and health workers comply with in their daily working life. The care certificate is a new set of minimum standards that can be covered as part of induction training of new care workers.

The Mental Capacity Act (MCA) 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

DoLS applications had appropriately been made to the local authority and staff were aware of the MCA principles and how they needed to be complied with. Staff had received the necessary training in relation to MCA and DoLS and the registered provider had consulted relevant guidance and best practice in relation to MCA and DoLS principles. Mental capacity assessments and DoLS applications had been completed where required. For example, we saw evidence of a person requiring bed rails as a measure to monitor and mitigate risk. We reviewed the paperwork which was in place and found that the person had been appropriately assessed and the introduction of bed rails was found to be in the persons 'best interest'.

At the last inspection we could not find evidence of 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) plans for some people who were living at the home. During this inspection we found that the manager had consulted the MCA guidance and embedded the correct procedures which needed to be in place for people who wished for their end of life care to be known. There was evidence of the DNACPR plans in care records as well as there being evidence of the relevant consultations taking place with GP and relative or representative.

During meal times people received the support they needed from staff. For example we observed staff cutting up lunch time meals and encouraging people to eat independently. People were also given the option of have seconds if they wished, and plenty of fluids were made available to people. We observed positive interactions and engagements between staff, people who lived in the home and relatives who were visiting. We joined people for lunch on both days of the inspection and found that tables were nicely presented, there was a large pictorial menu available for people to read and a variety of drinks and fruit made available for people living in the home as well as visitors.

People we spoke with were positive in relation to the food and drink provided. For example, comments included "The foods brilliant", "I can't fault the food" and relatives expressed "The food is wonderful" and "They [staff] always come round to ask what [relative] wants to eat and they know [relatives] likes and dislikes". We observed alternative dishes being served on both doth days of the inspection as well as pureed food being well presented and being visibly appetising for people who were required a specialist diet.

People were being weighed regularly and weights were being recorded and monitored. At the time of our inspection each person in the home people were being weighed using a variety of methods and any concerns which were recognised was immediately discussed and referrals were made to the necessary dietetics team. During the inspection we saw evidence of weight management records in place in each of

the care files as well as the necessary food and fluid charts which were in place for a number of people who were living in the home. People also had access to external health professionals and there was evidence of regular health check-ups and routine appointments taking place.

Is the service caring?

Our findings

During the inspection we observed staff positively interacting with people who lived at the home. Staff were very familiar with individual support needs and were able to provide person centred care. Observation between staff and those living at the home was caring, kind and compassionate. We received positive comments from everyone we spoke to, comments included, "The staff are very caring, very considerate and [relative] is always saying how happy [relative] is here", and "its brilliant here, [relative] has settled in so well [relative] they're [staff] all so caring, they [staff] know all of [relatives] care needs.

We observed staff providing support to people during the inspection in a manner which protected their dignity and privacy. We observed staff knocking on bedroom doors before they entered, we observed staff explaining what support they were providing, we witnessed staff supporting a vulnerable person in a dignified and respectful manner as well as staff having genuine and friendly conversations with people. One relative expressed "[Relative] is so happy and content here, I know [relative] is well cared for".

Staff expressed that they encouraged people to remain as independent as possible within their abilities. Staff described how they would encourage people to make day to day choices where possible such as encouraging people to choose what clothes they wished to wear, what food and drink they would like to have, involving themselves in the different activities and even encouraging people to help in the garden with the newly created vegetable and herb patch.

We were informed that the home would always celebrate birthdays and special events. One family member expressed "They [staff] celebrated [relatives] birthday, [staff] got a birthday cake. [Relative] is well looked after". Relatives expressed that they were involved in the care their relative was receiving from outset, best interest meetings were taking place in accordance with MCA and relatives were involved in such processes when appropriate. For those who did not have any family or friends to represent them, contact details for a local advocacy service were made available at the home. At the time of the inspection there was one person being supported by a local advocate. An advocate is someone who understands the duties involved in helping vulnerable people make decisions.

Staff were able to demonstrate their knowledge and understanding of people's support needs throughout the course of the inspection. Staff would always use first names when addressing people they were talking to, staff were committed to supporting people when they were requested to and it was evident that people were happy to receive the support from the staff who were providing the care.

Positive relationships between staff and people living in the home had developed. Staff always appeared attentive and compassionate as well as being able to demonstrate how they could support people who became particularly distressed. For example, one person became quite distressed and anxious over the lunch time period. Care was kindly given by a number of different staff; the staff offered genuine, compassionate care and they were able to support the person without causing any further distress.

When staff were asked of any particular support needs of people living in the home they were able to

provide detailed information in relation to their specific care needs and risk assessments. For example, one staff member was able to explain how one person had a gender specific preference when receiving personal care; the staff member explained how this preference was always accommodated.

Is the service responsive?

Our findings

We observed staff engaging well with people in the home over the course of the inspection. Staff demonstrated their skills and knowledge when supporting people and responding to people when they needed to. Staff provided compassionate care and it was evident that they were familiar and responsive to the care needs of the people who were living at the home. Positive comments we received included, "They [staff] know all of [relatives] care need, they know [relative] by first name ...we're very happy that [relative] is here and we know [relative] is happy here too as well as "[relative] is very happy here and I'm confident that [relative] is being looked after, they [staff] will always provide me with updates when I need them".

Care records were being reviewed on a monthly basis and there was good level of information being captured about the person before they began living in the home. Daily records, external professional health care records and relative communication records were regularly being updated which provided detailed information about the persons change in circumstances and day to day care needs which was being supported. We saw a range of different care plans in place for the different areas of care which needed to be supported such as medication, eating and drinking, behaviour, mobility, risk of falls and sleeping routines.

There was a 'My life history' in place which provided staff with information about the person's childhood, special memories, relatives, enjoyments and likes and dislikes. Providing this level of information enabled the staff team to develop a good level of understanding about the person and provide a person centred approach to care. For example, one care plan that we reviewed stated '[person] likes to get up between 9am and 10am, likes cornflakes and jam on toast as well as coffee with one sugar' another care plan identified how the person 'liked' be called be called a certain name and not by their birth name as well as this person liking 'a strong cup of tea, nice clothes, to have hair done regularly and listening to specific music on the radio'.

People were sufficiently assessed from the outset and we did see evidence of care records and risk assessments being regularly updated with relevant information although this is still an area which needs further improvement. We found that certain accidents or incidents which had occurred were then not captured in care plans or risk assessments in a timely manner. This meant that when there was a delay in records being updated, staff may not have been aware or familiar with the most up to date and relevant care needs and areas of risk which they would need to respond to.

There was no dedicated activities co-ordinator in post at the time of the inspection but we were informed that the care staff were encouraged to be arrange and organise activities as part of their roles. We saw a range of different activities advertised on the main foyer notice which contained details of pamper afternoons, easy listening sessions, sports afternoon, gardening and potting plant sessions, morning coffee and homemade cake mornings as well as knitting sessions and sing-along sessions. The large, colourful and pictorial notice board also provided people, visitors and relatives about 'The latest news' within the home such as the introduction on of the vegetable and herb patch as well as information in relation to the end of life care.

The feedback we received from the relatives about the activities was positive. One relative expressed "There's always lots of events going on, there's been a summer fair, Christmas parties, they [staff] are always trying to keep residents busy" and another relative expressed "Oh yes [relative] gets involved with the different activities, I know there's arm chair exercises, a range of different creative activities as well as summer and Christmas parties".

There was formal complaints policy in place and people and relatives were made aware of the complaints process. The procedure for making a complaint was clear and visible around the home and each bedroom contained a notice board with the complaints process available for people to read and familiarise themselves with. We were provided with a compliments and complaints folder and how these were recorded, how they were investigated and how they were responded to in a timely manner. We asked a relative if they were aware of the complaints process and they expressed "Yes I do and there's information in the bedrooms too but to be honest if I had any problems I'd just come to [manager] [manger] is really responsive and listens".

Newly revised handover sheets and communication books were being used by all staff. The handover sheet informed staff who the appointed first aid person was on each shift, who the allocated fire warden was and who was responsible for the controlled drugs keys. Significant information about the people who lived in the home was discussed. For example, all staff were made aware of who had received or due to receive district nurse visits, GP visits, hospital appointments and admissions as well as information in relation to social outings or activities, relative visits and concluded with an overall handover of each person living in the home.

Three handovers took place each day; this provided all staff with the relevant information in relation to the day's events. The methods of communication enabled staff to familiarise themselves with the care needs and risks which needed to be managed. One member of staff commented "The communication is really good here". One relative also expressed how the communication of the staff team was "Excellent".

Is the service well-led?

Our findings

At the previous inspection we identified a breach in regulation in relation to the service being well-led. Quality assurance systems and audits were not effectively in place which meant that the standards of the home were not being effectively monitored. During this inspection we found that there were a number of effective quality assurance systems in place. We saw evidence of monthly audits being conducted by the service director as well as action plans which had been completed in a timely manner. Evidence of actions which had been completed included full house heating refurbishment system, additional seating in the lounge area, new stainless steel kitchen appliances and a staff room refurbishment.

Other quality assurance systems which were in place included monthly care plan and risk assessment reviews being conducted by the service manager and quarterly provider's audits which was completed by senior managers. This quality audit focused on aspects of service delivery which included care plans, charts and monitoring, the medical room, staffing and service and maintenance records. There was an up to date "Business Continuity Plan" (BCP) in place which contained emergency contact details of both internal and external services as well providing advice and guidance to staff in the event of an emergency situation.

As well as internal audits which were completed there was also support provided by Liverpool NHS Trust. At their last audit visit, Liverpool NHS Trust recorded that the service needed to make a number of improvements in relation to infection control. When we reviewed the action plan which had been implemented, we found that all actions had been completed. For example, a new cleaning policy and procedure needed to have been implemented, there needed to be an updated hygiene policy and clean and unclean lined to be managed separately to manage cross contamination.

We reviewed a number of different quality assurance systems which were in place as a measure to maintain the quality and the safety of care being provided. Audit systems we reviewed included medication audits, health and safety audits, fire safety audits, infection control audits and housekeeping audits. Medication audits were not always effective. For example, they did not identify the issues we identified in relation to thickened fluids or medication temperatures. When we discussed this with the manager, they explained that changes would be made to the audit tool to reflect our findings and to ensure that processes which were in place would be strengthened.

We found that sufficient improvements had for the provider to be no longer in breach of this regulation. However, we recommend that the registered provider continues to consider their approach to quality assurance by referring to relevant best practice guidance.

Staff we spoke with were complimentary about the registered manager. One staff member expressed "[manager] is very approachable and very supportive-great manager" another staff member commented "[manager] is one of the fairest managers I've worked with" and the feedback from relatives we spoke to was positive. One relative expressed "Anything we need, we can just ask. The staff are always here if you need anything and [manager] is brilliant" and another relative said "It's excellent here, the staff and the manager is very caring and considerate-I'd come here myself if I had to".

All of the staff we spoke with expressed how much they enjoyed their jobs. One staff member said "I enjoy working here, it's a challenge at times but it's a great place to work". Another staff member said "there's lots of support, lots of training, we all work really well together and [manager] has an open door policy...it's a warm, friendly environment". From the observations which took place and also from the relevant discussions held with staff and relatives it was evident that there was an open and supportive culture within the home which promoted a person centred approach to care and support.

Team meetings were regularly taking place. Meeting agenda items included resident care plans and risk assessments, staff training, policy updates, activities, home improvements, team dynamics, medication processes, professional visits, maintaining privacy and dignity as well as complaints and health and safety.

Policies we reviewed included safeguarding, equality and diversity, data protection, medication and whistleblowing policies. Staff were able to describe their understanding and knowledge of such policies as well as explaining how to report any safeguarding incidents. We asked to review the different policies in place at the home and we were provided with up to date and accessible policies and procedures.

'Relatives' meetings were taking place however it was identified that 'group' relative meetings were proving unsuccessful. The manager explained that other alternatives had been explored but attendance was poor. The manager had decided to implement 'One to one' family meetings where discussions were held in relation to care plans and risk assessments, activities, nutrition and hydration, personal care, refurbishments which were taking place and healthcare support needs. When we asked a relative their opinions about the one to one meetings they expressed "[manager] offered us a few different dates to choose from, we picked a time and date to discuss different things, it was great. I learnt things about [relative] that I didn't know [relative] was involved in, such as the different activities, its lovely knowing [relative] has a good quality of life here".

Annual satisfaction surveys had been circulated to residents and relatives. The results of the surveys enabled the management to review the feedback of those living at the service and their loved ones who visited. The feedback received was particularly positive, with 81 per cent of people/relatives being happy with the service provided and 18.2 per cent of people and relatives feeling 'content' with and a very select few expressing they were 'sad' as they wanted to 'return to their families'. The survey returned 100 per cent of people and relatives being happy with the staff who were providing the care.

As of April 2015, providers were legally required to display their CQC rating. The ratings are designed to provide people who use services and the public, with a clear statement about the quality and safety of care being provided. The ratings inform the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for the home was displayed for people to see. The provider did not have a website at the time of inspection as this was under development. The provider is aware of their legal and regulatory responsibilities to display their rating once their website has been completed. This will continue to be monitored by the CQC. Statutory notifications were being submitted in accordance with regulatory requirements.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medication management procedures were not being safely or effectively managed.