Innocare Limited

Riverslie

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

Riverslie provides residential and nursing care for up to 30 people. Accommodation is provided over three floors, with a dining room, lounge and bedrooms on the ground floor. A passenger lift and ramps allow access to all parts of the home and the large enclosed garden.

This was an unannounced inspection which took place on 1, 4 and 6 April 2016. The service was last inspected in September 2015 and at that time was found in breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 which covers consent to care and treatment.

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 inspection we found breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 relating to medicines and the home's governance arrangements.

We reviewed the way people's medication was managed. We saw there were some good systems in place to monitor medication so that people received their medicines safely. However, we found some storage was not being monitored, some people's medicines had been missed, some medicines given 'when required' lacked supporting protocols and external medicines [creams] were not being recorded appropriately.
The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally by staff and from a visiting senior manager for the provider. We found some of these were not currently developed to ensure the most effective monitoring and in some areas there needed to be developments to ensure standards were identified and continually maintained.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home. We discussed the fact that a notification had not been made following two recent safeguarding investigations.

We found the outstanding breach of regulation regarding gaining peoples consent to care was now met. Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made and decisions made in the person's best interest.

The managers had made referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the applications were not fully completed and were not being fully monitored by the manager.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw checks had been made so that staff employed were 'fit' to work with vulnerable people.

Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Planned development / maintenance was assessed and planned well so that people were living in a comfortable environment.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. Staff were able to explain each person's care needs and how they communicated these needs. People we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the right care.

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

People we spoke with said they were happy living at Riverslie. They spoke about the nursing and care staff positively. When we observed staff interacting with people living they showed a caring nature with appropriate interventions to support people. Staff had time to spend with people and engage with them.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

We discussed the use of advocacy for people. There was information available in the home regarding local advocacy services if people required these. We were able to get an example of the use of advocacy for one person.

We asked people how their care was managed to meet their personal preferences and needs. People were satisfied with living in the home and felt the care of offered met their care needs.

People we spoke with said they were consulted about their care and we saw some examples in care planning documentation which showed evidence of people's input. This was not consistent however as we saw other care records and plans that displayed very little evidence of people's input.

Activities were organised in the home and these were appreciated by the people living at Riverslie. We saw some activity organised on all of the days we visited. The staff member who organised activities person was motivated to provide meaningful activities.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We could not find any obvious display of the complaints procedure in the home and this was addressed during the inspection. We saw that a record was made of any complaints and these had been responded to.

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

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.

We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

We found that people had had risks to their health effectively monitored.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There were enough staff on duty to help ensure people's care needs were consistently met. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards had been assessed and effective action to reduce any risk had been taken.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the applications to the local authority under the Deprivation of Liberty Safeguards were not fully completed and were not being fully monitored by the manager.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

Overall we found the home supported people to provide effective outcomes for their health and wellbeing.

We saw people's dietary needs were managed with reference to

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

Is the service caring?

Good

The service was caring.

When interacting with people staff showed a caring nature with appropriate interventions to support people. Staff had time to spend with people and engage with them.
People told us their privacy was respected and staff were careful to ensure peoples dignity was maintained.

There were opportunities for people to provide feedback and get involved in their care and the running of the home.

Is the service responsive?

Good

The service was responsive.

Care was planned with regard to people's individual preferences.

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

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a registered manager in post who provided a lead for the home.

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

The Care Quality Commission had not been notified of some reportable incidents in the home involving safeguarding investigations.

There was a system in place to get feedback from people so that the service could be developed with respect to their needs and wishes. These included regular meetings and other formal processes.

We found the management structure to have developed with clear lines of accountability and responsibility which helped promote good service development.

Riverslie

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 1, 4, 6 April 2016. The inspection was undertaken by an adult social care inspector.

During the visit we were able to meet and speak with seven of the people who were staying at the home. We spoke with two visiting family members and a family member by phone following the inspection visit. As part of the inspection we received feedback from three health and social care professionals who visit the home and who were able to give us some information regarding how the service supported people.

We spoke with 10 of the staff working at Riverslie including nursing staff, care/support staff, kitchen staff, domestic staff, the registered manager, deputy manager and a senior manager. We also spoke briefly with the nominated individual for the provider [owner] of the home who contacted us by phone.

We looked at the care records for four of the people staying at the home including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Requires Improvement

Is the service safe?

Our findings

At our previous visit in September 2015 we had some concerns about the way medicines were managed and administered within the home and we made a recommendation that systems were further developed. We spoke with the nurse in charge responsible for the safe management and administration of medicines in the home on the day of our inspection. We looked at Medication Administration Records (MARs) and care documents for four people who received staff support with their medicines.

Medicines were stored safely and were locked away securely to ensure that they were not misused. Staff had signed the MARs to evidence medicines had been administered to people. The MARs were easy to follow and it was clear what medicines had been received and were being carried over from the previous month.

We asked about people who were on PRN [give when needed] medication, for example for pain relief. We found clear care plans had been draw up to include supportive information for these medicines. The importance of a PRN care plan is that it supports consistent administration and on-going review.

There was one person having medicines given 'covertly' [without their knowledge in their best interest]. We saw that the nurse in charge was aware of best practice issues around this and these had been followed. The supporting care plan was clear and issues regarding consent had been clearly recorded.

Care records we saw confirmed that some people had been reviewed recently by a visiting GP.

Although we found that improvements had been sustained in some areas of medication management there were some anomalies that require further action to ensure all medicines were being administered safely.

We saw that some people were prescribed external medicines such as creams. We were told by the nurse that these were generally administered by care staff. We asked for records to identify which staff had administered the creams but these records were not completed appropriately. For example one record identified one cream to be administered but then recoded a number of creams. There were gaps in the chart so it was not clear if creams had been administered on some days. When creams were signed for by staff the cream was not identified in many instances. The record was unclear and confusing.

We spoke with another person who told us the cream they usually had administered by the night staff had not been administered that morning. The records indicating whether the cream had been given were unclear. There was no record on the persons 'cream chart'. This had not been completed for the past two nights.

We discussed the need to keep accurate administration records for staff who had administered medicines including creams. This had been an issue in the home previously.

One person was prescribed a medication at night. The MAR had been signed as given for the previous two nights. When we completed a stock check of the medicines we saw that none of this medicine had been

administered. This meant the person had not received this particular medicine for the previous two nights. The deputy manager explained that the error made was by an agency nurse and this was followed up after the inspection.

Although PRN care plans were see for a number of people on such medicines this did not extend to people on inhalers for chest conditions who had been prescribed these for use when necessary. It was unclear in what circumstances these were to be administered. It also meant that these medicines might not be evaluated or reviewed regularly in line with other aspects of the person care plan. We saw one person who was clearly not administering their inhaler correctly (they self-administered this) but this had not been formally identified. We discussed this with the nurse in charge who said they would review.

We saw a set of draws in medication storage room. The nurse in charge was unaware of the contents of this storage facility. We found some out of date medicines [water for injections] which the nurse was not aware of. Although other storage areas were identified on audits and were subject to regular checking this storage facility had been omitted.

We looked at a recent medication audit carried out by the manager on 8 March 2016. The audit tool included most areas of medication administration and safety. We saw however that the issues we had identified above had not been picked up on the audit. Some, (PRN care plans and all storage areas) were not on the audit tool. In some examples we found entries on the audit which contradicted some findings we made. For example an entry regarding the quality of the medications records said, 'The current MAR's are stored in a ring binder which is in good repair'. This was not the case when we looked at the record binder which was in poor condition.

These findings were a breach of Regulation 12(1) g of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection in January 2016 we received information following a review by social services contracting officer that the home may be experiencing some staffing issues with respect to provision of nursing staff cover. This had meant the registered manager and other nurses having to work extra hours to cover. We also received some information from a social worker that a person had complained about waiting an excess amount of time to receive personal care.

When we visited the home we checked to see if there were sufficient staff to carry out care in a timely and effective manner. We were told by the deputy manager that there had been some issues with nursing staff leaving and having to be replaced and that this had now been addressed. This had meant that the registered manager had covered a lot of the night shifts in recent months. The registered manager sometimes covered the nights to ensure consistency for the people who used the service, whilst the deputy manager ensured on-going effective running of the home during the day. We were told about a new nurse commencing night duty and this was confirmed on the duty rota.

There were 23 people living in the home at the time of our inspection. There was a nurse on duty on all three days of the inspection together with four care staff. In addition the home employed staff for 'activities' who was also observed to assist with meals and observations of people. There were ancillary staff such as an administrator, kitchen staff (all day), domestic cover and a person working in the laundry. When we looked at the duty rota we saw these staffing figures were reflected for the week of our inspection. We saw, however that in the previous week the care staff numbers had been reduced to three [from four] on five occasions. We clarified this with the registered manager and the operations manager who stated that four care staff was the standard to provide a good standard of personal care for people and this would be more consistently

applied going forward. The operations manager showed us the dependency assessment tool used to help ensure the right amount of staff were on duty. This had assessed the home as currently having enough staff.

During the inspection we made observations in the day area/lounge and spoke with people. The feedback was consistent in that people felt they were supported well and there were enough staff available. One person said, ''Yes I get good care. The staff are always there for me.'' another said there had been staffing inconsistency on nights, ''But generally there are enough staff available.''

The observations we made evidenced staff always available. We observed staff attending to people and supporting them to eat and drink as well as assisting with aspects of personal care. One staff told us, ''We are not rushed and can spend time with residents.''

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

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the Local Authority safeguarding team were available. A safeguarding incident had occurred regarding the management of wound care for one person. The home had liaised and worked with the safeguarding team to ensure issues were followed up and any lessons could be learnt.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We saw the general environment was safe. We observed some minor environmental issues that we reported to the maintenance person and these were addressed immediately. In particular we discussed the safety of the key pad used by staff to enter the home as ex member of staff had possession of the code. The registered manager said they would look at any issues surrounding this to ensure access to the home was safe.

A 'fire risk assessment' had been carried out and updated at intervals. We saw personal evacuation plans [PEEP's] were available for the people resident in the home to help ensure effective evacuation of the home in case of an emergency. We spot checked other safety certificates for electrical safety, gas safety and kitchen hygiene and these were up to date. This showed good attention with regards to ensuring safety in the home and on-going maintenance. We spoke to the maintenance person who told us the home was managed in this area so that any issues could be quickly picked up and dealt with if needed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2015 we found the home in breach of regulations covering consent to care and treatment because when people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed in that an assessment of the person's mental capacity was not made.

We looked to see if the home was working within the legal framework of the Mental Capacity Act (2005) [MCA]. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

On this inspection we found requirements were being met and people who lacked capacity to make certain decisions were now assessed appropriately.

For example we looked at one person who was being administered their medications 'covertly'. This meant without their knowledge. We saw that the person had been carefully assessed using the appropriate assessment tool regarding their capacity to consent to their medication administration and assessments had also included input from the pharmacist and GP. It was felt the person needed the medicine in their 'best interest' to ensure their health was maintained. The care plan contained good detail. This process showed a good understanding of the principals of the MCA and how they should be applied to ensure people's rights were protected.

We saw other examples where restrictions had been applied regarding people's care; for example when bedrails were in use. We found that risk assessments also included a measure of the person's capacity to consent. We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made and we could see the person involved had been consulted regarding this and, when necessary, the person's relatives. The DNACPR form we saw contained an assessment of capacity by the GP.

We found the home supported people who were assessed by the home as requiring authorisation to deprive them of their liberty. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (2005) and aim to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The deputy manager had made seven applications to the local authority for people who lacked the capacity to make a decision to stay in the home. We reviewed the applications for two people and saw the application had not been fully completed. We were told staff had been trained in how to complete the applications and the applications were completed as trained. The applications had also been accepted and processed by the DoLS team; therefore, the staff at Riverslie were not informed that there was any error. Staff, when questioned, were not fully understanding of the process involved. Staff were also not clear whether people had been assessed following the applications or at what stage the application was at as there was no record of this to show applications were being fully monitored. The deputy manager said this would be addressed. We (the Care

Quality Commission) would also be notified of the outcome of the applications. We observed staff provide support at key times and the interactions we saw showed how staff communicated and supported people and ask their consent to care. When we spoke with staff they were able to explain each person's care needs and how they communicated these needs.

We received feedback from three different health and social care professionals who were involved in the support of people at Riverslie. One professional told us the staff were caring but were not always very proactive in referring people who may need health input or follow up. We were given two examples when professionals considered people should have been referred to hospital earlier and the home had relied on visiting professionals to instigate this.

We reviewed the care of two people in detail on our inspection as well as asking about aspects of other people's health care and how effective this was. Each person's care file included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were well documented and followed through. For example one person had a specific medical diagnosis requiring careful monitoring and awareness by staff of key areas of risk. We saw these were explained in the care plan. The person told us they were supported by staff to attend routine medical appointments and we saw their health status was being monitored effectively.

Another person was very frail and needed support around dietary input. They had experienced a severe chest infection in recent months and had previously had a pressure ulcer. We saw the person who told us they were satisfied with the care by staff and felt they were being ''Well looked after.'' The person's care records showed evidence of regular input and review by health care professionals including the person's GP and a dietician. We saw some records that tracked the development of the pressure ulcer; the detail of these could have been improved and this was discussed. However, the records indicated effective care input as the wounds had now been healed. We had one concern regarding this person as they had lost some additional weight recently which had not been picked up by nursing staff and they were not aware of this recent weight loss. The registered manager and deputy said this would be followed up. This omission did evidence comments by visiting care professionals regarding the need for the home to be more proactive on occasions.

Generally we saw that care plans had been regularly reviewed and updated with reference to any external health support needed.

People we spoke with and relatives told us that staff had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. We looked at the training and support in place for staff. The deputy manager supplied a copy of a staff training calendar and records for training undertaken and planned. We saw training had been carried out for staff in 'statutory' subjects such as health and safety, safeguarding, infection control and fire awareness.
The registered manager informed us that many care staff had a qualification in care such as QCF (Qualifications Credits Framework) and confirmed this after the inspection visit telling us 100% of staff had attained a qualification.

Staff spoken with said they felt supported by the manager and the training provided. They told us that they had had appraisals and there were support systems in place such as supervision sessions. We asked about staff meetings and we were told that issues get discussed at daily handover as well as formal staff meetings arranged on a regular basis. Staff reported they were asked their opinions and felt the manager did their best to act on feedback they gave and this helped them feel acknowledged and supported.

We asked nursing staff we spoke with about support for further professional updates. We were told the deputy manager was the clinical lead for infection control and had liaised with the infection control team at Liverpool Community Health. The deputy showed us a new audit tool which was being trialled in the home. Other than this there was little evidence of nursing staff having more recent clinical updates. We asked the Registered Manager to consider how the home could support nurses with reference to the need for 'revalidation' for professional nurses now being mandatory to remain on the nursing register.

We observed the breakfast and lunch time provision in the lounge/dining room. At breakfast time there was staff input in the dining area and we saw each person had been given a breakfast and had drinks placed in front of them. We spoke with people in their bedrooms who told us there was no problem with the provision of meals and people could choose to have their meals in their rooms if they wished. People we spoke with told us that the meals were good and they were generally satisfied with meals provided. We saw the cook was actively involved in speaking with people and was knowledgeable regarding peoples individual dietary preferences. We saw that meals were generally a very sociable occasion and staff had plenty of time to assist people with their diet.

Good

Is the service caring?

Our findings

We observed the interactions between staff and people living at the home. We saw there was a rapport and understanding. We asked people if they were treated with dignity, respect, kindness and compassion. We received positive comments from people we spoke with. On person said, ''Staff are very good and will always listen.'' Another person told us ''Staff look after me well. They are always popping in and out [of my bedroom].''

Everyone told us privacy was maintained. One person commented, ''I spend most of my time in my room and staff understand this.'' Another person said, ''Staff help when they need to but are not invasive.'' People told us they felt they were listened to and generally staff acted on their views and opinions. We saw that meetings had been led by the Registered Manager to get feedback from people living at the home. Where necessary the registered manager had also visited people in their bedrooms to get opinions.

Staff told us that they spent time talking with people living at the home and this was mostly in the afternoon as mornings could be very busy. We made some observations of both day areas over the two days of the inspection. We saw there was extra support from an 'activities organiser' and this was appreciated by a lot of people living at Riverslie. The activities staff member was seen to have very positive relationships with people and encouraged a good communal atmosphere which was very evident. We saw all staff taking time to interact and involve people throughout the day. The interactive skills displayed by the staff were positive and people's sense of wellbeing was very evident.

Throughout the inspection we observed staff supporting people who lived at the home in a timely, dignified and respectful way. We saw staff respond in a timely and flexible way, so people did not have to wait long if they needed support. Staff were on hand.

We asked about visiting from relatives. We asked if there were any restrictions and were told relatives and visitors were free to visit at any time. One relative said, ''We are free to visit at any time. Staff are open and friendly.'' We saw an entry in the compliments' book from a visiting professional who had stated the staff were always welcoming and helpful. The staff we spoke with had a good knowledge of people's needs and spoke about the people they supported with warmth and understanding.

There was some information available in the home for people via the 'service user guide' and we were told this was in all of the bedrooms for people to get information from. We saw some of the information in people's rooms but this was not always consistent as some bedrooms did not have information available and other bedrooms had a service user guide mixed in with older information which made it confusing to access. The managers of the home aid they would address this.

We discussed the use of advocacy for people. Advocacy information was posted on the notice board opposite the office, but we were told this was often removed by one of the people who use the service. Together with the complaints procedure we discussed ways in which such information could be more actively promoted. There were no examples of anyone in the home currently using an advocate. We were

told of a person in the past who was resident at Riverslie and wasn't able to deal with their personal finances and house sale. The home worked with relatives and involved local advocacy services to support the person concerned.

Good

Is the service responsive?

Our findings

We asked people how their care was managed to meet their personal preferences and needs. People were satisfied with living in the home and felt the care offered met their needs. Most said they felt involved in their care in that staff asked them regularly how they felt and whether their care needed changing in anyway.

All of the care files we looked at were updated to reflect people's current care needs. These were organised and it was generally easy to find information. We saw they were being reviewed by nursing and care staff regularly. We saw evidence of people being involved in their care planning. For example we saw that in some instances people had signed their care plan and in others they had signed to say they had seen their care plan or it had been discussed with them. We also saw entries to say care had been discussed and updated with relatives where necessary. The evidence was not always as strong in all of the care files.

When we spoke with people they told us they felt involved in the planning of their care. Most did confirm that staff were regularly asking them how they felt or if they were okay, and all said they felt they could communicate their feelings or likes and dislikes to staff. Most residents could not recall or tell us the contents of their care plan but were able to say how the care being delivered met their immediate nursing or care needs. Some said that they had seen their care plan but had not been involved in ongoing reviews. One relative we spoke with told us they were always kept well informed regarding any issues with their relative. They had been involved in a care review recently with staff from the home and a social worker and felt fully aware of any issues.

Some of the people we spoke with had full capacity to plan their day and make their own decisions. They told us they were happy living at Riverslie. We spoke with one person who told us about the local day centre they attended. We were told also about regular trips out of the home to the local shops and there were trips out to a local coffee bar for lunch or a coffee. Over the three days of the inspection we saw the activities staff member organising a variety of communal activities in both the lounge and dining area. For example we saw people joining in with some armchair exercises. It was clear that communal integration is encouraged in the home and people were seen to enjoy the activities.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We could not find any obvious display of the complaints procedure in the home. We were shown a complaints book in the entrance foyer of the home. We saw this contained some information that might be deemed confidential. This was removed by the deputy and during the inspection a more identifiable complaints procedure was displayed with accompanying complaints forms if needed.

We saw there were good records of complaints made. We saw that all of the complaints had been investigated and addressed in terms of a response by the registered manager.

Requires Improvement

Is the service well-led?

Our findings

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The managers were able to evidence a series of quality assurance processes and audits carried out internally and externally from a visiting senior manager for the provider. These processes have generated a series of developments over the recent years to improve the quality monitoring in the home.

At the last inspection we found there was improved communication and support for the registered manager because the provider had introduced an operations manager who provided the supervision and support and visited the home on a four/six week basis to help coordinate areas of the running of the home. There was also a deputy manager employed so although the registered manager was not present at the inspection the deputy was able to give feedback and access information regarding the running of the home. There were therefore clear lines of accountability.

We did discuss the lack of presence of the registered manager at times in the home. These were for reasons such as covering night shifts due to staff shortage for a time. We fed back some comments from visiting professionals who said they had had little input, or even met the registered manager, and this might have an effect on the perceived leadership in the home. The registered manager said they would take the comments on board.

We found that some areas of care management could be better monitored. For example we were shown how accidents reported were analysed by the manager. We saw there was a monthly review by the manager for any accident or incidents reported. The operations manager sent us a copy of the latest 'trends analysis' report which monitored accidents and incidents in the home. Although we discussed, on our last inspection, the need to include any action point from the analysis these were still not included. For example one person had experienced a series of three falls in a short space of time of which two resulted in a minor injury. There were no action points recorded as to what this meant and whether there had been any changes to the person's care plan as a result. Contingencies such as time of day and staffing at the time of the accidents were also not included in any analysis.

Some of the other issues we feedback to the managers had also not been picked up on existing audits which could be better developed; for example the issues regarding medication management and the monitoring of Deprivation of Liberty applications and authorisations.
The deputy manager told us the operations manager visited regularly and was providing on-going support for the home. However they also did not pick up on the concerns we found.

These findings were a breach of Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspections we were concerned that the registered manager was not submitting statutory notifications informing us of significant events in the home. Over the past two inspections we have received

statutory notifications for death and serious injury. We had not received notifications, however, regarding one safeguarding investigation. The manager stated that they were not aware of the need as the investigation had been instigated external to the home and closed shortly afterwards. The inspector was informed by telephone of this. The submission of such notifications enables us (the Care Quality Commission), as regulators, to monitor the home.

From April 2015 it is a legal requirement for all services who have been awarded a quality rating following inspections to display this. We found the inspection report was available for people to read but this was not easily accessible or clearly advertised [it was pinned to the notice board but was very high up and could not easily be reached. The quality rating was not displayed elsewhere. We discussed how this could be made more accessible as it would enable people to see how the home was performing. Staff roles such as the administrator had been reviewed to provide more clearly defined support and this was working well. For example the recruitment processes in the home were now better managed and records generally were more accessible. From the interviews and feedback we received, both registered manager and deputy were seen as open and receptive.

We looked at and reviewed some of the processes such as the quality assurance systems in place to monitor performance and to drive continuous improvement. The deputy manager was able to show us a series of quality assurance processes and audits carried out internally by the manager; for example care plan audits and various health and safety and environmental audits. This had helped to ensure the home was being monitored in key areas.

We found management records were accessible and easy to find. We saw audits had been carried out on housekeeping, infection control, nursing equipment, bedrail safety and the kitchen. These internal audits were supported by some external monitoring and auditing by, for example, Liverpool Community Health (LCH) regarding infection control and the local council environmental health department. LCH had visited on June 2015 and found the home compliant in managing infection control and the clinical lead for home had continued to liaise to develop the auditing process in the home.

The registered manager had made improvements in developing ways of getting feedback from people living at the home. These were primarily through 'residents meetings' which were very well attended. We saw notes made for the last two meetings and there had been good input from people living at the home. Staff meetings had also been held fairly regularly with the last being held in February 2016. The notes included discussion and action points. The registered manager was careful to hold the meeting on two consecutive days to capture as many staff as possible. We discussed other ways to get feedback from visitors and professionals who visited the home.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Some of the systems for auditing the quality of the service needed further development to ensure better monitoring of key issues.

The enforcement action we took:

We issued a warning notice