Care Quality Commission

Greenacres Nursing Home Limited

Thomas Leigh Care Home

Inspection report

Thomas Lane
Knotty Ash
Liverpool
Merseyside
L14 5NX
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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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Thomas Leigh is located in the Knotty Ash area of Merseyside and provides accommodation for up to 54 adults. The service is provided in a purpose built building and is close to local public transport routes. Accommodation is over two floors and the first floor can be accessed via stairs or a passenger lift. All bedrooms are single and en-suite and people share communal lounges, dining rooms and bathrooms.

At the time of our inspection there were 27 people living at the home. Of these 15 people living on Lily unit were receiving nursing care and a further 12 people living on Poppy unit were receiving care without nursing.

The home does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We last inspected the home in September 2014. At that inspection we looked at the support people had received with their care and welfare, we also looked at whether people were safe, the support provided to staff, records, the premises and how the quality of the service was assessed by the provider. We found that the provider had met regulations in these areas. The registered provider did not meet the requirements of the Mental Capacity Act 2005 (MCA). They had not applied for Deprivation of Liberty Safeguards (DoLS) for people who may need them. This meant that people's liberty may be unduly restricted, it also meant that people's rights were not being fully protected.

Quality assurance systems were in place but did not operate effectively enough to ensure the home provided a safe, effective, caring and well led service.

People received the support they needed with their nutrition. However this support was not always provided in a way that promoted their dignity. Laundry services were not always effective enough to protect people's dignity.

Care plans provided sufficient information to inform staff about people's support needs. This included information about their health, nutrition and personal care.

Medication practices at the home were safe. People received their medication on time and it was stored correctly.

Staff had received training and understood their role in identifying and reporting any potential incidents of abuse. People felt confident to report any concerns or complaints they had to a member of the staff team.

A system was in place for recruiting new staff to work for the organisation. This included carrying out checks to help ensure the person was suitable to work with people who may be vulnerable.

There were enough staff working at the home to meet people's needs. A lack of permanent nursing staff had impacted on the quality of the service however this is now being addressed by the registered provider.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe.

Not all required safety checks on the building had been carried out to ensure it was a safe place for people to live.

Medication was safely managed within the home.

Staff had undertaken training in safeguarding adults and were aware of the procedures to follow if they suspected abuse had occurred.

Recruitment polices were in place and followed to ensure appropriate information was available about staff before they started working at the home. There were sufficient staff available to provide people with the support they needed.

Is the service effective?

Requires improvement

The service was not effective.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. Procedures for ensuring people were not unduly deprived of their liberty without consent from the person or relevant authorities had not been followed.

People were provided with the support they needed to manage their health and nutritional needs.

Staff had received the training they needed to support the people living at the home.

Is the service caring?

Requires improvement

The service was not caring.

The support people received at lunch time did not promote their dignity or make for a relaxing enjoyable experience.

The environment was not always adapted to support people with dementia to feel comfortable and to find their way around easily.

People liked the staff who supported them and staff spent time talking with people and reassuring them as well as meeting their care needs.

Staff were aware of and promoted people's right to privacy.

Is the service responsive?

Requires improvement

The service was not responsive.

The support people received to occupy their time was varied. Some arranged activities took place however at other times people had little to engage them.

Summary of findings

Care plans were up to date and comprehensive. Staff had a good knowledge of the support people needed and support was provided to people as described within their care plan.

A system was in place dealing with any complaints received. People knew how to raise a concern or complaint and said they would be confident to do so.

Is the service well-led?

Requires improvement

The service was not well led.

Quality assurance systems were in place to check the quality of the service provided. These were not always effective at noting and / or achieving improvements to quality and safety of the service.

The home had a manager in post however they were not registered with the Care Quality Commission.

Thomas Leigh Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 carried out on 16 and 20 April 2015. The inspection was carried out by two Adult Social Care Inspectors. During the visit we spoke with six of the people living at the home and met with several others. We spent time observing the support provided to people. We also spoke with four relatives of people living at Thomas Leigh, ten members of staff, including the appointed manager and providers and with five visiting professionals. We looked at shared areas of the home and visited people's bedrooms. We also looked at a range of records including care plans, medication records, staff records and records relating to health and safety.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the manager since our last inspection in September 2014.

Requires improvement

Is the service safe?

Our findings

People told us that they received their medication on time and when they needed it. One person explained, "She breaks it in half - that makes it easier for me to take." They also told us that if they needed pain medication they did not to have to wait long to receive it.

We looked at how medicines were administered to people. Two visiting health professionals told us there had been concerns in the past with how the home managed medicines. For example, some morning medications being given at lunch time. This meant they could not accurately assess people's behaviour as they had not received their medicines in a timely manner. We observed the morning medicine round and saw people received their medicines at the time recorded on their medicine record.

The provider had a medication policy which provided guidance to staff on how to manage medication safety. We saw medicines were stored safely in medicine trolleys on both units. We looked at fifteen medicine records and checked a sample of medication. We found this tallied with stocks held. Care plans contained guidance for staff to follow around the persons medication including medicines prescribed 'as required'. We observed a medicine round on both units. Staff provided the required level of support to people to help ensure they took their medicines.

A member of staff told us they had undertaken medicine training and had their competency checked following this training. This helped to ensure they had the skills and knowledge to administer medicine safely. Medicine training formed part of the Care Certificate staff were undertaking. We saw dates when medicine competencies were checked.

During the inspection we followed a fire exit sign from Lily unit into the garden. We found that access was not available as a bolt had been fitted on the far side of a door in a high fence which divided the garden. This meant that people would not be able to use this evacuation route safely and quickly. Once through this door we found that a padlock was fitted to the door leading out of the garden. This was rusted and could not be opened. The provider addressed both of these issues on the day. We reported our concerns to the local Fire Authority who visited the home to offer advice. However this showed us that the registered provider was not always taking appropriate steps to ensure the safety of the premises and people at all times.

We saw that certificates and checks were available for other parts of the premises, this included a gas and electrical certificate, checks of hoists, the lift and small electrical appliances had also been carried out.

The provider had polices in place to guide staff on how to identity and deal with any safeguarding adults incidents that arose. They also had polices in place for supporting staff through whistle blowing procedures. Whistle blowing protects staff who report something they suspect is wrong in the work place. Staff had a good understanding of these policies and their role in dealing with any safeguarding issues that arose. They told us that they would report any safeguarding concerns that they had. We saw that the registered provider had reported potential safeguarding adults incidents to the appropriate authorities and where requested by them, had provided information and carried out an investigation.

The manager had checked accidents that had occurred in the home. This included monthly checks on the number of people who had fallen to see if there were any patterns emerging that could be addressed to reduce reoccurrences.

We looked at the provider's recruitment practices including five staff files. All the necessary checks and references had been obtained for each member of staff. This included a Disclosure and Barring Check (DBS). These checks helped to ensure staff were suitable to work with people who may be vulnerable. A recently recruited member of staff explained that they had a formal and informal interview with the provider and manager, completed an application form and had checks and references obtained before they started working in the home.

We saw sufficient numbers of staff were available to provide care and support to people on Lilly and Poppy Unit. The staffing rota showed the numbers of staff had been maintained. We observed people receiving support with aspects of personal care when required and when requested. A relative told us that there had been times in the past when they had concerns regarding staffing levels particularly in the lounge areas. However, they said they raised this with senior staff and had noted this had improved.

Requires improvement

Is the service effective?

Our findings

One of the people living at Thomas Leigh told us that when they had been unwell staff had called the doctor for them quickly. Their relative confirmed this and told us that staff had promptly informed the family of the person's illness.

People living at the home had varied views regarding the meals. They told us they had enough to eat and drink and one person described meals as "beautiful." Two other people said the meals varied with one person explaining, "It depends who's on, some is good some isn't." A relative told us that in their opinion meals were, "Okay" and another relative told us they were "lovely."

We saw a care record for one person in which a health care professional had requested that an urgent Deprivation of Liberty Safeguard (DoLS) referral be made for the person. These laws and safeguards are a legal way to ensure people are not deprived of their liberty unduly. They also provide protection for people by ensuring decisions the person is unable to make are made in their best interests. We found that three days after the request had been made, no referral had been sent to the local authority.

One the first day of our inspection three people currently living at the home had a DoLS in place and no further applications had been made. As people living at Thomas Leigh may be under constant supervision and may have restrictions placed upon them whilst living at the home current guidance is that following an assessment a DoLS application should be made. We spoke to the manager who was aware that these applications should have been made. On the second day of our inspection the urgent application had been completed along with applications for some of the people living at the home. However it was likely that other people would need an application to be made on their behalf. Not applying for a DoLS for individuals who may need this meant that people's legal rights were not being protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.

The cook had been provided with a list of fortified diets and was aware of how to provide this diet. However we saw that some people needed a blended diet. This was sent to the unit with the contents of the meal blended together. When we asked, staff did not know what the meal was and were therefore unable to inform the person eating the meal. A choice of meals was available for people who did not need a blended diet.

Throughout our inspection we observed that people were offered drinks regularly and that drinks were provided for people who chose to sit in their bedrooms.

Where required people's weight had been monitored and action taken where records showed people had lost weight. Staff recorded people's food and fluid intake and people were given meal replacements drinks in accordance with their needs. Care plans recorded the support people needed with their nutrition and we saw staff provided people with this support when needed.

People had access to a range of health care professionals and care records showed this support was sourced at the appropriate time. For example, GP, community matron, dietician and district nurse team. Staff told us information was shared with them following these visits so they were aware of the care and support needed. Care plans provided staff with information about people's health needs. This included areas such as, sleep, communication, wound care, pain, elimination, eating and drinking and mobility.

One visiting health professional told us they had found care staff had a good knowledge of the people living at the home and they had noticed an improvement in the level of information staff were able to provide. Other visiting professionals told us that they had had concerns regarding staff knowledge and experience but this had improved. The staff we spoke to during our inspection had a good knowledge of the people living at the home and how to support them effectively. Staff provided us with examples of specific support individuals needed for medical conditions that required regular monitoring.

A member of care staff who had been recently appointed told us that they had received a good induction to the home and to the people living there. They told us they had been given the opportunity to shadow senior staff and had received support and supervision during their induction period. We observed that two newly appointed nurses were being inducted into the home by a permanent member of the nursing team and were being given the opportunity to shadow them.

Requires improvement

Is the service effective?

Staff told us they had received regular supervision from a senior member of staff and records we saw confirmed this. This provided staff with the opportunity to discuss their work and plan any training and support they may need.

The manager told us that care staff were undertaking a care awareness course with an external training provider. We spoke to the training provider who confirmed this and explained that subsequently staff would be supported to undertake the nationally recognised Care Certificate. The manager also told us that the community matron had offered to provide training in basic areas of care. We spoke to the community matron who confirmed this would be arranged shortly.

The registered provider arranged training centrally with a manager from another home within the organisation taking responsibility for this. We saw adverts within the home for forthcoming training in moving and handling people, supporting people to manage their behaviour, fire and health and safety. Records showed that staff had undertaken training in relevant areas including, supporting people with dementia, nutrition, end of life care and safeguarding adults.

We saw that the environment was clean, bright and clutter free. Everyone living at the home had their own en-suite bathroom and corridors were wide enough to accommodate people using a wheelchair. We saw that safety measures had been fitted to upstairs and outside doors so people who were unable to manage stairs unaided or go out safely alone were unable to do so without support. A passenger lift provided access to the first floor and adapted baths and showers were available to support people with their personal care.

Parts of the environment at Thomas Leigh do not meet current good practice guidance for supporting people with dementia. For example, corridors were long and had no obvious destination seating for people to use. Flip up chairs were attached to the wall on the corridor however these may not be easy for people living at the home to recognise and therefore use. Pictures hung in the corridor were of London rather than local areas that people living there could relate to. The pictures were hung at an angle which could cause confusion for people. There was not always clear signage leading to different areas of the home. For example toilets had written signs but toilet doors were not all painted a specific colour to help people who could no longer read identify the room.

The dining room for Poppy unit was large and partly open to the entrance hall. It held 7 sets of chairs and tables and could be seen by people entering the home. The lounge on Poppy unit was again very large with chairs and settees arranged around the room. None of these rooms were domestic in style or size as recommended for supporting people with dementia.

Some pictures had been placed in the dining room on Lily unit that were relevant to the use of the room and could help people to understand where they were. However, other pictures on corridors and in the dining room were laminated paper pictures, this not only appeared cluttered at times but also gave a childlike appearance to the environment.

We would recommend the provider refers to current good practice guidance and assessment tools for improving an environment for people who have dementia.

Some of the upstairs bedrooms felt very hot and we noted that although the windows were open the radiator was switched on and could not be individually turned off as the control was boxed in. The rooms were unoccupied at the time of the inspection however a room thermometer registered the temperature as 24 degrees in one of the bedrooms.

We recommend that a check is maintained of room temperatures to ensure they are not detrimental to the health and comfort of people living at Thomas Leigh.

Requires improvement

Is the service caring?

Our findings

We asked people who lived at the home and relatives if they though the service was caring. People's comments included, "I like it, staff are very good, they go out of their way," "We get on with the girls," and "I like it, very friendly people." A relative told us, "Great, the best place lovely staff."

One of the people living at the home told us, "I don't get my clothes back. Only got two jumpers now." Relatives also raised concerns with us around the laundry service as people's clothes were not always returned. One person told us their relative had clothes that did not belong to them in their wardrobe but currently did not have one pair of trousers belonging to them; despite the fact over seven pairs had been labelled with their name and left at the home. Another relative told us that their relative had no underwear in their bedroom despite the fact that they had labelled and supplied this. With their permission we checked the person's room and found this to be the case. We also noted that a stained top had been put in their drawers despite the fact it was labelled with someone else's name and was unfit to wear.

We found a table in the laundry room piled with clean socks and underwear. We checked samples of these and found them to be labelled with the person's name. However they had not been put into baskets for distribution to people. We brought this to the manager's attention and she advised it was due to laundry staff not being there at that time. When we returned to the home for the second day of our inspection we saw that the stock pile of laundry had been cleared and the manager told us it had been distributed to the people who owned it. The lack of a clear system for ensuring people have their own clothes in a timely manner compromises peoples dignity.

Meals were served from a hot trolley and we noted that there was little atmosphere in either dining room. We saw staff standing around, talking to each other and bustling around. This had the effect of making the meal time appear rushed. For example, we saw three members of staff ask one person to sit down for their meal, the meal had not yet been served, the table was not laid and the person clearly did not wish to sit at that time. We also saw a member of staff stand over two people whilst supporting them to eat their meal at the same time. A third person had an apron put over their head without being asked.

A notice on the door said families were 'not permitted' at mealtimes. We were told this was so that people could eat their meal in peace. However we observed one of the providers walk through the middle of the dining room whilst people were eating, carrying a take-a-way meal in his hand and without speaking to the people sitting there.

We saw that everyone on Lily unit was given plastic beakers and plates and everyone on Poppy unit was given plastic beakers. There appeared to be no rational for why everyone was given these. We also saw that tables were not laid on Poppy unit. No serviettes or condiments were provided. This added to sense of the meal being rushed rather than a relaxed occasion for people to enjoy and the use of plastic crockery undermined people's dignity.

We found that there were not a lot of communication aids available in the home to support people where their first language was not English or where their dementia was impacting on how they made choices and communicated. For example people were not offered a visual choice of meal, not all areas of the home were clearly signed with appropriate colours or pictures. Photograph frames were available by each bedroom door to help people locate their room, however not all of these had been used. However we saw that staff took the time to try to understand the different ways people communicated or to work out what the person may be upset about and to respond appropriately.

We saw staff spent time sitting with people and chatting with them as well as meeting their care needs. We also saw that people living at the home approached staff freely to converse with them. This showed us that staff had built relationships with the people who lived there and indicated that people trusted and liked the staff team.

Throughout our inspection we noted that staff knocked on people's bedroom doors before entering and ensured personal care was provided in private.

Requires improvement

Is the service responsive?

Our findings

One of the people living at Thomas Leigh told us that if they had any concerns or were worried about anything they would feel confident to tell, "Anyone" working at the home, another person told us, "I tell them." Two relatives told us that they would feel confident to report any concerns they had.

The complaints procedure was displayed in the main hallway so that it was easy for people to access. It contained details of how to raise a complaint and the timescales by which complaints would be dealt with. We saw a record of complaints made to the registered provider, this showed that they had been responded to in a timely manner.

Individual care files were in place for the people who lived at Thomas Leigh. The care documents were comprehensive and provided information about people's care and support needs. Reviews had been undertaken and reported on any changes and care records showed that staff sought advice and guidance from health and social care professionals to monitor people's health and wellbeing.

For people who had more complex needs we saw staff had completed observational charts and charts to monitor their dietary intake. Wound care was recorded and we saw people's wounds had been dressed in accordance with their plan of care. These detailed the effectiveness of the treatment and how the wound was improving. Equipment such as, pressure relieving mattresses and specialist beds were provided in accordance with people's assessed needs. A relative told us their family member had the necessary equipment to help make them comfortable. We observed staff attending to people's needs and this included changing people's position whilst in bed and carrying our regular safety checks.

People who lived at the home were supported to take part in some activities although staff and a relative told us that in their opinion these needed to be provided on a more frequent basis. One relative said, "They (people who lived at the home) are just sitting there vegetating - that's my concern." Another relative had commented in a 2015 questionnaire sent to them by the registered provider, that they felt more regular activities would benefit the people living there.

Activities were advertised on a noticeboard and included hairdressing, bingo and singing. A member of staff told us that communion was also provided regularly for people who wished to receive it. Staff told us that they did do activities with people including sitting on a one to one basis with them and singing. Although we observed staff talking with people and on one occasion singing with people we also saw staff sitting in the lounge with people but not engaging with them. On another occasion we noted music playing very loudly in Poppy unit whilst at the same time the television was on. Staff did not appear aware of this although some of the people living there told us they found it annoying.

Requires improvement

Is the service well-led?

Our findings

Checks and audits at Thomas Leigh had failed to identify issues we have noted within this report. This included the lack of a registered manager, blocked fire escape route, improving the environment for people living with dementia, improving activities and the laundry service and addressing meal times to make them more sociable occasions.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems and processes in the home were not effective in ensuring the safety and quality of the service.

The home did not have a registered manager in post. This is a condition of the registration of the home. The other conditions for registration had been met. The manager had worked at the home since July 2014 but had not applied for registration with the Care Quality Commission (CQC). She informed us she had recently applied for her Disclosure and Barring Service check and intended to submit an application. We discussed this with the registered provider who was aware the manager had not yet applied to register with CQC. Both the registered provider and manager were aware that it is a legal requirement for the home to have a manager in place who is registered with the CQC.

Prior to the inspection concerns around the home following instructions from health professionals and concerns about poor communication with external health professionals had been raised with us. During the inspection two visiting health professionals told us there had been an issue with poor communication in the past and staff not following their instructions. A third visiting health professional told us there had been communication problems in the past with the manager when they raised issues with them. This was exacerbated by the number of agency staff working in the home. Information was subsequently not always shared. However, visiting health professionals told us this was slowly improving.

We asked the manager how many hours she worked each week. She said she was on call 24 hours a day, 7 days a week. We looked at the signing in book for the week commencing 13th April 2015 and saw the manager had worked over 55 hours during a five day period. We brought this to the attention of the registered provider at the inspection. The manager told us that they had identified a need to employ a deputy manager for the home and had recruited twice to the post. However the post had since become vacant and they were planning to recruit again to the post.

The manager told us they had difficult recruiting permanent registered nurses and had advertised over the past few months. She explained the situation was beginning to improve with the employment of two part time Nurses and told us they used regular bank staff to provide continuity of care.

We talked to staff about the management of the home. A member of staff told us they had noted improvements in the management of the home recently and that it appeared better organised. Another member of staff told us they received the support they needed, communication had improved and they enjoyed working in the home.

We looked at systems and processes in place for monitoring the quality of the service provided. Regular safety checks of equipment including special mattresses, wheelchairs, hoists and call bells had been undertaken. However, we identified checks on the environment had failed to note, and therefore, address the bolt and rusted padlock blocking the fire exit.

Relatives told us that they had not been invited to attend a relatives meeting since 2014. A relatives meeting is one way for people to be able to express their views about the quality of the service provided by the home. We saw that some relatives had been given questionnaires to complete in 2015. Comments raised were similar to some of the areas we noted for improvement during our inspection. They included, "Rooms too hot," "I am not aware of any activities," and "Can you eat with your family." We saw no evidence that action had been taken to address these comments either by replying to the person or planning improvements to the service.

An audit file was available and we saw that audits had been carried out on medication, health and safety, infection control and accident monitoring.

We saw that the registered provider visited the home and recorded the findings of their visit. For example the last visit in February 2015 recorded, "Discussion over activities, audits reviewed and discussed."

Requires improvement

Is the service well-led?

However the checks and audits in place did not note and therefore plan improvements to the issues we identified including; the poor laundry service, lack of occupation for people, poor meal time experience and lack of appropriate signage and pictures in some parts of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes in the home did not operate effectively enough to ensure that the service provided was safe, effective, caring, or well led.**