Parveen Ltd

Thomas Leigh Care Home

Inspection report

1E Thomas Lane
Liverpool
Merseyside
L14 5NR

Tel: 01512547720

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30 September 2016
13 October 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Thomas Leigh is located in the Knotty Ash area of Merseyside and is registered to provide care and accommodation for up to 54 adults. The home could accommodate 19 people for nursing care and 35 people for residential care. At the time of our inspection 17 people were receiving nursing care and 31 people residential care.

The service is provided in a purpose built building. Accommodation is provided over two floors and the first floor can be accessed by stairs or passenger lift.

The home had a registered manager. 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.' The registered manager was in attendance throughout the inspection.

During our inspection, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulation 9 person centred care; 12 safe care and treatment; 13 Safeguarding service users from abuse; 17 good governance and 19 fit and proper persons employed, of the Health and Social Care Act 2014 Regulations. You can see what action we told the provider to take at the back of the full version of the report.

People received support with their health care. However care plans had not been updated accurately and contained guidance that if followed would pose a risk to people's health and safety. Risks to people's safety were not acted upon in a timely manner. Systems and processes for reporting potential abuse and keeping people safe did not work effectively and concerns had not been reported to the local authority or to CQC as required. Plans had not been put in place to manage identified risks to people's safety. Quality assurance systems were not effective regarding care planning and risk assessment systems.

There was no evidence that the services disciplinary policies and procedures had been appropriately followed and recruitment processes of staff did not effectively ensure new staff were recruited safely.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will

seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

People we spoke with told us they felt safe at the home and they had no worries or concerns. People's relatives and friends also told us they felt people were safe. The staff at the home knew the people they were supporting and the care they needed. We observed staff to be kind and respectful towards people. The home provided a range of activities to occupy and interest people.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had been adhered to in the home. The provider told us the majority of people at the home lacked capacity and that a number of Deprivation of Liberty Safeguard (DoLS) applications had been submitted to the Local Authority in relation to people's care.

Infection control standards at the home were good and these standards had been monitored and managed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

The provider had not taken appropriate action to ensure that people who lived in the home were safe from potential harm and abuse.

People's needs had changed and risk assessments had not been updated.

Disciplinary procedures had not been followed.

Staff were trained in safeguarding and whistle blowing procedures.

Is the service effective?

Requires Improvement

The service was not always effective

Parts of the environment did not always meet good practice guidance for supporting people living with dementia.

It was not always clear if staff had received an induction.

People's mental capacity had been assessed in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had been applied for.

Is the service caring?

Requires Improvement

The service was not always caring

We observed staff to be caring, respectful and approachable.

People appeared at ease with staff.

Staff did not always take the appropriate action to support people

Is the service responsive?

Requires Improvement

The service was not responsive

Some people who lived in the home did not have a plan of care that was appropriate and met their needs.

Some care records were illegible.

Records of referrals to other agencies did not always match information in daily logs.

A range of social activities was provided and the activities co-ordinator took time to build positive relationships with people and their families.

Is the service well-led?

Inadequate

The service was not well led

The manager had a lack of awareness and oversight of the service

Risks to people's health and safety were not acted upon in a timely manner.

Statutory notifications were not submitted to the Commission when required.

Notices to staff around the home did not encourage an open and transparent atmosphere with the home.

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 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.

Before this inspection we were made aware of a serious incident that had occurred in the home which had resulted in a safeguarding alert and police investigation.

This inspection took place on 29 and 30 September 2016, 13 October 2016 and 20 October 2016, this inspection was unannounced.

The inspection team consisted of one adult social care inspector an adult social; care inspection manager and a specialist professional advisor (SPA). The SPA was a registered nurse with experience of the care of people with dementia.

Before the inspection we asked for information from the local authority and we checked the website of Healthwatch Liverpool for any additional information about the home. We reviewed the information we already held about the service and any feedback we had received.

During our visits we spoke with five people who used the service, two people's relatives and five members of staff. We observed activities in the lounge and lunchtime in the dining room. We looked at care notes for seven people who used the service, medication storage and records, 11 staff records, accident and incident report forms, health and safety records, complaints records, and other records for the management of the home.

At the time of the inspection there were 48 people living at the home and 50 staff employed.

Inadequate

Is the service safe?

Our findings

People we spoke to told us they felt safe in the home, one relative told us "Yes, [name] is safe here". Safeguarding information and whistle blowing guidance was available on the notice board in the entrance of the home. One staff member told us, "Staff are trained in safeguarding and whistle blowing procedures".

Prior to this inspection we were made aware of an incident that had occurred in the home which had resulted in a safeguarding and police investigation. During the inspection we became aware of a number of other incidents that had occurred in the home that had not been reported to the local safeguarding authority, had not been notified to the Care Quality Commission and appropriate action had not been taken to ensure that people who lived in the home were safe from potential harm and abuse. This meant that the provider had not taken appropriate action. When we asked the manager about the incidents, she told us that she had not reported them because she didn't know about them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider and manager had not ensured that people who lived in the home were safe from harm and abuse.

We looked at risk assessments and found a number of concerns. We were aware that one person had mental health problems and often displayed behaviour that was difficult to manage and presented a risk to themselves and other people who lived in the home. This person did not have a risk assessment to identify this behaviour and inform staff what action to take in difficult times. We were also aware that one person was at risk from this behaviour and there was no risk assessment to inform staff what actions to take to protect them from harm. We also saw a falls risk assessment that had been dated March 2015 that stated the person was to be checked on a regular basis, this did not state the frequency of any checks needed. Another person had body maps in place showing injury, however this had no signature as to who completed it.

We were also aware of a number of circumstances where people's needs had changed. The risk assessments in place had not been updated to reflect the changes thus placing the people at risk from receiving inappropriate care. For example; one person had lost a significant amount of weight and their care plan and risk assessment had not been updated to reflect the change which meant that they were at risk of receiving inappropriate support that did not meet their needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider and manager had not taken the appropriate action to provide care in a safe way for people who lived in the home.

We saw that the registered manager did not always interview and recruit staff for Thomas Leigh Care Home. The owner also had two additional homes. The owner would interview and recruit staff including nurses for the other homes then swop staff to Thomas Leigh Care Home. This meant that the registered manager did not always have oversight of the staff coming to work and provide care and support for those who lived in the service. We also saw that the clinical lead for the home had been originally recruited for another home

as night staff, not by the registered manager of Thomas Leigh care home. This staff member then came to Thomas Leigh Care Home and became the clinical lead for the home. There was no evidence of a recruitment process being followed for this position. We questioned the validity of references in people's recruitment files as there was evidence of incorrect information. When we asked the registered manager about the references we were told that the person had been interviewed at the sister home and been brought to Thomas Leigh, again not by the registered manager. This meant the manager could not be assured as to the suitability of the person acting as the clinical lead for the home.

During the inspection we also saw in a staff member's file a hand written notepad sheet noting four points of poor practice that had been discussed between the staff member and owner. We asked the registered manager and were told that they had not been involved. The points warranted disciplinary action, yet none had been taken.

Approximately one month previous to the inspection a staff member had omitted to provide appropriate care for a person living in the home. We saw no evidence of an investigation into the staff conduct in relation to this issue. When we spoke to the registered manager regarding this they told us they had been on holiday at the time.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider and manager had not taken the appropriate action to ensure fit and proper persons were employed to provide care for people who lived in the home.

We saw that all staff in the home had a Disclosure and Barring service (DBS) check completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. We also saw that the registered nurses personal identification numbers (PIN) had been checked to ensure that the nurses were currently registered with the Nursing and Midwifery Council (NMC) as fit to practice. These checks were steps towards ensuiring that staff were suitable to work with people who are vulnerable.

We looked at the systems Thomas Leigh Care Home had in place for supporting people with their medication. We found that there were safe systems in place for the ordering, receipt, storage, administration and disposal of medicines, including controlled drugs. Policies and systems were in place to provide guidance to staff on how to manage people's medication safely.

We saw the premises were safe. We looked at a variety of safety certificates that demonstrated that utilities and services, such as gas, electric and small portable electrical appliances had been tested and maintained and we saw that the fire alarm system had been checked regularly. Personal Emergency Evacuation Plans (PEEPS) had been completed for all of the people who lived in the home and were readily available in a file in case they were required. We saw that the fire risk assessment relating to the home was in the process of being updated.

We observed that home was clean with no offensive odours. One relative told us, "It is spotless here and even when they're really busy, it's always clean" and a person using the service told us, "The beds are always clean". We noted that gloves and aprons were freely available and that antibacterial hand gel was available throughout the home.

Requires Improvement

Is the service effective?

Our findings

We asked people about the staff who supported them, they confirmed the staff were skilled and that there were enough staff to make sure people received the support and care they need. One person told us "I think the staff are well trained".

We were told that all staff had received an induction when first employed by the service, however this was not always apparent. When we looked through staff files and the training overview supplied by the service they did not have any record of induction dates for any staff documented on it, however we asked staff if they had received an induction and they all said that they had.

We looked at staff training and supervision records. We saw that staff had undertaken various training sessions including mental health awareness, causes and prevention of infection control, safeguarding and person centred care. We saw that 20 staff had achieved either their level 2 or 3 Diploma in Health and Social Care. There was also evidence of a supervision and appraisal system in place for the staff group. Supervisions had been carried out at regular intervals throughout the past year. Supervision provides staff and their manager with a formal opportunity to discuss their performance, any concerns the staff member may have and to plan future training needs. One staff member told us, "Yes I'm well supported".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was working within these principles. The registered manager was aware of their responsibilities under the MCA.

On our tour of the home we saw some doors had been propped open even though they were fire doors and that the premises did not always seem equipped or layed out to help people who have dementia. We saw a flickering light in one main corridor that could adversely affect people with sight problems. We saw bathrooms on first floor of the home that were not dementia friendly as they were all white. Some rooms on the first floor opened onto a low walled balcony therefore these rooms were always locked as it had previously been noted that this was unsafe. We also saw some clothes that belonged to a person living in the home piled in the bath in one bathroom on the first floor.

We observed lunchtime and saw the atmosphere to be friendly and relaxed. We spoke to the cook who was able to tell us about peoples dietary needs and that the kitchen staff had all received appropriate training, examples being level 2 food hygiene and level 2 NVQ's. We saw the menus were written in the dining room

so the people who lived in the home knew what food was available. Where people required support to eat, staff supported them in a friendly and unrushed manner and gently encouraged them with their meals.

Requires Improvement

Is the service caring?

Our findings

One relative told us that the staff were, "Most of the time excellent, really caring and they look after [name] well". Everyone we spoke with said that they were treated with dignity and respect. One person told us, "They always knock on the door and you can go to bed when you want". We observed staff interactions with people who lived in the home and people were approached and communicated with dignity and kindness.

We asked people if they were able to maintain their independence and we were told yes. One staff member told us how they encouraged people to make their own decisions by using specific strategies. This meant the person had control over aspects of their life and this was encouraged by staff. We asked if people could have visitors at any time, all told us they could. We also asked relatives about visiting and was told by one relative, "Yes we can visit at any time".

During our tour of the building we saw that there was a notice board in the reception area that had information displayed regarding DoLS, end of life, complaints, choice, dignity and respect and mental capacity information. There was also information regarding upcoming events for the benefit of the people living at the home and the relatives. The registered manger told us that the scheduled meeting for relatives and residents were not always well attended and so information was made available to everyone by using the notice boards.

Thomas Leigh Care Home had a service user guide that was available, this contained information regarding the care and assessment of people, advocacy agencies, accident procedures and an organisational flow chart. Relatives we spoke to told us that there was communication between them and the service and they felt they were kept informed of any issues. One person told us, "They ring us immediately".

We saw that staff throughout the day where respectful and discreet when supporting people with personal care. During our visit people moved about freely and communicated with us and staff. Staff engaged with people and visitors in a warm and friendly manner. We observed a staff member sitting next to a person who had become agitated and talking quietly to them giving reassurance and comfort, the person obviously benefitted from this. We also saw staff helping a person walk, this was done with patience and care.

Although there was no one currently receiving end of life care the registered manager informed us that there was an end of life protocol and that people's GP's were very supportive as was the Community Matron.

However we were concerned that during the course of the inspection we were aware of a number of incidences that were not responded to safely and appropriately. This meant that staff working at the home did not always recognise people's diversity. There were occasions where staff had omitted to respond to people's needs or provided information or support and this had significantly impacted on the well being of people living in the home.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we looked at eight care plans some of these had been reviewed monthly stating 'no change' to the care plan when changes had occurred to people's health. This meant that care plans had not been maintained or kept up to date and so did not reflect what people's current needs were. One person's care plan had not been reviewed since June 2016 despite there being incidents of challenging behaviour.

Another example was that one person had lost a significant amount of weight following a hospital admission and had gone from monthly weight checks to weekly. This was logged in weight charts and not reflected in care plans and subsequent risk assessments. We saw that some people had fluid intake charts, these had not been used to see if people were taking in adequate fluids. There was no evidence that the information was monitored to see if people were drinking enough in the day. We asked for care plan audits and the registered manager said she had not done any.

We looked at daily monitoring records for the people living in the home and found that some entries were illegible. This meant that important information was not easily located and so made the monitoring of a person's health or behaviour difficult, this could have led to inaccurate information being given to other staff and health professionals.

CQC had received a complaint about the service omitting to provide appropriate support for a person and this resulted in a hospital admission. We saw that following this people had prompt access to medical and other healthcare support as and when needed, however we saw some disconnect between care plans and daily records. An example of this being a referral to a health professional regarding a chesty cough, there was no mention in daily notes of the person having a chesty cough.

These examples are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that an up to date plan of care was maintained for people living in the home.

The home had a complaints policy that was on display for people to access, this was up to date and had been reviewed. This was displayed at the entrance to the building making it easily accessible for everyone. We asked people if they felt they could raise concerns and everyone said they could. One relative told us "If we have any issues, they respond and deal with them quickly".

We asked people about activities and interests and we were told that the activities co-ordinator who was employed five days a week "Keeps us going". People told us of outings that had been planned and taken place and that people thoroughly enjoyed the activities. We observed people singing on the first day of inspection and on the third day an entertainer was performing. This was a regular event. The activities co-ordinator had had the funding for this resource stopped and had been able to fund it through donations from family and staff as it was such a popular event. This was seen to be enjoyed by everyone who attended. One family member told us, "The activities organiser is good. If there is anything on in the other wing, they push mum's chair through and she can be part of things". We observed a group of ladies enjoying a card

game that appeared to be a regular occurrence, this meant socialising was encouraged.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who had been in post since October 2015 and who was present during all days of inspection.

During our inspection we became aware that incidents had not been submitted to the Care Quality Commission as statutory notifications. When asked the registered manager said that she wasn't always told about incidents at the home.

We saw that there were notices around the home directed towards staff which threatened dismissal if they did not adhere to instruction, an example being bringing chairs in from the garden as they weren't weather proof, on discussion with the registered manager we were told it was the owner who had put these up. The tone of the messages would not encourage an open and transparent atmosphere within the home.

The registered manager confirmed audits had not been carried out on care files and she had not recognised the risks to service users. This practice would have identified the issues and improved the quality of care documentation. We also saw that other quality assurance systems such as audits were in place, however we saw that some of the monthly audits had not been carried out such moving and handling equipment and falls audits.

We raised concerns about records in the home and the inconsistent recording of issues relating to care records. We also noted that some entries in care records were illegible and that this could impact on the care being given. We raised significant concerns that the manager and provider had failed to recognise serious risks to the health and well being of people living in the home and had failed to act upon these risks.

We also raised concerns surrounding the recruitment practices of the home and the risk of impact on the service delivery to the people living in the home.

These were breaches of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that systems and processes at the home operated effectively to assess and monitor the quality of the service provided.

During and following this inspection we shared our findings with the local authority commissioning and safeguarding teams.

The service had policies and procedures in place, these covered subjects such as complaints, health and safety, disciplinary, safeguarding and recruitment however these policies were not always followed.

We saw that the service had held staff team meetings and we were able to see meeting minutes that showed staff were able to air views and make comments about the service. We saw that this was used as an opportunity to improve the service, an example being were the registered manager informed the staff group that they had to ensure drinks were readily available and that there were no set times for drinks.

We asked staff if they felt supported by the manager and they all said that they did, one staff member said, "Yes [manager] is very approachable" another staff member said, "We work well as a team, there's no issue if you've got a problem". People we spoke with were able to identify the manager and told us they felt comfortable approaching her if they had any concerns.