Leonard Cheshire Disability

Mickley Hall - Care Home with Nursing Physical Disabilities

Inspection report

Mickley Lane
Totley
Sheffield
South Yorkshire
S17 4HE

Tel: 01142369952
Website: www.leonardcheshire.org

Date of inspection visit:
11 January 2018

Date of publication:
10 April 2018

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 11 January 2018 and was unannounced. This meant the staff and registered provider did not know we would be visiting.

Mickley Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service can provide accommodation for up to 40 people. At the time of the inspection 33 people were using the service.

The manager had applied to register with the Care Quality Commission. 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.

At the last inspection in May 2017 the service's overall rating was 'Requires Improvement' with no breaches of the Health and Social Care Act 2008. At this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The service's overall rating is 'Requires Improvement'.

Although people told us they felt safe, we found there were not effective systems and processes established at the service to ensure people were consistently safe and protected from improper treatment.

We saw the service's accident and incident reporting process for staff to report concerns about risks, safety and incidents was not always operated effectively. This showed that risks were not always identified or managed. We saw there was a risk that reportable incidents may not be shared appropriately with the Care Quality Commission and/or the local safeguarding authority.

We found the registered provider had not ensured all the staff working at the service had been provided with safeguarding vulnerable adults training so they had an understanding of their responsibilities to protect people from harm.

At the last inspection we saw the deployment of staff required improvement to ensure people who were unable to summon assistance were not left unattended. We saw it was important to have staff supervision on hand to respond to people if they showed any signs of distress through facial expressions or coughing. Without a staff member in place we saw people were left at risk. At this inspection, we saw the deployment of staff required further improvement so people were not left unattended in the lounge area.

We found the management of medicines required improvement. Since the last inspection the provider had introduced an electronic medication administration record (EMAR) system. We saw medicines administration rounds took a very long time and that it was difficult to ensure people received their

medicines at the correct time.

Although regular checks of the building were carried out to help keep people safe, we saw no action had been planned to enable people to access the garden area safely. If people and relatives chose to access this area, there was a notice stating they did so at their own risk.

We found the registered provider had not ensured that all the staff working at the service had received adequate training to ensure they had the appropriate skills and knowledge.

Although staff told us they felt supported, we found the registered provider had not ensured there was a robust system in place to ensure staff received appropriate support according to their policies.

In people's records we found evidence of involvement from other professionals such as doctors, optician, tissue viability nurses and speech and language practitioners.

Throughout our inspection the atmosphere within the service was calm, supportive and friendly. We saw positive interactions between people and staff who worked across the service.

People we spoke with were satisfied with the quality of care they had received and made positive comments about the staff.

All the relatives we spoke with made very positive comments about the care their family member had received and about the staff working at the service. They also told us that they were fully involved in their family member's care planning.

People we spoke with made very positive comments about the food provided at the service. We saw the arrangements at mealtimes were a positive and enjoyable experience for people using the service.

We found the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards were not always being followed. For example, we saw the decision to give one person their medication covertly had not been made in accordance with the Mental Capacity Act 2005.

At the last inspection we found some concerns about people's dignity not always being upheld. We saw sufficient action had not been taken by the registered provider about the lack of bathing or shower facilities at the service. We were informed at the last inspection these concerns would be addressed in three months.

Our findings during the inspection showed the system in place to respond to incidents that occurred at the service required improvement. This meant some people's risk assessment and care plans were not always reviewed in response to an incident to check whether their plan of care needed to be changed.

The service promoted people's wellbeing by providing daytime activities and regular trips during the year for people to participate in.

People and relatives we spoke with felt if they had any concerns or complaints they would be listened to.

We found the registered provider's quality assurance and governance processes to assess the safety and quality of the service required improvement.

We found the systems in place to gather and monitor safety related information to look for themes and trends was ineffective in practice.

During the inspection we found the registered provider had not ensured CQC were being informed about all notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Although people told us they felt safe, we found there were not effective systems and processes established at the service to ensure people were consistently safe and protected from improper treatment.

There were sufficient staff to meet people's needs. However, the deployment of staff to ensure people were safe required improvement.

The staff responsible for administering medicines required further training on using the EMAR system to ensure people received their medicines at the right time.

Is the service effective?

Requires Improvement

The service was not always effective.

We saw that some staff had not been provided with relevant training and supervision so they had the skills they needed to undertake their role.

The principles of the Mental Capacity Act and Deprivation of Liberty Safeguards were not always being followed.

People were assisted to maintain their health by being provided with a balanced diet and having access to a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

We found some concerns about people's dignity not always being upheld. People could not routinely be offered a daily shower or bath due to the lack of bathing and shower facilities.

People we spoke with told us they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The system in place to respond to incidents that occurred at the service required improvement. This meant some people's risk assessment and care plans were not reviewed in response to an incident to check whether their plan of care needed to be changed.

People were satisfied with the quality of care they had received.

We saw the service promoted people's wellbeing by taking account of their needs including daytime activities.

All the people and relatives we spoke with felt confident that any concerns would be listened to by staff.

There were end of life care arrangements in place to ensure people had a comfortable and dignified death.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were quality assurance systems in place to monitor the quality and the safety of the service provided, but our findings during the inspection showed some systems required improvement.

We found the registered providers governance and performance management was ineffective in practice.

We found the system in place to monitor incidents to identify any trends and prevent recurrences where possible required improvement.

We received positive comments about the manager and deputy manager from people, relatives and staff.

Mickley Hall - Care Home with Nursing Physical Disabilities

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.

This inspection took place on 11 January 2018 and was unannounced. The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a coroner investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

The membership of the inspection team consisted of two adult social care inspectors, two specialist advisors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One specialist was a pharmacist and the other was a registered nurse who had experience of looking after people with complex needs.

Before our inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example, where a person who uses the service experiences a serious injury.

We gathered information from the local authority and Healthwatch. Healthwatch is an independent

consumer champion that gathers and represents the views of the public about health and social care services in England. This information was reviewed and used to assist with our inspection. Due to the inspection being brought forward, the provider was not asked to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service. We were not able to speak with some people using the service because we were unable to communicate verbally with them in a meaningful way. We spent time observing the daily life in the service including the care and support being delivered. We spoke with seven people who used the service and four relatives (one relative was contacted by telephone). We also spoke with the manager, the deputy manager, two nurses, the physiotherapist, the physio assistant, two team leaders, two support workers, the maintenance manager, activities organiser, activities volunteer, the administrator and the cook. We looked round different areas of the service; the communal areas, the kitchen, bathroom, toilets and with their permission some people's bedrooms. We reviewed a range of records including, five people's care records, three staff files, electronic medication administration records, accident and incident records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt "safe" and did not have any worries or concerns. Relatives we spoke with did not raise any concerns about the safety of their family member.

At the last inspection we found some concerns with the management of medicines. Since the last inspection the registered provider had introduced an electronic medication administration recording (EMAR) system. The deputy manager told us the service had been using the system for two months.

We observed medicines administration to six people and noted that there was a good rapport between the nurses administering the medicines and people and that all necessary procedures and records were carried out correctly and to a high standard. We saw that the nurse remained with the person to ensure that they had taken their medication and signed the EMAR after medicine administration. We saw that the two medicines trollies were kept in the locked treatment room. We noted that the nurses took medicines for one person at a time and did not take the medicines trollies with them when administering medicines. We observed that nurses returned to the treatment room each time to record administration on the EMAR lap-top computer before assembling medicines for the next person. We were told by nurses that they had to do this as poor Wi-Fi reception throughout the home meant that the lap-tops had to remain in the treatment room where they were wired in to the internet. We observed that this whole process meant that each medicines administration round took a very long time. We saw using a medicines trolley would make it easier for staff to ensure people received their medicines at the right time. This would save all the time walking back and forth to the treatment room and this would give them time for other duties. We shared this feedback with the manager and deputy manager. The deputy manager told us there was facility for staff to work offline so they could take the trollies and laptop with them whilst administering medicines. This showed that staff required further training in using the EMAR system to ensure people received medicines at the right time.

Procedures were in place to ensure that people who required topical administration of prescription creams and ointments received them at the appropriate time and as per the guidelines on the EMAR form. We noted that some topical emollient creams were applied by care staff who verbally informed senior nurses when this was done so that the nurse could record this on the EMAR. We were told that care staff had received training on how to record this administration directly on the EMAR form, but this system was not being used. The practice of a staff member making a record other than the staff member carrying out the task is in itself inherently unsafe. If the care worker is applying the cream then they should be making the record of application. It is important that a written or electronic record is made of administration of all topical medicines. We shared this information with the manager and deputy manager; they told us they would contact the company providing the service for further guidance.

Medicines were kept safely. We saw the temperature of the treatment room was monitored to ensure medicines were stored at the right temperatures.

We found appropriate arrangements were in place for obtaining and handling medicines. Medicines that

are controlled drugs (CDs) were kept in cupboards that complied with the law. This meant that medicines could not be mishandled or misused by other people, and that they were safe to use. Medicines were disposed of appropriately.

We noted that opened bottles of liquid medicines and tubes of creams were all marked with the date of opening with an appropriate expiry date. However, we noted several sterile needle packs in the treatment room which were past their expiry date. These were immediately removed from stock and disposed of safely by staff.

We observed that oxygen cylinders were kept in the treatment room, but that they were 'free-standing' and that one cylinder was kept close to a hot-water radiator. It is important that oxygen cylinders are secured to the wall using appropriate racking or metal chains to ensure that they do not fall over and that they are not subjected to extremes of temperatures. We brought this to the attention of staff and the oxygen cylinder was moved away from the radiator during our inspection.

We did not see evidence that the service had a written contingency plan to administer and record medication should there be a complete failure of the EMAR system. This is necessary to ensure that peoples continue to receive their medication at the correct time even if the EMAR is unavailable. The deputy manager was able to describe how the records could be accessed if there was a system failure. It is important that a contingency plan is available for staff to follow.

At the last inspection we found some concerns about people's safety which required improvement. At this inspection we checked to see if there were effective systems and processes established at the service to ensure people were consistently safe and protected from improper treatment.

We saw people's care plans included an assessment of their potential risks and the measures in place to reduce and manage the risks to the person. For example, the risk to a person's skin integrity. One person's records stated their weight should be measured and monitored every week to minimise their risk of malnutrition. We saw they had not been weighed since 12 December 2017. We shared this information with the manager so appropriate action could be taken. Although we did not find this had negatively impacted on the person, it is important that there are robust systems in place to ensure the measures to minimise the risk to a person are followed by staff.

The service had an 'Incident/Accident Report Form' for staff to use to report concerns about risks, safety and incidents. The manager told us they had recently updated this form.

The manager showed us the registered providers computerised accident and incident recording (AIR) system. The manager told us the system was used by the registered provider to monitor the accidents and incidents in the service. We saw three incidents about one person had been recorded on the AIR system in January 2018. During the inspection we noted there were a significant amount of incidents that had not been recorded on the AIR system. This showed the systems in place to gather and monitor safety related information to look for themes and trends was ineffective in practice. It is important that systems are used effectively to enable a service and provider to learn from concerns, accidents, incidents and adverse events.

We looked at a sample of incidents that had not been recorded on the AIR system.

We saw an incident had been reported by staff in October 2017 about a person sustaining an injury whilst being supported in their room by a staff member. The person had required treatment from an Emergency Care Practitioner (ECP). On the incident form it stated that a copy of the incident form had been put under

the service manager's door. There were no details of the action taken or details of an investigation by senior staff. The manager and the deputy manager both told us they had never seen a copy of the incident form. It is important that a thorough investigation is completed when a person sustains an injury. It is important that senior staff ensure all reasonable practicable action has been taken to mitigate any risks to the person. An investigation also needs to take place to ensure reportable incidents are identified and notified to the CQC and the Health Safety Executive HSE appropriately. The person's injury was a notifiable incident under Regulation 18.

The information shared with CQC prior to the inspection about an incident indicated potential concerns about the management of risk of choking. This inspection examined those risks.

During the inspection we reviewed two people's care plans that required nil by mouth care. We noted there had been an incident on 26 November 2017 about one person being given a small amount of liquid by a staff member when they were nil by mouth. We saw the incident form contained details of the investigation and action taken in response to the incident. However, there was no information on the form to show that this had been reported to the local safeguarding authority or to the CQC. The manager told us the deputy manager had contacted the local safeguarding authority for advice, they did not share the person's details and were told it was not reportable as the service had classed it as a near miss.

We also checked to see if the action stated on the incident form had been completed to minimise the risk of reoccurrence. Part of the action was to review the person's risk assessment. The manager had signed the incident form to confirm this action had been completed. The deputy manager told us the risk assessment had been completed by a nurse and was on the computer, but a hard copy had not been included in the person's care plan. The lack of an updated risk assessment in place for this person meant they were exposed to the potential of receiving unsafe care and treatment. During the inspection we saw conflicting information was held in the person's care plan. We also saw conflicting information was available to staff in the kitchen area. This information stated the person was able to have drinks stage 3 and thick puree tasters. We also saw that the service's handover sheet stated the person was nil by mouth, but also held details of tasters and stage 3 fluids. After the inspection the manager sent us further documentation which included 'How support to me' folder for staff to follow about the person's diet and nutrition. It was dated 17 December 2017. It stated the following "Strictly nothing through the mouth (until further notice) as recent assessment shows that I am at high risk of aspiration pneumonia". When there is inconsistent information available there is an increased risk that people will receive inappropriate care and may be harmed.

We looked at a sample of incidents about people displaying challenging behaviour and found the service did always operate effective systems to mitigate risks. We saw some positive examples where appropriate action had been taken in response by the deputy manager. For example, one person's risk assessment had been reviewed and a behaviour monitoring chart had been introduced. However, we also saw some examples where there was no record of the action taken in response to an incident reported by staff. It is important that people's individual risk assessments are reviewed in response to any incidents, to ensure effective management plans are in place to ensure that these are managed safely and effectively. It is important that consistent strategies are in place for preventing and reducing anxieties and when behaviour escalates.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

There is a requirement that CQC is notified of any neglect either intentional or unintentional which places a person at the risk of harm. There is a requirement that CQC is notified of any injury that has resulted in the

changes of the structure of a person's body. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw the manager had recorded an incident between two people on the registered provider's accident and incident recording system. One person had displayed aggressive behaviour towards another person using the service. We also saw the regional manager had noted the incident in their records on the 2 January 2017. The regional manager had recorded "This to be reported as safeguarding". However, there was no information to show that this had been reported to the local safeguarding authority or to the CQC by the manager. The manager told us they had spoken with the local safeguarding authority and was told it was not reportable. Following the inspection the manager sent us further evidence, but this was about an incident involving a staff member and the person. We also noted that an incident involving this person displaying aggressive behaviour towards staff had been reported by staff in December 2017. There was no information on the incident to show this had been reviewed by a senior manager or that any action taken to mitigate the risk. At the time of the inspection the person was no longer living at the service.

The services key performance indicator training records showed that only fifty three percent of staff working at the service had completed safeguarding vulnerable adults training at the service. It is important that all staff complete training and this regularly updated so they have a good understanding of their responsibilities to protect people from harm.

People must be protected from abuse and improper treatment in accordance with this regulation.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

We examined three people's financial transaction records. We found there were satisfactory arrangements in place for people who had monies managed by the service and safeguard them from financial abuse

The manager told us there had been a number of staff changes at the service. A deputy manager had been appointed in September 2017. A number of care staff had left and new staff had been recruited for the service. During the inspection we did not receive any concerns from relatives, people or staff about the staffing levels at the service.

At the last inspection we saw the deployment of staff required improvement to ensure people who were unable to summon assistance were not left unattended. Some people living at the service had complex needs and did not communicate verbally. We saw it was important to have staff supervision on hand to respond to people if they showed any signs of distress through facial expressions or coughing. Without a staff member in place we saw people were left at risk. At this inspection we check to see if this had improved. During the inspection we noticed there were periods of time (15 minutes or more) when people who were not able to summon assistance were left unattended in the lounge area. We spoke with the manager; they assured us they would review the deployment of staff to ensure people received appropriate support and supervision.

We looked at the safety of the building. We found the registered provider had up to date certificates for aspects of the building, including fire equipment and the servicing and safety of equipment which was in use in the service. We saw that signs were on the doors to the garden area warning people about the uneven surface, to please proceed with caution and do so at their own risk. We spoke with the manager; they told us there were no plans in place yet to address this area. It is important that people have the freedom to access outside space which is safe for people to use. During the inspection we also requested a non-

working bathroom to be locked as it presented a hazard to people.

We reviewed three staff members' recruitment records. The records contained a range of information including, a job application, references, employment contract, interview records and Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. This meant people were cared for by suitably qualified staff who had been assessed as safe to work with people. We also saw evidence that nurse's annual registration and membership with the Nursing and Midwifery Council had been checked to see if they had retained their registration status.

A fire risk assessment had been completed at the service. This showed that there were systems in place to ensure the premises were safe for their intended purpose. The manager told us each person living at the service had a personal emergency evacuation plan in place.

During the inspection we did not identify any concerns in relation to infection control. We saw regular infection control audits were completed by senior staff at the service. One person said, "The place is very clean and spotless, staff help me clean my room to keep it tidy."

Requires Improvement

Is the service effective?

Our findings

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

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Prior to the inspection we reviewed the notifications sent to CQC by the service and the registered provider. We had not received any notifications about the outcome or withdrawal of an application to deprive a person of their liberty. We spoke with the manager; they told us that some people living at the service were subject to a DoLS authorisation. They were not aware that a notification was required. Registered providers need to have robust systems in place to ensure the CQC is notified of outcomes without delay. This showed the registered provider had not checked that the previous manager and the current manager were submitting notifications as required.

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

The manager was unable to tell us the total number of people subject to DoLS authorisation, or the number of applications that had been made. They were able to provide details of some peoples DoLS authorisations and conditions in detail. The manager told us the deputy manager was in the process of gathering all the documentation relating to Dols applications and authorisations in a central file. They told us these records had been previously stored in people's individual records. We noted in the central file that two people's DoLS authorisation had expired. Following the inspection the manager sent us details of all the people who were subject to a DoLS authorisation and confirmed the two people's DoLS had expired. When an authorisation ends, the managing authority cannot lawfully continue to deprive a person of their liberty. If the managing authority considers that a person will still need to be deprived of liberty after the authorisation ends, they need to request a further standard authorisation, in a timely manner, to begin immediately after the expiry of the existing authorisation. The managing authority is the person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty. This showed the manager was not aware of their responsibilities as the managing authority.

The manager and deputy manager told us none of the people living at the service received any medicines covertly. Covert medication is the administration of any medicine in a disguised form without the person knowing. For example, the person's medicine is put in a drink or food. If a person does not have the capacity to consent, any decision to administer medicines covertly must be subject to a best interest

decision. We identified that one person living at the service was being given medicine covertly. There was a letter from the person's GP dated June 2017 about the covert medication, but we did not see any record of a multi-disciplinary 'Best Interest' meeting to discuss this. We also did not see a record of whether the pharmacist had been asked to advice on the correct method of administering the medicines covertly to the person. It is important that the decision to administer medicines covertly is reviewed regularly by a multi-disciplinary team and to include involvement of the people's family or close relatives in the process. This showed the decision to administer the medicine covertly had been made for the person without appropriate legal processes being followed.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Need for consent.

Staff we spoke told us they felt supported and told us senior staff working at the service were friendly and approachable. Some staff told us staff morale at the service had improved with introduction of new staff and others felt the communication within the service had improved.

We checked to see if staff were being appropriately supported and according to the registered provider's policy. The manager provided us with a copy of Mickley Hall staff supervision matrix. Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. This included supervisions that had been completed from September 2017 onwards. We saw that some staff had been provided with regular supervision, whilst we saw some examples when staff had not received any supervision sessions since September 2017. The registered provider's supervision and performance review policy and procedures states that employees will have a minimum of four one to one supervision sessions per year (i.e. every three months) after they had completed their induction. We noted on the matrix that the manager had stated that the safety huddle meetings they completed with senior staff could be classed as a group supervision. However, the registered provider's policy stated that group supervision could only be held with groups of staff who had the same job title and responsibilities. The senior staff who attended these meeting did not all have the same job title and responsibilities. This showed the registered providers had not ensured there was a robust system in place at the service, to ensure staff received appropriate support according to their policies and procedures.

The manager gave us examples where individual staff had been supported to develop their professional skills. However, the services training spreadsheet showed that some staff were not adequately trained and may not have the skills, knowledge and competence that is required. For example, the spreadsheet showed that some support workers had not completed manual handling practical training and/or safeguarding training. Three domestic assistants had not completed infection control training and nine domestics including the supervisor had not completed safeguarding training. The manager told us a letter had been issued to all staff informing them to complete their training by the end of January 2017 or they would not be allocated a shift. This showed the registered provider had not ensured that all staff working at the service had received adequate training.

We also saw the procedures in place to check the competency of all staff who administered medication on an annual basis required improvement. This competency check is recommended by the National Institute for Health and Clinical Excellence (NICE). We shared this information with the manager. They told us they would arrange for staff who had not received a competency check to be completed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Staffing.

A few people were able to share their some of their experience by using non-verbal communications methods to confirm they were satisfied with the quality of care they had received. People we spoke with were satisfied with the quality of care they had received. Comments included, "I'm really happy here, I wouldn't of stuck it here for 14 years and didn't like it, it's really good, the staff are really nice. I've been here 14 years and there have been lots of changes, all for the good. We have some new staff in now; some of the old staff have left. Other staff that have been here a long time are really enjoying having new people here. The new staff are energised, really happy and look like they enjoy the job. They are a breath of fresh air" and "I think this is one of the best places I've ever been to. Why? - Staff have got time for you, they listen to you, you can do what you want, when you want to and in your own time at your own pace. You are allowed to go out any time in the grounds."

In people's records we found evidence of involvement from other professionals such as doctors, optician, tissue viability nurses and speech and language practitioners. Relatives we spoke with also told us they were satisfied with the quality of care their family member had received. Comments included, "I am very happy with the support my [family member] gets here; they [staff] support her really well. There's nothing I would change about the place," "My experience this home it is very positive, they have been in my experience supportive helpful and all of our family have complete peace of mind knowing how well looked after our [family member] is," "Since being at this place [family member] health has improved dramatically, with much less need for hospital," and "My [family member] has been here about x months, I'm very happy the care, and with his health. One family member described the positive impact the treatment from the service's physiotherapist had on their family member. They said, "[Family member] is well looked after. [Family Member] health has been much more stable since being here; the physiotherapist has made huge improvements with his mobility. They [staff] manages his health really well, when I go home I'm not worrying."

We spoke with the cook who described how they planned people's meals and they described people's individual likes and dislikes. They had access to information about people who needed a specialised diet and/or soft diet. During the inspection we identified that some of this information was not correct for one person living at the service. People we spoke with made positive comments about the food provided at the service. Comments included, "The food is very good," and "The food is really really good, I enjoy the food here."

We observed the mealtime arrangements at lunchtime at the service. We saw these arrangements had improved since the last inspection. The dining area was pleasant and food was served from 12 till 2pm. People could choose what time they went to the dining area. People were able to go to the counter and choose what they would like to eat. We saw people were given a choice of food to eat including the option of a vegetarian meal. There was also choice for dessert. The food looked very appetising. We saw no one had to wait for food and that it was well organised. The kitchen staff serving and cooking the food were very pleasant and interacted with people. Support staff were available to support people to get their food if needed. We saw people who needed assistance to eat were appropriately supported. They were offered a food choice by staff and the food was brought to their table. Some people chose to eat food in their rooms. Some people were eating independently and some people were being assisted to eat by staff. We observed this was a positive experience for people as staff were caring whilst providing assistance.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found some concerns about people's dignity not always being upheld. We saw there had been some improvements since the last inspection. For example, we observed the mealtime arrangements at lunchtime and we saw the needs of people now came before staff. Staff working for the registered provider no longer used a corner table in the dining room to eat their lunch. Staff had a staff room now available for them to use. People, relatives and staff all made positive comments about the introduction of new staff at the service and the positive impact this had on the service. The manager told us there had been a change of culture within the service since the last inspection so it was more person centred and people's dignity was promoted. All the staff we spoke with told us they enjoyed working at the service and felt positive changes had been made to the service.

Throughout our inspection the atmosphere within the service was calm, supportive and friendly. We saw positive interactions between people and staff who worked across the service. We saw people enjoying the interaction with staff. We also saw examples of how staff adapted their communication style whilst supporting people. For example, kneeling down so they were on the same level as the person. Support staff we spoke with were able to describe how some people used facial expression, verbal noises, body language and gestures to communicate their choice. One staff member described how one person used objects as terms of reference, to demonstrate they wanted something. For example, the person would pick up a towel to show they wanted a shower.

However, we saw sufficient action had not been taken by the registered provider about the lack of bathing or shower facilities at the service. We were informed at the last inspection these concerns would be addressed in three months. So people could still not routinely be offered a daily shower or bath. A few staff told us they encouraged people to have baths rather than showers because of the limited facilities. The manager told us they had a meeting scheduled with the architect and the contractor in January 2018 to discuss the programme of improvement works. During the inspection we saw warning notices had been put on the windows to the garden about the uneven surface and people choose to enter this area at their own risk. The manager told us that the registered provider had not yet organised the improvements to this area. We saw people did not have the freedom to access this area safely.

Staff were aware of maintaining people's confidentiality and did not speak about people in front of other people. We saw people's personal information was stored appropriately.

People were able to bring personal items with them and we saw people had personalised their bedrooms according to their individual choice.

People told us they were treated with dignity and respect and made positive comments about the staff. Comments included, "I'm very happy here, I think the staff here are absolutely fabulous, deputy manager is really kind and helpful, staff are here to help you and they really do help you" and "It feels like home to me." People were able to bring personal items with them and we saw people had personalised their bedrooms according to their individual choice.

Relatives we spoke with felt their family member was treated with dignity and respect. Relatives described how they also felt supported by staff. Comments included, "Staff are brilliant with both my [family member] and myself, I always feel comfortable when I'm here and I'm made to feel very welcome," "I'm very happy with the care and support [family member] receives here. I'm invited to go on days out with the other residents, I'm always made very welcome when I come here it's like my second home" and "The staff are supportive and caring. I feel we get good support from the staff, I can't find any fault with them." One relative told us how staff had arranged for their family member to go to another city for a family get together. This had never happened before and this had made a difference to their family.

Requires Improvement

Is the service responsive?

Our findings

The service had a written and verbal process in place for the staff handover between shifts. The written documentation gave an overview of the care provided on the previous shift and people's health needs and wellbeing. Robust handovers can help staff to identify and respond effectively to people's changing needs. The manager told us they held 'safety huddle meetings' each morning at the service with the heads of departments. We saw these meetings covered a range of areas including: any falls, any incidents and any safeguarding. However, our findings during the inspection showed the system in place to respond to incidents that occurred at the service required improvement.

The registered provider had a manager on call for weekends and bank holidays; the on call service was for any concerns or situations where the person in charge could call for advice, support or there was an emergency situation or an incident had occurred.

The manager told us the service was in the process of reviewing people's care plans so they were person centred. During the inspection we saw examples of care plans that had not yet been reviewed which were personalised, but not yet person centred. We also saw an example of a care plan that had been reviewed by the deputy manager and saw this was person centred. An account of the person, their personality and life experience, their religious and spiritual beliefs had been recorded in their records. The plan gave in detail how the person liked to be supported.

One person's care records showed they had a risk of Autonomic Dysreflexia (AD). This is a condition that can occur in people with spinal cord injury at or about the sixth thoracic vertebra. This is potentially life threatening and should be treated as a medical emergency. We saw there was a good care plan in place and a copy of this was in the person's room and the service's clinical room. We spoke with the agency nurse working at the service; they had been worked regularly at the service for over a year. They told us they were not aware of this person's risk and had not read the care plan. The nurse assured us they would read the care plan.

Relatives we spoke with told us that they were fully involved in their family member's care planning. Staff kept them informed of any changes in their family member's wellbeing. Some people we spoke with described how they were involved in their care planning. One person said, "Yes I have planning meetings with the manager, my social worker, myself and we all work on the plan, I'm part of that. I'm involved in all the things that happened in my life here."

We saw there was a range of activities provided at the service. On the day of the inspection a few people were supported to go to a shopping centre in the service's mini bus. Some people enjoyed a visit from the 'pat dog'; Jasper the dog regularly visited the service. Some of the people we spoke with described the activities they liked to do outside the service. One person said, "I like going out on day trips, I've been to Southport, Filey and I've been to Halifax." One person told us they liked going to the tram museum and going on holiday.

The service had a large activities room which was split into several sections. This included a computer room, a kitchen area for baking, a music area and an arts and crafts area. One person told us the only thing they would change about the activities would be to open the computer room after 7pm so they could use the computer in the evenings.

People we spoke with told us about the activities they liked to do. Comments included, "I really enjoy me camera and have a video film as well. I enjoy using my computer and having a printer to print the birthday cards off in my room. I have a list of birthdays (people living at the service) and start to prepare the month before. I listening to music 60 70s and 80s. In the summer I do the tubs outside in the garden, I like gardening, this year I going to put some radishes and lettuces out so that we can eat them, last year I did tomatoes I tried sweet peas, but they kept getting blown down" and "I have my laptop, and my own Internet in my room, I like to go on and look at music on YouTube." One person played a song they had composed using a music app on the computer. They had also completed a demo video with support from the activities workers to enter a talent competition. Another person had been supported by staff to adopt two horses at a rescue centre and enjoyed receiving regular updates about the horses.

The Accessible Information Standard 2017 aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand. We saw assisted technology was used effectively to assist people to be more involved in their care planning and pursue independence and to have a more active social life. We asked the manager to provide us with examples of accessible information available at the service. The manager told us the service had an easy read complaints process. We saw the service would benefit from having more documentation available that people can access and understand.

We reviewed the service's complaints log. We saw complaints were responded to in line with the providers' procedures. People we spoke with told us they speak with staff and/or the manager if they had any concerns. One person said, "oh yeah I'd have no problem telling them [staff], I speak to staff when things are not going well, if not I can speak to the [manager], there all lovely folk here. I get on with everybody, Id change nothing; I couldn't improve on it at all."

Relatives we spoke with told us they would speak with the manager if they had any complaints or concerns. They told us they felt confident that the manager would listen and take appropriate action to address their concerns. Comments included, "If you got any concerns, like in the beginning there are a few hick ups, they put things right" and "[Manager] has an open door policy and you can speak to her about anything. If things go wrong they don't hide it, they are honest and talk through things, things are not pushed to one side, and it's very transparent. They [Manager] really try put things in place."

There were end of life care arrangements in place to ensure people had a comfortable and dignified death. At the time of the inspection there was nobody living at the service receiving end of life care. The service was participating in the Extension of Community Healthcare Outcomes ECHO being run by Hospice UK. This is a tool to develop new ways of sharing specialist palliative care knowledge and collaborating with all those involved in supporting the care of people in the last phase of their lives.

Requires Improvement

Is the service well-led?

Our findings

Since the last inspection the interim manager had left the service. The new manager had been managing the service for just over seven months. The manager had applied to register with the Care Quality Commission. A deputy manager had been appointed in September 2017. The manager told us the registered provider was in the process of restructuring senior management and their roles and responsibilities. A new regional manager had been appointed, but they had not started working for the provider.

During the inspection we received positive comments about the manager and the deputy manager from people, their relatives and staff we spoke with. Staff told us the communication in the service had improved. People and relatives told us the manager had an open door policy and listened to any concerns they had.

Since the last inspection, we saw the manager had made a number of changes at the service. For example, recruited new staff, changed the deployment of staff and changed the handover procedures. The manager told us their aim had been to change the culture within the service so it was more person centred. The culture within a service directly impacts on a person's experience of care. The manager provided us with a copy of their overarching action plan dated 5 December 2017. We saw this covered a range of areas including, team leader development and staff deployment. We received positive feedback from the people, relatives and staff we spoke with about the changes that had taken place at the service.

We saw there were regular planned checks completed at the service by senior staff. For example, medication and infection control audits. However, our findings during the inspection showed some of the quality assurance processes required improvement.

This inspection was prompted in part by notification of an incident. We found concerns at service and provider level about the management of risk to people using the service. We saw the service's accident and incident reporting process for staff to report concerns about risks, safety and incidents was not always operated effectively. This showed that risks were not always identified or managed. We saw there was a risk that reportable incidents may not be shared appropriately with the Care Quality Commission and/or the local safeguarding authority. We found examples of incidents that had not been recorded on the registered provider's accident and incident recording system.

We found the systems in place at both service and at provider level to gather and monitor safety related information to look for themes and trends was ineffective in practice. It is important that systems are used effectively to enable a service and provider to learn from concerns, accidents, incidents and adverse events. This showed the registered provider's governance and performance management required improvement.

The manager told us the regional manager regularly visited the service. The manager told us they made handwritten notes of their visit. After the inspection we were sent a copy of the regional manager's handwritten notes. We saw they had regularly visited to the service. Their notes showed they reviewed a range of areas including complaints, individual incidents, staffing and any ongoing safeguarding

investigations. We saw within their notes there were some agreed actions for the manager to complete, but the manager was not provided with a written action plan. We reviewed the service's health and safety checklist record dated 4 December 2017. This record had been signed by the regional manager. We saw under the accident report section the following had been typed in, "All reports have now been put on AIR" (provider's accident and incident recording system). Our findings during the inspection showed this statement was incorrect. This showed the registered providers governance and performance management was ineffective in practice.

During the inspection we found the registered provider had not ensured CQC were being informed about all notifiable incidents and circumstances in line with the Health and Social Care Act 2008. This showed the registered providers governance and performance management was ineffective in practice.

The service had been using a new EMAR system for two months. We saw the registered provider had not ensured that staff received sufficient training and support. For example, we were told by the deputy manager that staff could use the laptop offline, but the two nurses we spoke with were not aware of this. We saw the checks to ensure staff were using the system effectively and to identify whether they needed further training required improvement. This showed the registered providers performance management was ineffective in practice.

During the inspection we found some concerns about one person's records. We saw there was conflicting information for staff to follow about their diet and nutrition. The person required nil by mouth care. When there is inconsistent information available there is an increased risk that people will receive inappropriate care and may be harmed. We saw evidence that this care plan had been audited on the 12 December 2017.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Good governance.

We requested the minutes of the last two residents meetings held at the service. We reviewed the minutes of the meeting held in April 2017. We saw a range of topics had been discussed including, an events calendar and equipment in the activities room. We reviewed the minutes of the meeting held in July 2017. We saw various topics had been discussed including: the redecorating of rooms, the recruitment of new staff, new staff who had started and infection control. We saw a discussion had taken place about the bathrooms and toilets. The response had been that the properties team had visited and were looking at all the options including the refurbishment of the bathrooms and toilets. At the time of the inspection the bathrooms and the toilets had still not been refurbished.

The manager told us that as of result of the "You said, we did" feedback received from relatives and residents in 2017. The service had re-introduced the tea trolley service and introduced staff uniforms. We noticed that the suggestion for staff to have name badges had not been agreed to. The manager told us they were in the process of putting together a portfolio containing information about the different staff members working at the service. This would be available for people and relatives to look at.

Staff meetings took place to review the quality of service provided and to identify where improvements could be made. We looked at the minutes of the October and November 2017 care staff meetings. We saw a range of topics had been discussed in the October meeting including: daily records, training and incident accident reporting. In the November meeting the topics covered included communication, the tea trolley, staffing, staff training and inappropriate moving and handling. Staff meetings can help service's continuously improve.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not ensured CQC were being informed about all notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that care and treatment of service users was only provided with the consent of the relevant person.

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 The provider had not ensured that the risks to the health and safety of service users were assessed in response to any incidents. The provider had not ensured that all reasonably practicable action was taken to mitigate any such risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users must be protected from abuse and improper treatment in accordance with this regulation. Systems and processes must be

operated effectively to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that all staff had received appropriate support and training that is necessary for them to carry out the duties they are employed to perform.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the systems were operated effectively to assess, monitor and improve the quality and safety of the services provided. The provider had not ensured the systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others were effectively operated.

The enforcement action we took:

A warning notice was issued.