Wellbeing Residential Ltd

The Broughtons

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on Wednesday 6 July 2016.

The Broughtons provides residential care for up to 39 elderly people. The home is a detached building, situated in a residential area of Salford and is close to local shops and public transport. Parking facilities are available to the front and side of the building.

At our last inspection of The Broughtons on 30 September 2014, we found the home was meeting all of the standards assessed.

During this inspection we found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment (two parts), staffing (two parts), person centred care, dignity and respect, safeguarding and good governance. You can see what action we have asked the home to take at the back of the report.

People living at the home told us they felt safe as a result of the care they received. Staff also displayed a good understanding of safeguarding and how they would report concerns.

We found staff were recruited safely, with appropriate checks undertaken before staff started working at the home.

We found medication was not handled safely. There were no photographs of people on their Medication Administration Records (MAR's), to reduce the risk of confusion and ensure medicines were given to the correct person. We also found there were no cream charts in place, to demonstrate when creams were applied and to what areas of the body.

We found there wasn't always sufficient staff with the correct skills to look after people living at the home at night. On the night of 5 July 2016, one person had asked for pain relief during the night, however there were no trained staff on shift to administer this safely.

People had risk assessments in their care plans covering areas such as mobility, nutrition and pressure sores, however we found these were out of date and needed to be reviewed. Risk assessments were also not reviewed following accidents and incidents.

We observed one person who was at risk of skin breakdown and needed to be sat on a pressure relieving cushion wasn't sat on one during the inspection, despite raising this with a member of staff.

The environment was not consistently safe. When we arrived at the home and throughout the day, we saw tools such as a power drill and saw had been left unattended in a bedroom which was being refurbished. This increased the risk of people accessing the tools in an unsafe manner, placing people a risk.

Staff told us they received enough training and felt well supported. However two members of staff we spoke with felt they had not been provided with sufficient training and induction since working at the home, yet had been expected to oversee the home in the absence of the home manager. This included being provided with training such as moving and handling.

Staff told us they received supervision at regular intervals from their line manager. We saw records to confirm these had taken place.

We saw the environment at the home was not dementia friendly, with little signage around the building to help people orientate themselves around the building and establish where they needed to go.

We saw restrictive practice in operation at the home. For example, one person's cigarettes were kept on a trolley which the staff dispensed at certain intervals. We could not find a capacity assessment, restrictive screening tool or evidence that a best interest meeting had been convened regarding this practice in the person's file.

The people living at the home and their relatives told us they were happy with the care provided. They told us staff were kind and caring.

We saw instances where the privacy and dignity of people living at the home was compromised. On arrival at the premises we saw that people's underwear was hung over the handrails in the corridors outside their bedrooms. Another person used a urine bottle in their bedroom, however this was left on display, with this person also telling us staff did not always empty it in a timely manner. We also observed this person had baked beans on their clothing, approximately two hours after eating their lunch.

We identified one person living at the home, who did not have a care plan in place, despite living at the home for several weeks. The other care plans we looked at were not updated and reviewed at regular intervals. The care plans we looked at also did not contain photographs of each person. This would make it easier for staff to identify the correct people when delivering care. Two visiting relatives also said they didn't feel involved in the care of their family member.

We saw complaints were handled appropriately. The service also maintained a record of compliments, made by family members and relatives.

The home employed an activities coordinator and we saw people taking part in an activity during the inspection.

On the day of the inspection, the home manager was not present. Two care co-ordinators had been tasked with overseeing the home in their absence. We observed there to be a lack of visible leadership on the day of the inspection. For example, in communal areas we saw people weren't always seated into chairs safely and sat on appropriate pressure relieving cushions. There was nobody overseeing that these tasks were completed correctly by staff, with the co-ordinators predominantly based in the reception area and the senior carer undertaking a medication round for large parts of the day.

The manager undertook audits of areas such as care plans, medication and the environment. The provider also undertook regular audits to ensure high standards were being maintained. However, we questioned the effectiveness of these given they did not highlight the concerns we had identified such as a lack of care plan and risk assessment updates, missing life history information and no cream charts being in use.

One member of staff told us an open and transparent culture was not promoted at the home and that if staff caused a problem for the home during a CQC inspection, that they would be 'Found out'.

The home had a range of policies and procedures in place which provided staff with guidance and advice about various systems and processes to follow.

We saw minutes from recent team meetings, where staff told us they felt able to raise concerns and contribute towards discussions.

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

Not all aspects of the service were safe.

Medication was not given to people safely. The medication rounds took a long time to complete and people did not have cream charts in place.

Risk assessments were not reviewed and updated following accidents and incidents. We also saw tools such as power drills and a saw were left unattended overnight and during the day which could have placed people at risk. One person who needed to be sat on a pressure relieving cushion was not sat on one during the inspection

The skill mix of staff working at the home was not always sufficient to care for people safely at night.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

We saw evidence of restrictive practice where a person's cigarettes were kept on a trolley. We saw no evidence of a capacity assessment or best interest meeting around this decision.

Two members of staff told us their induction was not sufficient and had not been provided with training such as moving and handling.

We saw there were no adaptations around the building to make the environment more dementia friendly.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

We saw instances where people's privacy and dignity was compromised.

People said staff were kind and caring.

People told us staff promoted their independence where possible.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

One person living at the home did not have a care plan in place despite living at the home for several weeks.

The care plans we looked at were not reviewed at regular intervals. The care plans did not always provide sufficient information about people's care such as how to communicate effectively.

Two visiting relatives told us they were not involved in reviews and the initial assessment process.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

We saw there were a number of audits undertaken, however they did not highlight the concerns we had found during the inspection. There was also a lack of oversight during the inspection from senior members of staff.

One member of staff said an open and transparent culture was not promoted.

Feedback about manager and leadership was mainly positive.

The Broughtons

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.

We carried out this unannounced inspection on Wednesday 6 July 2016. The inspection team consisted of three adult social care inspectors from the Care Quality Commission (CQC).

Before the inspection we reviewed all of the information we held about the home. This included notifications sent to us, safeguarding incidents, unexpected/expected deaths, serious injuries which had occurred and previous inspection reports. We also contacted other agencies involved with the home. This included the local Safeguarding team, Healthwatch, Environmental Health, CCG (Clinical Commissioning Group) and Infection Control.

During this inspection we spoke with the following people: the proprietor, four people who lived at the home, four relatives, a visiting healthcare professional, the activities co-ordinator and six members of staff.

We looked at the following documentation; seven care plans and associated documentation, five staff files including recruitment & selection records, a variety of training & development records, audit & quality assurance, policies & procedures and safety & maintenance certificates.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with told us they felt safe living at the home. The visiting relatives we spoke with also told us they felt their family members were safe. One person living at the home told us, "I feel safe. The call alarm is always in reach." Another person said, "I feel safe living here. Nothing has gone missing. I sleep well. I can't lock my door when I leave my bedroom because the key is missing but I just pop a paper in it so I can get back in and nobody ever goes in." A visiting relative also added, "I've no concerns about safety here."

During the inspection we found there were not adequate systems in place to ensure that people had access to their medication when they needed them. We saw medicine rounds were carried out almost consecutively to each other. The morning round which started at 08.00 only finished at 11:00. The senior staff member explained that the lunch time round would usually commence at 12.00 but would commence later at 13.00 due to maintaining the timings between medication. However, the time for administration of pain relief was not consistently recorded so it was impossible to ensure appropriate intervals were maintained between medicines.

We saw people's photograph was not on the MAR chart to support the identification of the person and there were no cream charts in place to inform staff regarding the application of creams. The senior explained that cream charts were in people's bedroom. We checked the bedrooms of three people that were prescribed creams and found no charts available. We asked the senior to show us where the cream chart would be in one of the people's bedrooms. The senior looked through the file and acknowledged that there was no cream chart in place. The MAR chart was not signed to indicate cream's had been applied.

We could not determine that medicines that needed to be given before food were administered prior to people eating because the MAR's were all signed at breakfast/morning and did not indicate the time administered. We found that the registered person had not protected people against the risk of associated with the safe management of medication. This was in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation Safe Care and Treatment.

We found that the home did not always mitigate risk well. On arrival at the home, we saw that a bedroom on the second floor of the home was in the process of being refurbished. The bedroom door had been left open and unlocked overnight with tools such as a saw and power drill left unattended. Additionally, at various points during the day, we also observed this area to left unattended, with the tools not stored away safely. We saw that several people living at the home were mobile, which meant they could potentially access the tools and use them in an unsafe manner.

We looked at the care plan of one person living at the home who was at risk of developing pressure sores, although their skin was currently intact. The care plan stated they should be on a pressure relieving cushion when in the lounge; however we observed they weren't sat on one. We raised this with the senior carer who took no action to address this due to undertaking a medication round. We also spoke with the manager about it following the inspection who stated that because this person was currently mobile, they often changed seats during the day. However we had observed there was a lack of oversight in the lounge area to

ensure tasks such as this were being completed.

We saw that people had risk assessments in their files covering areas such as Malnutrition Universal Screening Tool (MUST), falls and pressure sores. In the care plans we looked at, we noted that these were last reviewed in February 2016. We saw evidence of where this had an impact on people living at the home. For example, we noted that four people in particular had fallen since their falls risk assessment was last updated. This meant staff would not have up to date information available to them about how to effectively mitigate any risks presented to people living at the home. We saw that the risk had been mitigated however, due to falls service referrals being made and appropriate equipment being in place.

Due to the risk assessments not being reviewed, people not being sat on appropriate pressure relieving equipment and the environment not being consistently safe, this meant there had been a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. This was because the home was not doing all that was possible to mitigate risk.

We checked to see if there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed at the home. We received a mixed response from staff about current staffing levels. One member of staff said, "I would say we cope pretty well at nights, but last night there was nobody on to give medication when a person asked for it." Another member of staff said, "Today has been a struggle due to sickness. It has impacted on people getting up at the times they want and for their preferred time for breakfast." Another member of staff said, "I've worked both days and nights here and I now feel there are enough staff." Another member of staff added, "Staffing levels are ok at the minute. There are six on during the days and we are able to meet people's needs."

We were told there was no formal dependency tool in place to determine staffing levels at the home. We arrived at the home at approximately 7am and saw the home was staffed by three care assistants. We found there had been no senior member of staff on duty that night that was able to administer medication. This had resulted in a person that had requested paracetamol being unable to be given any. We spoke to the person to ascertain whether they had been left in discomfort but they were unable to remember requesting the pain relief. We were told that the senior member of staff had called in sick that night but was not replaced. A senior member of staff was 'on call' during the night and could be contacted for assistance with tasks such as administering medication. However on this occasion, the member of staff wasn't contacted until earlier the next morning. The day shift was staffed by two care co-ordinators, three care assistants and a senior carer. The senior carer on duty had been called in at the last minute to replace a member of staff that wasn't coming in that day.

We saw staff were not always deployed in the correct areas of the home. For example, we observed, on three occasions that the lounge area was left unattended for between seven and 10 minutes, where up to nine people were seated. We observed that staff were elsewhere in the home such as assisting people in their bedrooms, or congregated near the main reception area. At one point, we saw a person enter the lounge area using their zimmer frame. They looked unsteady on their feet and struggled to seat themselves in an arm chair. This person's care plan described them as being at 'Extremely High Risk' of falls. According to accident and incident records, they had also had several unwitnessed falls, some of which were in the lounge area. Another resident asked this person if they were ok and got up and helped them to safely manoeuvre into the chair, however no staff were present to assist this person.

Due to their being no senior member of staff at night and staff not always being deployed in correct areas of the home, this meant there had been breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to Staffing.

We saw there were appropriate systems in place to safeguard people from abuse. Staff also displayed a good understanding of how they would report concerns. One member of staff said, "I have raised a few safeguarding concerns since working at the home. Signs and symptoms of abuse could include people being withdrawn, teary, not being themselves or if I saw any bruising. I would document everything and report it to my manager." Another member of staff told us, "Safeguarding is all about keeping people safe. Cuts, marks on their body or people not being given food could be signs of potential abuse." A third member of staff added, "We must protect people living here first and foremost. If people's money was disappearing, then that could be a sign of financial abuse."

We found people were protected against the risks of abuse, because the home had appropriate recruitment procedures in place. We saw that appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection we looked at five staff personnel files. Each file contained job application forms, interview questions, proof of identification, a contract of employment and suitable references. A Criminal Records Bureau or Disclosure Barring Service (CRB or DBS) check had been undertaken before staff commenced in employment. CRB and DBS checks help employers make safer recruiting decisions and prevent unsuitable people from working with vulnerable adults.

We checked to see if the home was clean, tidy and well maintained. The home employed two domestic members of staff who worked 80 hours each week between them. We saw there were daily, weekly and monthly cleaning schedules in place and had been completed. We observed domestic staff wearing personal protective equipment as appropriate and saw chemicals were stored safely. During the inspection we looked around the building. The home was clean throughout and free from mal-odours.

There was a range of documentation in place relating to the maintenance of the building which we saw were all up to date. These included: legionella checks, portable appliance testing, fire extinguisher checks, fire risk assessment and evacuation plan, weekly check of means of escape, weekly test of emergency lighting, gas safety inspection certificate, lift servicing and repair records, pest control inspection, hoist examination certificates and water temperature checks in bedrooms.

Requires Improvement

Is the service effective?

Our findings

We looked at the induction and training staff received whilst working at the home. Two members of staff told us they felt the induction and training they had received had not been sufficient. This was because they had been expected to oversee the home in the absence of the registered manager, yet had only worked at the home for four and nine weeks respectively. One member of staff told us, "I've not yet been provided with safeguarding and moving and handling training and it wasn't covered in my induction. I think we definitely need moving and handling training and we are hands on and are expected to get involved with care and answer buzzers." Another member of staff said, "It wasn't what I expected and the induction wasn't sufficient and we are in charge of the building at the minute. I expected more input from management. It feels as though we have just been told to get on with it without being given everything we need. I've not yet been given training in moving and handling, health and safety and infection control. The manager acknowledged that this training had not yet been provided, but would be prioritised following the inspection.

This meant there had been a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to Staffing. This was because staff did not always receive such appropriate training to enable them to carry out the duties they are employed to perform.

The remainder of staff were spoke with were more complimentary about the training, support and induction they received. One member of staff said, "I did receive an induction and it was ok. It gave me everything I needed. It's good to get refresher courses." Another member of staff said, "There is enough training available and it is always on going. We always seem able to ask for advice. I feel appreciated here." Another member of staff added, "The induction gave me a good introduction into working at the home. I feel like I get enough training. I do training in my own time, but the support is always there."

Staff told us they received supervision at regular intervals from their line manager. We saw records to confirm these had taken place. We saw these provided a focus on current duties/tasks, training, policies and procedures, safeguarding, infection control, food hygiene, medication and any additional concerns. The staff we spoke with told us supervision was consistent. One member of staff said, "We tend to get roughly four supervisions a year. They seem to be pretty good at keeping on top of them."

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 registered manager was unable to facilitate our inspection and we found that none of the staff on duty had access to the information required. The staff were unable to identify the people living at the home who were subject to DoLS or inform us what the safeguards entailed. The registered manager sent us a DoLS matrix but this did not indicate when the request had been submitted, granted or followed up with the local authority.

We saw restrictive practice in operation at the home. For example, people's cigarettes were kept on a trolley which the staff dispensed at certain intervals. One person told us, "They keep my tobacco. I get it at set times; after breakfast, after dinner, after tea. They say that I smoke too much but I think it's my choice."

We could not find a capacity assessment, restrictive screening tool or evidence that a best interest meeting had been convened regarding this practice in the person's file. We asked the staff why there was a cigarette trolley and we were told, "Some of the families had asked that their relative's cigarettes are restricted." We asked whether the people had capacity and if not whether their family members had power of attorney for health and welfare. Staff acknowledged that some of the people that had cigarettes on the trolley possibly did have capacity and the staff were unsure regarding power of attorney for other people. This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safeguarding people from abuse and improper treatment.

We looked at how the home sought consent from people living at the home, however we saw there was no written consent in people's care plans to demonstrate people were in agreement with the care they received. We raised this with the manager when we gave feedback following the inspection. We observed staff seeking consent from people prior to assisting with moving and handling and when placing tabards on people during meal times. The staff we spoke with were able to demonstrate how they sought consent from people living at the home. One member of staff said, "I always ask people what exactly it is they need and how they would like me to help them."

We saw the environment at the home was not dementia friendly, with little signage to help people orientate themselves around the building and establish where they needed to go. Several bedrooms had information on the door about whose room it was, but this was inconsistent throughout the home, with some just having a room number. We saw there was no signage towards areas such as the dining room, bedrooms and the lounge area. During the inspection we encountered two people asking where they were and how to get their bedrooms.

We recommend the home looks at appropriate guidance about how to make the home more 'Dementia Friendly'.

We looked at how people were supported to maintain good nutrition and hydration. We saw people's nutritional needs were assessed and people had nutritional care plans in place.
The nutritional plan identified whether people had special dietary requirements, for example, one person was diabetic which was clearly documented. We saw the service worked closely with other professionals and agencies to meet people's health needs. However, eliciting the information to demonstrate involvement with these services was difficult and care plans had not been updated to reflect the input or recommendations.

We observed the meal time experience at the home at both breakfast and lunch time. We observed staff asking people what people wanted for breakfast, however we saw no full English breakfast was provided as the chef only came on duty at 10.30am. However we saw one person asked for boiled eggs and this was provided.

At approximately 11.45 prior to lunch, we observed 10 people seated in the lounge, with no staff present and no conversations taking place between people. Staff later came in to inform people it was lunch time. At approximately 12pm, 18 residents were sat in the dining room waiting for lunch. We noted a vinyl record player was playing loudly until the activities coordinator came in and turned it down. The menu was displayed on the dining room wall, which was hand written. We saw the lunch provided was cheese and onion pie with chips and beans or shepherd's pie with vegetables, and artic roll. One person required a forked-mash diet and this was provided. Staff observed this person throughout the lunch from a distance. We observed most people were able to eat independently without staff assistance.

We saw tables had cutlery and condiments on them, with staff wearing appropriate equipment such as gloves and aprons. Three people had their meals taken to their bedrooms, which staff told us was their choice. We saw staff completed individual food and fluid charts as people finished their meal. The kitchen had an information sheet that identified people's different diets such as if they were diabetic. We observed that staff were kind and demonstrated patience when interacting with people. One person was observed to become agitated on several occasions (raising their voice but no other aggression) and staff quickly de-escalated the situation, calming the person down quickly.

We asked people for their opinions of the food at the home. One person said, "The food is good, really enjoy it." Another person said, "The food is good and lots of choice. We get fruit and there is always a jug of juice in my room." However a third person told us, "The foods not bad but it could be better. We get sandwiches a lot. We don't get a choice of foods, it's mainly frozen pies and stuff out of tins. We don't get many vegetables and we definitely don't get the fruit and vegetables that we should."

Requires Improvement

Is the service caring?

Our findings

The majority of people we spoke with said they liked living at The Broughtons and were happy living there. One person living at the home told us, "It's okay living here. It's a quiet home and that suits me. No care home could be absolutely perfect. I think this one is okay." Another person said, "I feel well looked after here and think I am receiving good care." A third person said, "I like some of the staff. They are very friendly and go out of their way to help you."

A visiting health care professional also said to us, "The staff interactions with people living here are good. I've only observed positives. Staff knock on people's doors when they are showing me to a person's room. The staff treat people with respect."

The visiting relatives we spoke with told us they were happy with the care being provided at the home. One relative said, "In my honest opinion, I have been taken aback with the politeness and kindness of the staff. It's the same from the lowest to the highest. The home feels more relaxed than others I have been in. Overall I think the care is reasonably good." Another relative said, "The majority of the girls are absolutely fabulous and our relative gets on with them great. They have a laugh. The staff do go the extra mile. When we see the staff and the interactions. It is really nice."

During the inspection we observed interactions between staff and people living at the home. We observed lots of appropriate kissing, holding hands and joking/banter. The people who lived at the home and relatives told us they felt staff were kind and caring. One relative told us, "The staff look after everybody and seem to work very hard."

As part of the inspection we checked to see that people were treated with dignity and respect by staff, however we saw instances where this was compromised. For example on arrival at the home, when walking around the building, we saw people's underwear was hung over the handrails in the corridors outside their bedrooms which anybody could easily see when they walked past. Another person used a urine bottle in their bedroom, however this was left on display, with this person also telling us staff did not always empty it in a timely manner. We also observed this person had baked beans on their clothing, approximately two hours after being supported to eat their lunch. This person also told us, "They are sometimes a long time before they answer the call bell though and then I have an accident. There are some nice staff and other staff that just say 'No'. I've buzzed and when they've come they say they are busy but they don't come back." This meant there had been a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Dignity and Respect.

We asked staff about their understanding about treating people with dignity and respect. One member of staff said, "When people are incontinent, we are discreet. I wouldn't let anybody else hear. When in the bathroom, the door is shut. When I change people and they are undressed, I make sure they are covered with a towel and not exposed. Speak with people all the time so they are relaxed and tell them what you are doing." Another member of staff told us, "I always ensure privacy during person care. I discuss things with people in private and never discuss people's circumstances in front of others."

We also spoke with staff about how they aimed to promote people's independence when providing care. One member of staff told us, "I say to people, if you don't use it. You'll lose it. Staff think they are helping by doing things for people but it's not. It's about supporting and encouraging people to do it. There is a person here that would go in their wheelchair all the time but I always encourage them to walk a short distance or they'll lose the ability." Another member of staff said, "I'll see what people can do for themselves. I'll allow people to wash themselves on their own and even small things such letting people hold a cup and drink themselves."

Requires Improvement

Is the service responsive?

Our findings

We saw examples of where the home had been responsive to people's needs. For example, where people had suffered several falls, the home had made appropriate referrals to the falls service and had got appropriate equipment in place such as sensor mats to alert staff when they tried to mobilise.

People living at the Broughtons had their own care plan in place. During the inspection we looked at seven care plans and saw they provided a focus on people's daily routines, personal care/continence, eating and drinking, skin, washing/dressing, mobility/transfers and communication. We found that care plans were not dated and we saw no evidence that care plans were updated and reviewed at regular intervals. The manager told us the care plans were reviewed and held on a computer and would send evidence of this following the inspection, however this was not sent to us.

One person living at the home also did not have their own care plan. We raised this with staff and were shown an initial care plan produced by the local authority. The manager told us they would send the care plan following the inspection, however they sent us the same one from the inspection (from the local authority). We found care plans did not always contain sufficient information about people's care. For example, in one care plan we looked, it described how a person struggled to communicate verbally and was hard of hearing. We saw there was insufficient information about how to communicate with this person effectively, with nothing to tell staff about what to do. This meant staff did not have up to date and current information about people's care needs.

In the care plans we looked at, we saw there were no pictures of people, which made it difficult identifying people living at the home. This would be of particular importance for new members of staff, to ensure they provided care to the correct people. People also had life history information and details about their personal preferences, however we observed some of these were incomplete and had not been assessed. This meant staff would not always have access to information about how to provide person centred care to people. Following the inspection we were sent a blank 'Map of Life' template, which we were told would be completed for each person.

Two visiting relatives we spoke with said they didn't feel involved in the care of their family member. One relative told us, "No. I wasn't involved in an initial assessment and they've never asked me about [my relative] and what they were like before they came here." Another relative said, "No. Nobody asked me about a life history, likes/dislikes. I have also not been invited to reviews or ever seen and been involved in the care plan."

The issues relating to regularly assessing and reviewing care plans, involving relevant people, assessing people's life history information and ensuring care plans contained all relevant information meant there had been a breach of Regulation 9 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Person Centred Care.

We looked at the activities available at the home and how people were stimulated whilst living at the home.

During the inspection we spoke with the activities coordinator, who was employed to work at the home 20 hours per week. They told us twelve people were visiting Blackpool the following week, using community transport. A hotel had been booked for the day to include bingo, food and entertainment. A risk assessment had also been completed for each person to ensure their safety. Several staff were attending and would be met by family members when they got there, with family members travelling also.

There was an activities schedule in place which included singers, bingo, arts/crafts, film day, songs and a dance class. We saw examples of posters that had been created for different events which were posted on notice boards such as 'Charleston Charlies' and Queens Birthday celebrations. The activity co-ordinator told us they met with people each month to discuss ideas, and we saw records to support these discussions, and also went round the home with a mobile shop selling snacks, toiletries and sundries. We saw some other activities which were waiting for dates to be identified included visiting the Ukrainian club, exotic animal encounter, donkey sanctuary, Salford museum, garden open day, race night, Bolton academy, ballet and tap class, morris dancers and Irish dancers.

We saw complaints were handled appropriately, with a response detailing any investigations that had taken place. A complaints and compliments file was in place and information on how to make a complaint was posted in people's bedrooms. The home had also received several compliments, which read, 'We can't thank you enough for the care love and support you gave Mum. You were a huge part of not only Mums life, but ours too. We will never forget every one of you'. Another one read, 'All your hard work, love, support and effort is truly appreciated, so thank you for looking after me'. One person living at the home said, "I've not needed to complain. I'd tell one of the care workers if I had a problem and they'd sort it out."

Requires Improvement

Is the service well-led?

Our findings

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

The staff we spoke with said they felt the service was well-led. One member of staff said, "The manager is approachable." Another member of staff said, "It's alright I would say. The manager seems to have a good relationship with staff from what I've seen and interacts well." A third member of staff said, "The manager is fine and I haven't got a bad word to say. Also seems to be quite flexible around personal circumstances." A fourth member of staff told us, "We all seem to work together as a team. We can raise concerns."

On the day of the inspection, the home manager was not present. Two care co-ordinators had been tasked with overseeing the home in their absence. We observed there to be a lack of visible leadership on the day of the inspection. For example, in communal areas we saw people weren't always seated into chairs safely and sat on appropriate pressure relieving cushions. There was nobody overseeing that these tasks were completed correctly by staff, with the co-ordinators predominantly based in the reception area and the senior carer undertaking a medication round for large parts of the day. We had also observed tools to be left unattended throughout the day in a bedroom being refurbished, however staff had not raised this as an issue.

We looked at how the quality of service was being monitored to ensure good governance. The manager undertook audits of areas such as care plans, medication and the environment. The provider also undertook regular audits to ensure high standards were being maintained. However, we questioned the effectiveness of these given they did not highlight the concerns we had identified during the inspection. This included a lack of care plan and risk assessment updates, restrictive practice screening tools not being completed, care plans lacking detail about people's care, missing life history information in care plans and no cream charts being in use to show when they had been applied. These issues meant there had been a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Good Governance. This was because the home did not have effective systems to assess, monitor and improve the quality and safety of the services provided.

We looked at the minutes from a recent staff meeting that had taken place. Some of the topics for discussion included arranging appointments, care plans, reviews, auditing food & fluid charts, turning charts, rotas, supervisions, medication audits and weights. Other things discussed included budgets, concerns and the key worker system. The staff we spoke with said these meetings were regular and they were able to contribute towards agenda items and the content of the meeting. However, one member of staff told us that an open and transparent culture was not promoted at the home. We were told, "Staff feel positively depressed. It's not a nice atmosphere to work. It's a poor culture and staff can't speak out through fear and we can't influence change. We were told at a meeting, we'd be found out if we caused a problem for the home with CQC. Bully tactics are used and shifts drop if you speak out. It feels like we could lose our job

at any time."

Providers are required by law to notify CQC of certain events in the service such as deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

The home had policies and procedures in place, which covered all aspects of the service. The policies and procedures included safeguarding, complaints, whistleblowing, and medication. This meant that staff had access to relevant guidance if they needed to seek advice or clarity about a particular area.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There were in effective systems in place to ensure the home had carried out, with the relevant person, an assessment of the needs and preferences for each person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There were ineffective systems in place to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were ineffective systems in place to ensure people were safeguarded from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems in place to ensure the quality of service was being monitored effectively to ensure good governance.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were ineffective systems in place to manage medication safely. There were ineffective systems in place to mitigate risk at the home.

The enforcement action we took:

We issued a warning notice against this regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive sufficient training to support them to undertake their role effectively. Staff were not always deployed effectively within the home and did not always have the correct skills.

The enforcement action we took:

We issued a warning notice against this regulation